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

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PowerPoint Slides and Handouts
Available Online:

www.PatriciaFennell.com/AOSW

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

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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

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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

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Why the Shift to Chronic Illness?

- Increased prevalence of chronic illnesses
- Advances in public health
- Advances in medical care
- Aging population

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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)

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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

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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

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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

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Cancer and the Fennell Four Phase Model

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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

Trauma Types

- Disease/Syndrome Trauma
- Iatrogenic Trauma
- Cultural Trauma
- Vicarious Trauma

-
- Pre-Morbid / Co-Morbid Trauma

Chronic Cancer Care in Context and Culture

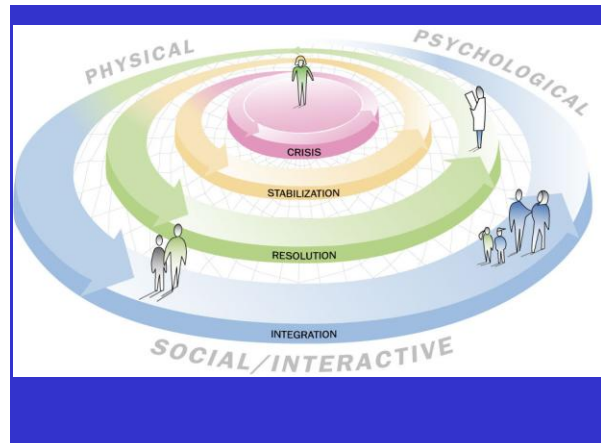
- The Health Care System
- Levels of Discourse
- Socio-Cultural Factors
- Domain Assumptions
- Traumagenic Effects

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 EFFECTS

- | | |
|--|--|
| <ul style="list-style-type: none"> • Social/Clinical Controversy • Pressure for Non-disclosure • Negative Reinforcement for “Genuine Reporting” • Attitude Conveyed of Characterological Inferiority • Iatrogenic Health Care Experiences | <ul style="list-style-type: none"> • Avoidance of Intimacy • “Passing” • Addiction • Social Abandonment/Rejection • Social Contract Violation |
|--|--|

Factor: Intolerance of Ambiguity
DYNAMICS EFFECTS

- | | |
|--|--|
| <ul style="list-style-type: none"> • Contagion/Contamination / Powerlessness Fear Transferred • Unknown Etiology/Prognosis • “Just” World or Deserved Punishment Notion • Survivor as Burden | <ul style="list-style-type: none"> • Generalized Guilt • Grief • Depression |
|--|--|

Factor: Intolerance of Chronic vs Acute Syndromes
DYNAMICS EFFECTS

- | | |
|--|--|
| <ul style="list-style-type: none"> • Pressure for “Cure”/ Normalization • Inadequate Treatment Models • Competence Frustration Conveyed • Punishment of Healthy Self Care • Reward of Unhealthy Self Care | <ul style="list-style-type: none"> • Normalization Failure • Identify Confusion • Increased Salience of Abuse Issues • Avoidance of Intimacy • “Passing” • Social Withdrawal / Suicide |
|--|--|

Factor: Cultural Climate
DYNAMICS EFFECTS

- | | |
|--|--|
| <ul style="list-style-type: none"> • Pre-sentiment of Suspicion Conveyed • Negative Personality Characteristics Assigned • Survivor perceived as Damaged/Social Example | <ul style="list-style-type: none"> • Social Shame • Diminished Self-worth • Cultural “Pariah” |
|--|--|

Factor: Media
DYNAMICS EFFECTS

- | | |
|---|---|
| <ul style="list-style-type: none"> • Scapegoating • Public Ridicule/Support • Public Judgment • Public Assignment of Role and Worth | <ul style="list-style-type: none"> • Loss of Privacy • Increased Fear/Anxiety • Increased Isolation • Increased Grief • Decreased Sense of Worth |
|---|---|

Factor: Syndrome Enculturation
DYNAMICS EFFECTS

- | | |
|---|---|
| <ul style="list-style-type: none"> • Inadequate Language/ Models/ Metaphors • Impact of Discourse • Disease Maturity - Societal Acceptance | <ul style="list-style-type: none"> • 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

Treatment Summary

I	II	III	IV
Build	Collect Data	Create	Integrate
Assess	Differentiate	Maintain	
Teach	Insight Dev.	Refine	
Oversee	Needs Goals		
Support			

Unique Characteristics of Four Phase Case Management

- Utilizes a focused priority approach
- Facilitates treatment/management within a chronic framework
- Incorporates all stakeholders/participants

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**
 - **B**ond
 - **A**ffirm
 - **T**each-Grief Response, Trauma Reaction, Phases
 - **O**bserve
 - **S**afety 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**
 - **C**ollect Data
 - **D**ifferentiate
 - **I**nsight Development
 - **N**orms/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**
 - **G**rieve
 - **M**aintain
 - **R**eframe
- 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

Phase I
Countertransference - Clinical Stance

- Revulsion
- Fear
- Anger
- Disbelief
- Triggered Trauma
- Rejection/Over-identification
- Self Examination
- Equal Exchange
- Compassion/Affirmation
- Modeling Toleration of Affect and Ambiguity
- Normalization

Phase II
Countertransference - Clinical Stance

- Conflict
- Normalization Failure
- Relationship Rupture
- Vicarious Traumatization
- Coaching/Structuring
- Modeling Toleration of Chronicity
- Modeling Containment

Phase III
Countertransference - Clinical Stance

- Inadequacy
- Terror
- Depression
- Withdrawal
- Rejection
- Resolution
- Parallel Process
- Witnessing

Phase IV
Countertransference - Clinical Stance

- Attachment
- Grief
- Loss
- Pride
- Integration of Parallel Process
- Release