Improving Outcomes For Families Facing Cancer: A Four Phase Treatment Approach

Paradigm Shift in Medicine

• 20th century: focus on acute illness
• Expectation was that treatment resolved illness OR patient died
• 21st century: increasing focus on chronic illness

Paradigm Shift in Medicine

• Increased prevalence of chronic illnesses
• Chronic vs. acute care
• Necessity of chronic care models
• Chronic comprehensive case management
• Comprehensive case management vs. clinical treatment
Chronic vs. Acute Illness

• Traditional chronic illness manifests differently than acute illness
• Chronic illness can be difficult to measure and treat
• Chronic illnesses tend to affect several different body systems at the same time
• Impact of chronic illness on the physical, emotional and social domains persists and affects reporting, compliance and coping

Chronic vs. Acute Illness

• Medicine has not adapted to the chronic model of care
• Patients with chronic conditions often fare poorly in the acute, episodic care-delivery environment
• Necessary interventions require multiple disciplines and tight coordination of care

Chronic vs. Acute Illness

• Patient needs vary over the duration and phase of the illness
• Patients suffer from social stigma, economic losses, and lack of knowledge and understanding about their conditions
• Health care providers, patients, family members and friends can become frustrated with the unpredictable symptoms and chronicity
• These factors may exacerbate the patient’s condition

Why the Shift to Chronic Illness?

• Increased prevalence of chronic illnesses
• Advances in public health
• Advances in medical care
• Aging population
Chronic Illness is the Leading Cause of Death and Disability

- Chronic diseases caused approximately 60% of deaths worldwide in 2005.
- Chronic disease-related deaths will increase by 17% over the next 10 years, from 35 million to 41 million.
- Chronic disease is not restricted to developed nations or older populations; it is growing fastest in low-income countries; almost half of those who die from chronic diseases are younger than 70.

(PriceWaterhouseCoopers & World Economic Forum. Working Towards Wellness. 2007.)

Chronic Illness is the Leading Cause of Death and Disability in the U.S.

- One third of U.S. doctor visits are for chronic conditions
- Two-thirds of all U.S. deaths are caused by a chronic condition
- 78% of total U.S. medical care expenditures are related to chronic conditions – over a trillion dollars a year
- 2005: 129 million people with chronic conditions
- 2030: 171 million predicted (32% increase)

4 Groups of Chronically Ill

- Acute illness survivors with managed symptoms (cancer, cardiovascular disease)
- Traditional chronic (MS, FM, CFS, asthma, lupus)
- “Persistent acute” (HIV/AIDS, stroke)
- Natural consequences of aging in an aging population

Sociological Factors in Chronic Illness

- Chronic illness and the global community
- Chronic illness differentiated by:
  - gender, ethnicity, religious/philosophical belief, SES, etc.
  - geographic region
  - political environment
  - economic environment
Chronic Illness Management and Managed Care

• Historically there has been little coordination across multiple settings, providers and treatments
• Managed care has not achieved initial promise of truly coordinated care
• Managed care doesn’t address the complexity of chronic conditions, so it may result in more, rather than fewer, encounters with the health care system
• Management strategy influences behavioral health

Philosophy of the Phase Method

• A Systemic Approach
• False Dichotomies
• The Phenomenon of Chronicity
• Traumatization and Chronicity
• The Integration Assumption
• Palliation
• Clinician as Active Equal Participant

Cancer and the Fennell Four Phase Model

Trauma Types

• Disease/Syndrome Trauma
• Iatrogenic Trauma
• Cultural Trauma
• Vicarious Trauma

• Pre-Morbid / Co-Morbid Trauma
Chronic Cancer Care in Context and Culture

- The Health Care System
- Levels of Discourse
- Socio-Cultural Factors
- Domain Assumptions
- Traumagenic Effects

Socio-Cultural Factors

- Cultural Intolerance of Suffering
- Cultural Intolerance of Ambiguity
- Cultural Intolerance of Chronic vs. Acute Syndromes
- Pre-existing Cultural Climate Toward Chronic Syndromes
- Media
- Initial Syndrome Illegitimacy and Subsequent Enculturation

The Four Phases of Chronic Change

_The Smith Family’s Story: Survivors of Cancer_
Phase I – Trauma / Crisis
• Physical / Behavioral
  – Coping Stage
  – Onset Stage
  – Acute / Emergency Stage
• Psychological
  – Loss of Psychological Control/ Ego Loss
  – Intrusive Shame, Self Hatred, Despair
  – Shock, Disorientation, Dissociation
  – Fear of Others, Isolation, Mood Swings
• Social/Interactive
  – Others Experience Shock, Disbelief, Revulsion
  – Vicarious Traumatization
  – Family/Organizational Maturation
  – Suspicion/Support Continuum

Phase II – Stabilization / Normalization Failure
• Physical / Behavioral
  • Plateau
  • Stabilization
• Psychological
  • Increased Caution / Secondary Wounding
  • Social Withdrawals, Social Searching
  • Service Confusion/Searching
  • Boundary Confusion
• Social/Interactive
  • Interactive Conflict/Cooperation
  • Vicarious Secondary Wounding
  • Vicarious Traumatic Manifestation
  • Normalization Failure

Phase III – Resolution
• Physical/Behavioral
  – Emergency
    Stage/Diminishment/Improvement
  – Continued Plateau/Stabilization
  – Relapse
• Psychological
  – Grief Reaction/Compassion Response
  – Identification of Pre-crisis – “Self”
  – Role/Identity Experimentation
  – Returning Locus of Control
  – Awareness of Societal Effects
  – Spiritual Development
• Social/Interactive
  – Breaking Silence/Engulfment in Stigma
  – Confrontation
  – Role Experimentation – Social, Vocational
  – Integration / Separation / Loss of Supporters

Phase IV – Integration
• Physical/Behavioral
  – Recovery Stage
  – Continued Plateau/Improvement/Relapse
• Psychological
  – Role/Identity Integration
  – New Personal Best
  – Continued Spiritual/Emotional Development
• Social/Interactive
  – New/Reintegrated Supporters
  – Alternative Vocation/Activities
### Socio-Cultural Factors

**Chronic Syndromes and Traumagenic Effects**

**Factor: Intolerance of Suffering**

**DYNAMICS**
- Social/Clinical Controversy
- Pressure for Non-disclosure
- Negative Reinforcement for “Genuine Reporting”
- Attitude Conveyed of Characterological Inferiority
- Iatrogenic Health Care Experiences

**EFFECTS**
- Avoidance of Intimacy
- “Passing”
- Addiction
- Social Abandonment/Rejection
- Social Contract Violation

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**Factor: Intolerance of Ambiguity**

**DYNAMICS**
- Contagion/Contamination / Powerlessness Fear Transferred
- Unknown Etiology/Prognosis
- “Just” World or Deserved Punishment Notion
- Survivor as Burden

**EFFECTS**
- Generalized Guilt
- Grief
- Depression

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**Factor: Intolerance of Chronic vs Acute Syndromes**

**DYNAMICS**
- Pressure for “Cure”/Normalization
- Inadequate Treatment Models
- Competence Frustration Conveyed
- Punishment of Healthy Self Care
- Reward of Unhealthy Self Care

**EFFECTS**
- Normalization Failure
- Identify Confusion
- Increased Salience of Abuse Issues
- Avoidance of Intimacy
- “Passing”
- Social Withdrawal / Suicide
Factor: Cultural Climate

**DYNAMICS**
- Pre-sentiment of Suspicion Conveyed
- Negative Personality Characteristics Assigned
- Survivor perceived as Damaged/Social Example

**EFFECTS**
- Social Shame
- Diminished Self-worth
- Cultural “Pariah”

Factor: Media

**DYNAMICS**
- Scapegoating
- Public Ridicule/Support
- Public Judgment
- Public Assignment of Role and Worth

**EFFECTS**
- Loss of Privacy
- Increased Fear/Anxiety
- Increased Isolation
- Increased Grief
- Decreased Sense of Worth

Factor: Syndrome Enculturation

**DYNAMICS**
- Inadequate Language/Models/Metaphors
- Impact of Discourse
- Disease Maturity - Societal Acceptance

**EFFECTS**
- Increased/Decreased Powerlessness
- Increased/Decreased Sense of Efficacy
- Increased/Decreased Sense of General Safety, Trust and Stigmatization

Treating Cancer Patients and Their Families Using FFPT™ Within Four Phase Case Management (FPCM)

*Matching Intervention to Phase*
Unique Characteristics of FFPT™

- Integrates the physical/medical, psychological, sociological, legal and financial aspects of chronic illness
- Helps clinicians to develop better, targeted management strategies that move patients toward healing.
- Pursues this integration through the chronic phased experience.

The Four Phases: Treatment Goals

- Treatment Phase I: Reduction of Trauma Symptomatology
- Treatment Phase II: Stabilization and Restructuring
- Treatment Phase III: Meaning Development
- Treatment Phase IV: Integration

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FPCM Focus/Priority Criteria

- Disability
- Treatment/triage support (self-management)
- Psychological support/intervention
- Matching medical intervention to Phase

FPCM Focus:
Disability

- Disability assessment
- Disability prep
- Record review
- Referral
  - Legal
  - Medical
  - Auxiliary/Social Services

FPCM Focus:
Treatment/Triage Support

- Enhancing capacity to network
- Enhancing capacity to negotiate medical systems
- Facilitating family/community/workplace participation
- Facilitating patient/family self-management

FPCM Focus:
Psychological Support/Intervention

- Chronic illness orientation/education
- Capacity for self-management
- Locus of control
- Societal awareness
- Health system sophistication
Four Phase Case Management and Phase 1 Treatment

• Clinical goal: Trauma and crisis management
• FPCM goal: Establish case management focus

FPCM and Phase 1

• Clinical goal: Trauma and crisis management -- BATOS
  • Bond
  • Affirm
  • Teach-Grief Response, Trauma Reaction, Phases
  • Observe
  • Safety Plan
• FPCM goal: Establish case management focus

FPCM and Phase 1

• Clinical goal: Trauma and crisis management
• FPCM goal: Establish case management focus

• Restructuring Activities of Daily Living
• Family Case Management
• Health Care System Management
• Workplace/Employer Intervention
• Clinician Advocacy

Four Phase Case Management and Phase 2 Treatment

• Clinical Goal: Stabilization
• FPCM Goal: Data collection/activity restructuring
FPCM and Phase 2

• Clinical Goal: Stabilization—CDIN
  • Collect Data
  • Differentiate
  • Insight Development
  • Norms/Goals
• FPCM Goal: Data collection/activity restructuring

FPCM and Phase 2

• Clinical Goal: Stabilization
• FPCM Goal: Data collection/activity restructuring
  • Assess and Restructure Activity Levels
  • New Parameter and Norm Development
  • Family Case Management
  • Health Care System Management
  • Workplace/Employer Intervention
  • Clinician Advocacy

Four Phase Case Management and Phase 3 Treatment

• Clinical goals: Development of meaning and Construction of new self
• FPCM goal: Self-management skill development

FPCM and Phase 3

• Clinical goals: Development of meaning and Construction of new self—GMR
  • Grieve
  • Maintain
  • Reframe
• FPCM goal: Self-management skill development
FPCM and Phase 3

• Clinical goals: Development of meaning and Construction of new self
• FPCM goal: Self-management skill development:
  • Activity Monitoring
  • Medical Coordination
  • Health Care Advocacy
  • Self Advocacy

Four Phase Case Management and Phase 4 Treatment

• Clinical goal: Integration
• FPCM goal: Ongoing self-management

For More Information:

Please contact AHMA at---
communications@albanyhealthmanagement.com
www.albanyhealthmanagement.com

• Certification in the FFPT™ approach
• The Fennell Phase Inventory™
• Research projects
• Books and related articles
• Clinical services
• Consulting
• Education and training

Objective Phase Placement

• Phase Placement I
  – Diagnostic/Treatment Urgency
  – Treatment / Cure Locus Outside Self
  – Increased Self Pathologizing
  – Increased Intrusion or Denial
  – Decreased Tolerance of Ambiguity
• Phase Placement II
  – Locus of Control Returning to Self
  – Seeks Alternative Sources of Treatment/Support/Identification
  – Decreased Tolerance of Chronicity
  – Decreased Self Pathologizing
  – Decreased Intrusion or Denial

• Phase Placement III
  – Increased Awareness of Societal Effects
  – Increased Internalization of Locus of Control
  – Increased Tolerance of Ambiguity / Chronicity
  – Expression of Self Compassion
  – Patient Constructs Chronic Illness Experience

• Phase Placement IV
  – Recovery/Stabilization/Integration
  – Integration of Pre/Post Crisis Self
  – Reconstructed Definition of Self
  – Reconstructed Cultural Role and Relationships

Purposeful Utilization of the Self: Countertransference and Treatment

• Countertransference as a universal experience
• Definitions
• Vicarious traumatization
• Countertransference as a treatment necessity
• Common countertransference reactions to the psyche-soma/chronic patient
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