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The important role of physicians in addressing the psychological aspects of Interstitial Cystitis/Bladder Pain Syndrome (IC/BPS): A qualitative analysis

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Abstract

Introduction—Interstitial cystitis/bladder pain syndrome (IC/BPS) is a poorly understood source of chronic pain causing significant morbidity, with variable treatment success. Despite the need to understand patient perspectives in chronic pain, there is a paucity of qualitative data for IC/BPS. We aimed to acquire information regarding patient experience with IC/BPS symptoms and with their medical care to elicit suggestions to improve patient satisfaction with that care.

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Methods—Fifteen women with IC/PBS participated in a total of four focus groups. Sessions were recorded, transcribed, and information was de-identified. Focus groups were conducted until thematic saturation was reached. All transcripts were coded and analyzed by a minimum of 3 independent physician reviewers. Investigators identified emergent themes and concepts using grounded theory methodology.

Results—Participant's mean age was 52.6 years with an average IC/BPS duration of 6.3 years. Thematic saturation was reached after 4 focus groups. We identified three emergent patient experience concepts; IC/PBS is debilitating, the disease course is unpredictable and unrelenting, and patients experience significant isolation. Importantly, suicidal ideation was expressed in each group. Patients voiced strong preference for physicians who provided education regarding the condition, an array of treatment options, presented organized treatment plans and offered optimism and hope regarding treatment outcomes.

Conclusions—Our study presents novel findings of the importance of patient-physician interaction in IC/BPS and reinforces the tremendous disability and burden of this disease, which frequently manifests in suicidal ideation. Patients preferred organized treatment plans with diverse choices, and providers who offered hope in dealing with their condition.

MeSH Terms

Chronic pain; Complementary Therapies; Cystitis; Interstitial; Emotional Stress; Qualitative research

Introduction

Interstitial cystitis, also known as bladder pain syndrome (IC/BPS), is defined by the American Urologic Association as “an unpleasant sensation, perceived to be related to the urinary bladder, associated with lower urinary tract symptoms of more than six weeks duration, in the absence of infection or other identifiable causes” [1]. Though estimates vary, as many as 2–7% of women are affected by IC/BPS [1], and some argue the disorder is significantly underdiagnosed [2]. IC/BPS causes considerable morbidity, loss of function at work and at home, and has been specifically associated with an increased risk of depression and suicidal ideation. [3–7]

The pathologic etiology for IC/BPS remains poorly understood [8], and given that it is a symptom complex by definition, it may represent the end state of several different pathologic processes [9,10]. Unsurprisingly, there is wide variation in treatment success [11]. The majority of prior research has been focused on elucidating bladder pathology and treatment regimens. IC/BPS heterogeneity, chronicity and resistance to treatment mirrors other chronic pain syndromes and a patient centered treatment approach may improve treatment efficacy [9].

Understanding patients' perspectives is important in chronic pain, where currently available treatments fail and the provider-patient interaction may increase the probability of treatment response [12,13]. Patient-centered care has been demonstrated to improve overall health outcomes [14]. Specifically, the importance of the patient-physician interaction on symptom improvement in chronic pain syndromes should not be underestimated [15]. Unlike

quantitative research which sets out to test a hypothesis, qualitative research uses patients' input to generate further understanding about a condition, which then produces new hypotheses. Qualitative research provides insights into disease classification and, among women with overactive bladder, has allowed for defining treatment goals in a more patient centered manner [16–18]. Focus groups are used to gather information and it is known that interaction between patients with the same condition facilitates discussion, revealing underlying issues or themes[21]. Focus groups have characterized flares in women with IC/BPS [19,20], but have not addressed patient satisfaction with care or patient-provider relationships. The purpose of this study was to gain further understanding of IC/BPS from a patient centered perspective based on grounded theory [21]. This study used focus groups to 1) understand IC/ BPS from the patient perspective, and to 2) describe patient satisfaction with their medical care, ultimately aiming to improve treatment delivery.

Methods

Institutional Review Board approval (#15–117) for the study was obtained and written consent was obtained from all participants prior to focus group participation. Patients with a diagnosis of IC/BPS were recruited from the UNM urogynecology clinic, and were invited to participate in a focus group to discuss their experience with the condition. Inclusion criteria included non-pregnant, non-incarcerated women with a known diagnosis of IC/BPS as defined by the American Urologic Association and has been noted previously as, “an unpleasant sensation...perceived to be related to the...bladder...of more than six weeks duration...in the absence of other...causes [1]. Inclusion criteria also included age greater than 18 years old and ability to speak and understand English. Those who agreed to participate attended any 1 of 4 focus groups, depending on their availability. Prior to initiation of the focus groups, the investigators generated a focus group script including specific questions or probes (Table 1) to explore patients' experience with the condition and their experiences with physicians. Written informed consent was obtained and demographic and clinical information were collected. Each focus group was led by an experienced non-clinical moderator, using open-ended questions to facilitate discussion and allow group participants to dictate important issues. An iterative process was used, with revisions to the script made prior to each focus group session as needed. This allowed for additional exploration of issues and concepts brought up by focus group participants. Focus groups were conducted until thematic saturation was reached; that is until sufficient repetition of themes were noted by multiple investigators.

During each focus group the moderator introduced each session with a brief introduction and helped guide the discussion using the previously described focus group script. Each focus group session was anticipated to last 2 hours but continued as long as participants had additional information to discuss. Focus groups were recorded, de-identified and transcribed, and “coded” by at least 3 authors per transcript using the Dedoose 6.2.21 software (Los Angeles, CA). Coding is the act of assigning 1 or more categories to ideas that are discussed, and based upon grounded method theory, ideas from codes were grouped into themes, which were then organized into emergent concepts [21,22]. Using constant comparative methodology [21,23], new ideas were continually compared to what had already been generated in order to combine like ideas. Content reviews were conducted after focus groups

2, 3 and 4 to generate a list of conceptual gaps that had not been explored sufficiently or probes that may have been overrepresented. Minimal revision of probes occurred throughout the process. Following completion of all focus groups and during the analytic process, themes were further organized, refined and decided upon by investigators, in order to create a conceptual framework which best represented the ideas generated by the focus groups. Patient characteristics were evaluated with descriptive statistics, including means and frequencies.

Results

Between September and December of 2015, 4 focus groups were conducted, comprised of 2–6 patients per group. The majority of patients were recruited from the UNMH urogynecology clinic, were well educated, Caucasian, with a mean age of 52.6 ± 9.7 years. Participants had the diagnosis of IC/BPS for an average of 6.3 years, had been symptomatic for an average of 12 years, and accordingly, were not treatment naive. Other patient characteristics are described in Table 1.

After line-by-line coding was performed, qualitative analysis revealed 3 emergent concepts regarding patients' conception of their condition, as well as several themes concerning patients' perceptions of their medical care (Tables 3 and 4). Overall, the theme of pain was the most commonly mentioned by focus group participants, and played a central role in shaping each of the emergent concepts. Notably, the theme of suicidality was brought up in each of the 4 focus groups spontaneously.

PATIENT CONCEPTS OF THE CONDITION

Emergent Concept 1- IC/BPS is a life altering debilitating condition—Patients were initially prompted to discuss their experience with IC/BPS and to describe the impact it had on their lives. Probes around this topic prompted patients to elaborate on the severity and quality of their pain, eliciting statements such as: *“Like somebody is taking sizzling hot cattle prods and sticking it in your bladder”*. Other comments revealed the level to which symptoms have interfered with patients' lives, especially concerning the impact it had on their quality of life. *“I love going to a theater, but it's to the point where I can't sit through a movie”*. Patients consistently described the effect on their quality and duration of sleep and the difficulties caused with travel and activities of daily living. Another common theme surrounded the impact of IC on the patient's ability to work and a lack of understanding on the part of their employers. For example, a patient stated, *“I haven't changed my job because I don't know what job I could do where I could have my IC and function in the job.”* Given the stated negative effects of IC/BPS and the limitations placed on their lives, it is not surprising that the themes of desperation, depression and suicidality presented itself in each group. Patients spoke of feeling that they wanted to end their lives due to the impact IC/BPS has: *“I think the last full flare that I had, I really contemplated ending my life. It was so miserable”*. Whether IC/BPS precipitated this feeling of depression or if depression itself might predispose to IC/BPS was unclear due to the qualitative nature of the information derived from these focus groups. Investigators agreed that these themes represented the emergent concept of life-altering debilitation.

Emergent Concept 2-Fear and Anxiety from the unrelenting and unpredictable nature of the disease

Patients often remarked that the chronic nature of the disease contributed to their suffering. Given the lack of understanding of the pathophysiology of IC/BPS as well as difficulty finding a successful treatment or cure, a major concern for patients was that their diagnosis was, "...a life sentence." Patients were aware from friends and/or the internet of the potential severity and unrelenting nature of the disease, as well as the "last resorts" for treatment, stating: *"I'm getting older ... I worry, you know, because I'm not a person who would walk around with one of these external bladder bags."* This idea was overwhelming for some people. The inability to predict the course of the disease and its potential progression was extremely unsettling. *"At some point you're just gonna have a flare that's so bad that the current treatments for it don't work and then, what do you do?"* Patients were bothered by the unpredictability of IC/BPS flares and noted that *"it is always lurking."* The uncertainty and unpredictability of their suffering made patients reluctant to plan for the future.

Emergent Concept 3-Isolation—We specifically asked patients how they felt their condition was perceived and understood by others. Patients with IC/BPS frequently described the isolation that comes from the specific limitations imposed by their disease. This emergent concept of isolation stemmed from a lack of understanding from family, friends, and employers. Focus group discussion commonly revolved around comments that family members did not understand what it was like to live with the condition: *"They don't really understand when I'm in pain... It's just like, well, mom, how am I gonna get to school?"* As IC/BPS flares can be exacerbated by foods and beverages such as alcohol or caffeine, maintaining social relationships with friends and family (which also revolve around food and beverages) was noted to be particularly difficult. A patient stated, *"My friends, ... they love to enjoy life and when you can't go out to dinner ... it can be difficult to maintain those relationships"*. Sexual intimacy, an important part of many relationships, appeared to be a particular struggle for many with IC/BPS. A patient noted: *"I think we've probably all had times where we were hurting and we just kind of went through with it anyway and, you know, paid the price."* Besides lack of understanding from friends and family, patients also expressed isolation resulting from lack of provider understanding regarding their condition: *"Then they kind of treat you like you're a hypochondriac. I'm like you, believe me, I don't ever want to go to a doctor if I don't have to. I avoid the instillations.I don't want to complain. I want to forget about feeling horrible. I am not a hypochondriac and my doctors should all know that because every time that I have complained about something repeatedly it has always turned out to be something."* Not surprisingly, many patients related stories about providers who did not understand or believe in their condition. The theme of significant loneliness and isolation emerged from the lack of understanding experienced by patients from family, friends and providers as well as the cost that IC/BPS imposed upon work and inter-personal relationships.

PROVIDER IMPACT

Patient-identified themes on how providers can positively impact this condition—Given the chronic nature of IC/BPS and the lack of curative treatments, investigators were particularly interested in how to most effectively improve patient care.

Participants were asked about both the positive and negative experiences they'd had with physicians and other providers, and what patients desired to hear or needed from their doctor. From their responses, we identified 3 major themes that seemed crucial in caring for this group of patients (Table 4): 1) Patients wanted to know that all their providers (irrespective of whether they were physicians, nurses, physical therapists or otherwise) were truly listening to them. Many expressed that they had been very discouraged about their condition when this failed to happen: *"We live inside these bodies, they don't... I was trying to share information with them and it was as if there was a total blank wall there"*. They stated that effective treatment required providers to understand that their disease experiences were real and that their needs were valid. 2) Focus group participants desired increased knowledge about their condition and largely preferred to hear about treatment options. During initial visits patients wished to acquire knowledge about IC/PBS, requested information of potential causes of IC/BPS and alternatives to treating it. When patients had undergone unsuccessful treatments, they wanted to know about the additional options that existed rather than hearing that there was nothing that could be done for them: *"She talked about acupuncture again. She talked about tai chi. She talked about relaxation. She is so great. She is so creative. She wants to try everything. You know, so that kind of saved me."* Many participants preferred a discussion that included complementary/alternative medicine treatments. They asked for information about these therapies, even if data regarding effectiveness were still lacking. They stated that willingness to discuss the treatments was preferable to being given the impression that there were no further options and being abandoned by frustrated care-providers. 3) Last, it was clear that provider expression of hope for improvement of their symptoms was vital: *"the emphasis on just the treatability versus the curability aspect is very important as a patient...to really sound encouraging instead of, 'oh, we're going to try this again'. I think as far as like the depression issue is concerned, I think respect, creativity, hope helps a lot."* Encouragement from providers that they were willing to explore other potential avenues for improvement was very important to patients. They expressed the need to form a partnership with physicians and medical personnel in order to develop workable treatment plans to cope with this chronic and unpredictable condition.

Discussion

We found that focus groups allowed effective investigation of the patient experience with IC/BPS and investigation into what they desired from care providers. We found 3 emergent themes defining the IC/BPS patient experience and identified specific ways in which physicians could positively affect the patient experience. The 3 emergent themes central to the IC/BPS patient experience included descriptions regarding; 1) how debilitating it is 2) how unrelenting and unpredictable it can be and 3) the isolation that results from it. Providers need to listen to patients, express hope that their symptoms will improve, and, after educating them about the condition, encourage patients to try a variety of treatments, including alternative therapies.

Though patient suffering can be measured by a visual analog pain scale or the O'leary Sant Symptom Problem Index, the specific descriptions given by patients regarding their pain (Table 3) may more aptly describe their experiences. The impact of IC/BPS on quality of life

issues, such as insomnia, has been described in prior qualitative studies [24], and was echoed by the patients in our focus groups. The physical impact of the disease, as well as its disruptive effect on work and travel (Table 3) contributed to the disability caused by IC/BPS. This certainly illustrates why, as of 2002, IC/BPS has been considered a valid condition for individuals to receive Social Security Disability Insurance (SSDI) benefits [25].

The unpredictable nature of IC/BPS causes suffering. Fear of unexpected occurrence of pain in any chronic pain condition can be debilitating. A qualitative study by Sutcliffe et al. [19] noted that the unpredictability of flares can be extremely detrimental, often discouraging patients from carrying out day-to-day activities and planning for long-term goals. We also found that the unpredictable nature of this disease with regard to short-term and long-term outcomes is a major patient concern, including potential for disease progression. Participants seemed well aware of the limitations in knowledge about IC/BPS pathophysiology as well as the shortcomings of treatments, which could increase patient concern about the condition's unpredictability. These issues contributed to patients' fear of its long-term progression. The accessibility of online IC/BPS information, which disseminates other patients' experiences including worse case scenarios was evidenced by one participant's concern for ultimately needing a urostomy bag. While for some the online information may be helpful, for others it may result in increasing patient fears about disease progression and may decrease patient's sense of control over their situation. In previous work, helplessness and catastrophizing were shown to have a negative impact on both mental and physical quality of life in patients with IC/BPS [26]. A focus on restoring control and decreasing catastrophizing may be important in minimizing the morbidity of this condition.

Past work has described how disruptive flares are, causing patients to miss works, school, or request disability, all of which result in reduced social engagement [19]. This is consistent with our identified emergent theme of isolation. Lack of understanding from family, friends, and physicians, difficulty with intimacy and difficulty participating in social events led us to recognize isolation as an emergent theme central to the IC/BPS patient experience.

Perhaps due in part to the level of disability, isolation or due to the unpredictable nature of this disease, the theme of suicidal ideation presented itself unprompted in all 4 focus group sessions. IC/BPS has been noted to be a significant predictor for depression [24,5,6], and for suicidal ideation [4]. The rate of suicidal ideation was found in 11% of women in a population with IC/BPS [4] and appeared to be more related to patients' degree of depression than degree of IC/BPS symptoms. The increased risk of suicidality above that of the general population highlights the need for vigilance and screening for this associated manifestation of the disease.

Our second objective was to use patient input to improve clinical care. The themes we identified included patient's desire for validation from their providers and a hope that providers would listen to their concerns. They also wanted to be counselled about the various treatment options, and to have this information presented in a way that emphasized hope and optimism despite the chronic, unpredictable nature of this condition. Patients in our focus groups seemed well-versed in the lack of an effective single treatment, but expressed desire to hear a menu of treatment options, including alternate options. The above

themes could have a profound impact on their attitude allowing them to move forward with their lives despite this condition. In other chronic conditions such as severe menstrual pain [12], chronic back pain [27] and osteoarthritis[13] empathy and communication style have played important role and have had a beneficial effect on patients' outcomes. Given the role that stress and anxiety play in IC/BPS, this communication style may be important in improving patient attitudes and symptoms. Presenting patients with options and optimism provides them a means to restore control, providing other avenues by which they can positively affect their disease process.

Our emergent concepts of the psychological effects of the disease led us to hypothesize how these may affect both disease progression and ultimately depression and suicidality (Figure 1). Pain, which is a known central feature of IC/BPS, can be debilitating and cause isolation. As stress is a known trigger for IC/BPS [28–30], stress that results from the unpredictability, isolation and disability caused by IC/BPS, may ultimately increase symptom severity. As noted in the diagram, many of these features can contribute to depression, which may worsen the disease, or ultimately result in suicidal ideation. From patient's descriptions regarding the desired attributes of physicians, we have also hypothesized how and why these attributes may positively impact patient experience, and perhaps the disease process. We believe that listening and validating patients' experience with IC/BPS is crucial to combat the isolation that results from patients being misunderstood by family, friends, and other physicians, who may not understand the condition. In addressing isolation, physicians would in turn help to decrease depression, which may also improve patient symptoms. Providing options rather than a single treatment, may give patients a feeling that even though they may not be able to predict when a flare occurs, they will have a variety of treatments available to address a flare. Giving patients a sense of realistic hope, we believe, acts to guard against the sense of the unrelenting progression of the disease. Decreasing the unpredictable and unrelenting nature of IC/BPS, may improve the isolation and depression, which may be important in disease progression.

Although many of the above hypotheses may not directly affect the physiology of IC/BPS, they do provide additional targets for future intervention. They also help to explain why a multimodal approach addressing the psychosocial aspects of chronic pain may be important in treating IC/BPS. In recent work by our group [31], we found that Mindfulness-Based Stress Reduction improved IC/BPS self-efficacy. The impact of this intervention may be explained by its effect on the isolation aspect of the condition, or perhaps from helping to calm patients' minds to guard against the unpredictable nature of the process. Other complementary alternative therapies and psychologically-based therapies may ultimately work in a similar fashion.

Strengths of this study included the use of focus groups with a patient-centered iterative process. This assured that issues raised by patients were considered important and assured their inclusion in this manuscript. Verification was used throughout the analysis process. Multiple coders/reviewers verified and reviewed findings to increase validity. Peer-review by "disinterested peers" not intimately involved in the study increased the reliability of this study's findings [32]. Weaknesses of this study include the potential for self-selection as focus group participants were comprised of patients who sought care for IC/BPS and who

chose to participate in a group where they would be required to discuss their experience. Many of the participants may have had more severe IC/BPS as the mean time since diagnosis was over 6 years, representing a later stage of IC/BPS and may not be representative of those with a more recent diagnosis. In addition, though thematic saturation was clearly achieved, the sample size was relatively small and diversity of participants in this study was limited, as they were recruited from a single institution representing a discrete geographic area.

In conclusion, we identified that the IC/BPS experience included 3 themes; debility, an unpredictable and unrelenting course, often culminating in isolation. Patients also suggested specific interventions for providers to use in their clinical interactions. Physicians should be vigilant in detecting depression and suicidal ideation, which were commonly reported by these focus groups. Last, despite the shortcomings of current treatment regimens, physicians can make a positive impact on patients' lives by listening to and validating their concerns, and offering options for treatment while continuing to provide hope regarding finding effective treatment combinations.

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Brief Summary

Patient experience with IC/BPS is that of debilitation from an unrelenting unpredictable course, which results in isolation. Physicians can do much to help.

Figure 1.

Schematic of interaction between disease factors, psychological effects of IC/BPS, and how physicians can impact the condition. Options allow patients to better manage flares when they come. Hope from providers is important to patients when facing a debilitating condition. Providers listening and validation is important as patients may not be receiving this from usual support systems given the public's lack of understanding about the condition. All of these interventions may ultimately effect the disease process and associated depression.

Table 1

Focus group script and probes

Personal experience with IC/BPS (10 min)

- 1 Please talk about your experience with interstitial cystitis/bladder pain syndrome (IC/BPS).
- 2 How long have you had this condition?
- 3 How has it impacted your life?
 - a. What activities are particularly difficult for you?
- 4 How has this condition affected relationships with friends and family?
 - a. How has it affected your relationships with intimate partners, including your sex life?
- 5 What scares you about IC/BPS?

Part II: Social perceptions of IC/BPS (10 min)

- 6 How is your condition perceived by others?
- 7 Do your friends and family understand your condition and what it's like for you?
 - a. What do they know?
 - b. What don't they know?

Part III: Providers and IC/BPS (70 min)

- 1 Do you think your healthcare providers (e.g., physicians, nurse practitioners, physician's assistants, etc.) understand and respect your condition? Explain.
 - a. What positive things have happened with providers?
 - b. What negative things have happened?
- 2 What do you wish providers knew about the disease?
- 3 What types of providers are better or worse about understanding your disease?
- 4 What types of providers would you feel more or less comfortable seeing?
- 5 How have providers made you feel respected or disrespected?
- 6 What did your providers say or do well when treating you and your disease?
- 7 What do you wish your providers said or did differently?
- 8 What do you wish providers knew about the disease?
- 9 What information do you think newly diagnosed patients should receive from their providers?
 - a. Is there anything you heard from providers that you wish you knew earlier?
 - b. Is there anything you have heard from providers that was particularly encouraging or discouraging?
- 10 Any other thoughts or comments?

Table 2

Patient characteristics

Patient Characteristics	n=15
Age in years (Mean +/- SD)	52.6 (9.7)
Parity (Mean +/- SD)	1.5 (1.5)
Vaginal deliveries (Mean +/- SD)	1.5 (1.5)
Cesarean sections (Mean +/- SD)	0.7 (0.3)
Time since IC/BPS diagnosis in years (Mean +/- SD)	6.3 (6.0)
Time with IC/BPS symptoms in years (Mean +/- SD)	12.0 (8.0)
Surgical history (%)	
Incontinence	3 (20.0%)
Prolapse	2 (13.3%)
Hysterectomy	5 (33.3%)
Race	
American Indian/Alaskan Native	2 (13.3%)
Non-Hispanic Caucasian	6 (40.0%)
Hispanic	4 (26.7%)
Other	3 (20.0%)
Insurance	
Medicaid/Medicare	5 (33.3%)
Military	1 (6.7%)
Multiple Insurances	4 (26.7%)
Private	5 (33.3%)
Education (n=13)	
High school or equiv.	2 (13.3%)
Some college	1 (6.7%)
Associate's Degree	0
Bachelor's or graduate Degree	10 (66.7%)

Table 3

Primary themes, topics and supporting quotations

Emergent Concept	Theme	Quotation
<u>IC/BPS is a life altering debilitating condition</u>	Pain	<i>"sometimes the pain is so bad I almost cannot breath and it's all I can think about"</i>
	Sleep disruption	<i>"I'm exhausted all the time because I'm up peeing half the night"</i>
	Difficulty with work	<i>"In my line of work, I need to ask to go to the bathroom...and it's embarrassing to ask several times"</i>
	Difficulty with travel	<i>"I would say that road trips are most embarrassing for me."</i>
	Depression/suicidality	<i>"I've actually thought about offing myself, like sometimes it's so bad I don't think I can go on"</i>
<u>Fear and Anxiety from the unrelenting and unpredictable nature of the disease</u>	Flares may come without warning, always lurking	<i>"I didn't know it was interstitial cystitis or painful bladder syndrome"</i>
	Life sentence, aging with disease	<i>"at some point you're just gonna have a flare that's so bad and then, what do you do."</i>
	Fear of disease progression	<i>"I am 40, I'm not 90, how, is it going to get worse?"</i>
<u>Isolation</u>	Lack of understanding from family members/friends	<i>"I don't think they quite understand all the, how debilitating it is"</i>
	Lack of understanding from health care providers	<i>"Then they kind of treat you like you're a hypochondriac"</i>
	Effect of dietary restriction on social events	<i>"My friends, ... they love to enjoy life and when you can't go out to dinner ... it can be difficult to maintain those relationships"</i>
	Difficulty with intimacy	<i>"He's very patient and loving, it just, he's trying, you know, but there's just so much you can do and it just isn't the way it was before and it's just sad"</i>

Table 4

Physician impact

Theme	Quotation
Listen/Validate	<i>"And as far as, you know, just having some empathy and understanding and just validating that, you know, this does exist."</i>
Provide Options	<i>I think there's time for personal opinion and time for ideas. Hope. Encouraging. Giving people options, like the hypnotherapy that you guys are trying, that's brilliant</i>
Provide Optimism/Hope	<i>"I saw one person who basically said it was hopeless. I just, I wanted to die"</i>