Chronic Illness and the Fennell Four Phase Treatment™ Approach: Working with People Who Don't Get Better

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Abstract -

Chronic mental and physical illnesses can be traumatizing, life-changing experiences. The empirically validated Fennell Four Phase Treatment (FFPT™) model recognizes the influences of cultural, psychosocial, and physical factors in assessment and treatment. The multi-phased approach provides a narrative framework and cognitive map for understanding and integrating chronic illness.

Phase 1, Crisis: Individuals move from illness onset, which may be specifically detectable or may happen gradually, to an emergency period when it's obvious that something is seriously wrong. The task of the individual, caregivers and clinicians during this phase is to cope with urgency and trauma.

Phase 2, Stabilization: Individuals discover that they fail to return to "normal" regardless of interventions or behavior. The task in this phase is to initiate stabilization and life restructuring.

Phase 3, Resolution: Individuals recognize deeply that their old life will never return. Early in this phase, most people experience profound existential despair. The task of this phase is to begin establishing an authentic new self and start developing a supportive, meaningful philosophy.

Phase 4, Integration: Individuals define a new self in which illness may be an important, but not primary life factor. The goal is integration of the illness into a meaningful life.

Within each phase, the Fennell Four-Phase Model addresses three domains: physical/behavioral, psychological, and social/interactive. The experience of chronic illness does not remain the same over time; needs in the early phases of illness may differ from those several years later. Also, life changes that may be unrelated to illness may cause the individual to move backward or forward within the Phases over the course of a lifetime.

FFPT helps clinicians treat patients more effectively and can greatly reduce practitioner frustration. It offers a step-by-step, research-based approach, grounded in clinical practice, to help people with chronic illnesses solve problems and create positive change.

Key Words: Chronic illness, Fennell Four Phase Model, trauma, coping, FFPM, FFPT, matching intervention to phase.

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1. The Challenge of Chronic Illness

Managing chronic illness is one of the greatest, growing challenges facing health care systems today. The World Health Organization reported in June 2011

that between 15.6% and 19.4% of people worldwide have a disability; between 2.2% and 3.8% have disabilities considered "severe."[1] These numbers have increased since the 1970s, when 10% of the world's population had a disability, and are expected to continue rising due to the aging of the world's population and improvements in medical care that have transformed previously fatal illnesses, such as cancer and HIV/AIDS, into chronic conditions.

Patients with chronic conditions often fare poorly in the current primary care delivery environment, which is structured for acute, episodic care. Because chronic illnesses tend to affect several different body systems at the same time, coordination of care--across settings, providers and treatments--is essential.[2]

The impact of the illness on the patient's physical, emotional and social condition persists over time and significantly affects patient reporting, compliance and coping. In addition, the needs of a patient in the early phases of the chronic illness experience can be considerably different from the needs of the patient who has been ill for several years, so the best approach is a flexible one that considers where the individual is within the disease process.

2. Types of Chronic Illnesses

Historically, multiple conceptual dichotomies -- including illness as opposed to disease, professional as opposed to personal, clinician as opposed to patient, and mental as opposed to physical -- have created false dualities that have produced havoc in the experience of patient care in acute and chronic illness.[3] "Mental" conditions were often ascribed to a deficiency of character or personal control, while "physical" impairments were considered outside of the individual's control and therefore not his/her fault. Increasingly, "mental" illnesses are being described by their physical components (e.g., neurochemical imbalances in depression, etc.), and there is increasing recognition that the experience of living with a "physical" disability, such as multiple sclerosis, is inherently traumatic due to the response of medical, workplace, social, and other systems to the individual's symptoms and suffering.

Today, we recognize four groups of chronic illness:[4]

-- Survivors of acute, formerly fatal illnesses, such as cancer
-- The "traditional" chronic, which includes multiple sclerosis
-- People with "persistent acute" illnesses, such as HIV/AIDS
-- The natural consequences of aging

Chronic illnesses can also be static or dynamic.[5] Static illnesses are those whose symptoms and treatments largely remain the same over time: paralysis, visual or hearing impairments, for example. Dynamic illnesses are those whose symptoms wax and wane and produce cycles of relapse and remission: asthma, diabetes, or arthritis, for example.

Trauma is a very real consequence of living with a chronic illness. The loss of function, livelihood, friends, and esteem conveyed by disability is deeply upsetting to individuals. Chronic illness-associated trauma can stem from several sources:

-- **Disease/Syndrome Trauma:** Realization that something is profoundly wrong and that what was once considered 'normal' is no longer so. Lifestyle, livelihood, function, and predictability are some of the losses that can result in trauma.

-- **Iatrogenic Trauma:** Health care providers who question the veracity or severity of a person's symptoms, or suggest that the person is morally or mentally weak, or somehow responsible for their illness (or inability to recover) can precipitate trauma in patients.

-- **Cultural Trauma:** Bias against the chronically ill is common in our culture and may be fostered by sensational media accounts of unexpected recovery, preliminary research findings, or 'against the odds' performance by athletes or other luminaries. Friends, family members, colleagues, and general society can show fear, misunderstanding, or bias toward the chronically ill and their disabilities. As a result of these attitudes, many people find themselves without jobs, housing, friends, or other support.

-- **Vicarious Trauma:** People who live with and care for the chronically ill can also suffer trauma. Stigmas conveyed by health care providers, the media, and general society against the chronically ill can result in traumas in family members and friends who support them. The need to take time from work to accompany their loved one to medical appointments can result in job loss or career stagnation.

-- **Pre-Morbid / Co-Morbid Trauma:** Serious trauma may exacerbate illness symptoms. These might include a death in the family or natural disaster. In addition, pre-morbid trauma, such as an auto accident, may decrease resilience and therefore may make it more difficult to cope with additional traumas.

Research has shown that having a chronic illness increases the likelihood of having depression comorbidly, and depression significantly worsens health status. Moussavi, et al., wrote: "After adjustment for socioeconomic factors and health conditions, depression had the largest effect on worsening mean health scores compared with the other chronic conditions. Consistently across countries and different demographic characteristics, respondents with depression comorbid with one or more chronic diseases had the worst health scores of all the disease states."[6]

It must be noted that this association of depression with chronic illness is a correlation, and does not suppose causation. Many people -- professionals, family members, the media, and the general public -- have erred in writing off a chronic illness as "only depression" i.e., a colloquial way of suggesting that an illness is not "real" inferring that a patient may be attempting to shirk his or her responsibilities or is vaguely weak or immoral. This error in assumption may provoke a traumatic response in a person who justifiably feels depressed because

of the loss of function, livelihood, friendships, and stability resulting from having a chronic, disabling illness.

To improve the individual's quality of life and health status, it is critical that we consider not only the physical consequences of chronic illness, but also the psychological and social effects, and react accordingly within our medical interventions.

3. The Fennell Four-Phase Treatment (FFPT)™ Model

The Fennell Four-Phase Treatment (FFPT) is a flexible clinical approach, empirical paradigm, and assessment tool designed to enhance current managed care approaches by helping the health care team determine what may be expected over time and the best ways to intervene to improve the patient's quality of life at any given point. Research supports the concept that individuals coping with chronic illness progress through four distinct phases as they learn to deal with their illness.[7,8,9,10,11]

FFPT is a phase, not a stage, model. The changing social, medical, psychological, or other circumstances that may be unrelated to the chronic illness may cause the patient to move backward or forward within the Phases multiple times over the course of his or her lifetime. The physical, emotional, and social needs of a patient in the early phases of the chronic illness experience can be considerably different from the needs of the patient who has been ill for several years. It is common in the early years of illness for a person to move back and forth between Phase 1, Crisis, and Phase 2, Stabilization, based on current health status and other factors.

The FFPT provides a framework and a narrative map for understanding this critical process. Patients may respond differently to various treatment modalities depending upon which Phase of Illness they are in. Research has suggested that matching best medical practice to phase of illness can help both physicians and allied health professionals treat patients more effectively, increase compliancy and save time and resources.[12,13,14]

Within each Phase, the FFPT addresses three domains: the physical/behavioral, the psychological, and the social/interactive. In **Phase 1, Crisis**, the individual moves from onset of illness, which may be specifically detectable or may happen gradually, to an emergency period when the patient knows that something is seriously wrong. The task of the individual, caregivers, and clinicians during this Phase is to cope with and contain urgency and trauma.

In **Phase 2, Stabilization**, the individual discovers that he or she fails, sometimes repeatedly, to return to normal regardless of interventions or behavior. The task in this Phase is to initiate stabilization and life restructuring.

In **Phase 3, Resolution**, the individual recognizes deeply that his or her old life will never return. Early in this Phase, many experience significant grief and loss.

The task of this Phase is to begin establishing an authentic new self and start developing a supportive, meaningful philosophy.

In **Phase 4, Integration**, the individual defines a new self in which illness may be an important factor, but it is not the only or even the primary one in his or her life. Integration of the illness into a meaningful life is the goal the individual seeks. For a graphic example of matching medical intervention to phase of illness for a specific chronic illness, see the chart below.[15]

4. Matching Intervention To Phase of Illness

What makes FFPT unique among popular chronic illness models[16,17] is its multidisciplinary, interdisciplinary. team-based approach to patient management, and its commitment to matching medical interventions to the patient's phase of illness. This philosophy of care is important given the ebbs and flows of symptoms, and the cycles of relapse and remission that characterize many chronic conditions.

Table 1 – Matching Best Practices with Phases of Illness

	Phase 1 Crisis	**Phase 2 Stabilization**	**Phase 3 Resolution**	**Phase 4 Integration**
Definition	Individual moves from illness onset (sudden/gradual) to emergency period when he/she knows something is seriously wrong	Patient begins to understand symptom complex and develops new norms and behaviors	Patient recognizes that old life will not return and wrestles with existential questions	Patient defines a new self in which illness may be an important factor, but is not primary in his/her life
Task	Contain the crisis; manage urgency and possible trauma	Facilitate stabilization of symptoms through medical treatment and life restructuring	Continue ongoing management of medical plan and help patient develop meaning in suffering	Assist patient in integrating the illness into a meaningful life
Medical Assessment & Intervention	Complete a comprehensive medical history; conduct physical exam; do lab tests as indicated; confirm diagnosis; develop a working list of problems and treatment plan	Schedule frequent patient visits to systematically address major symptoms (sleep, mood/cognitive, pain, fatigue, etc.); review lab tests and do routine ongoing screening; manage all comorbid and secondary conditions; monitor medications and simplify when possible; coordinate rehabilitation efforts	Monitor and manage symptoms, modifying treatment plan as needed; simplify and/or reduce medications as appropriate; continue routine health screenings; continue regimen to improve physical fitness within the confines of	Continue monitoring of patient functioning; continue focus on guarding against deconditioning utilizing physical conditioning regimen; emphasize lowest effective doses or nondrug interventions; help patient balance trying new

		(physical/occupational therapy)	chronic illness limitations	treatments with "just living"
Phase Assessment & Intervention	Conduct psycho-social interview and other relevant evaluations (may include neurological/psychological tests, sleep studies, etc.); establish multidisciplinary team; build relationship with patients; analyze activity threshold and restructure activity levels as needed	Initiate values clarification and development of new norms; review and modify activity levels; assist patient in coping with challenges like grief and "illness etiquette"; patient/family case management; workplace intervention and/or modification, or exploration of disability options	Facilitate patient's exploration of existential questions and developing meaning; encourage patient to become own care coordinator and advocate; consider job modifications or workplace separation	Continue meaning development and integration of pre- and post-crisis self; review workplace modifications and/or alternative vocations and activities; maintain dialogue among members of multidisciplinary treatment team

A holistic approach such as this captures essential elements of experience that can determine whether interventions will be successful. It particularly points to the necessity of solving problems -- familial, social, economic, and philosophical, among others -- that are rarely part of the conventional medical treatment model. Because teamwork is essential, among a broad assortment of professionals, all committed to involving the patient whenever possible in the process, a case management approach seems best suited accomplish this in a successful, ethical manner.

5. Summary

The Fennell Four-Phase Treatment (FFPT)™ channels the efforts of the health care team to match best medical practices to the patient's phase of illness. By identifying different functional capacities and symptoms at different phases, the FFPT™ helps the physician, nurse case manager, and other members of the health care team select the most appropriate and effective interventions and avoid choosing treatments that, although useful at another time, may be counterproductive at the patient's current Phase of Illness. By intervening with treatments suited to the patient's particular Phase -- a time when they are more likely to be compliant -- health care providers can help patients break out of a pattern of repeated crises that usually require more extensive resources in response. The goal of this approach is not pursuing the ever-elusive cure, but integration of the illness into the patient's life. For patients and their families, the FFPT™ helps them to organize a narrative of their experience, essential for patient education and self-management.

Notes

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[15] Patricia A. Fennell, and Lucinda Bateman, 'A Team Approach to Treating CFS: Matching Best Medical Practices to Phases of Illness,' *CFS Research Review* Summer (2005): 6-11.

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