

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

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

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

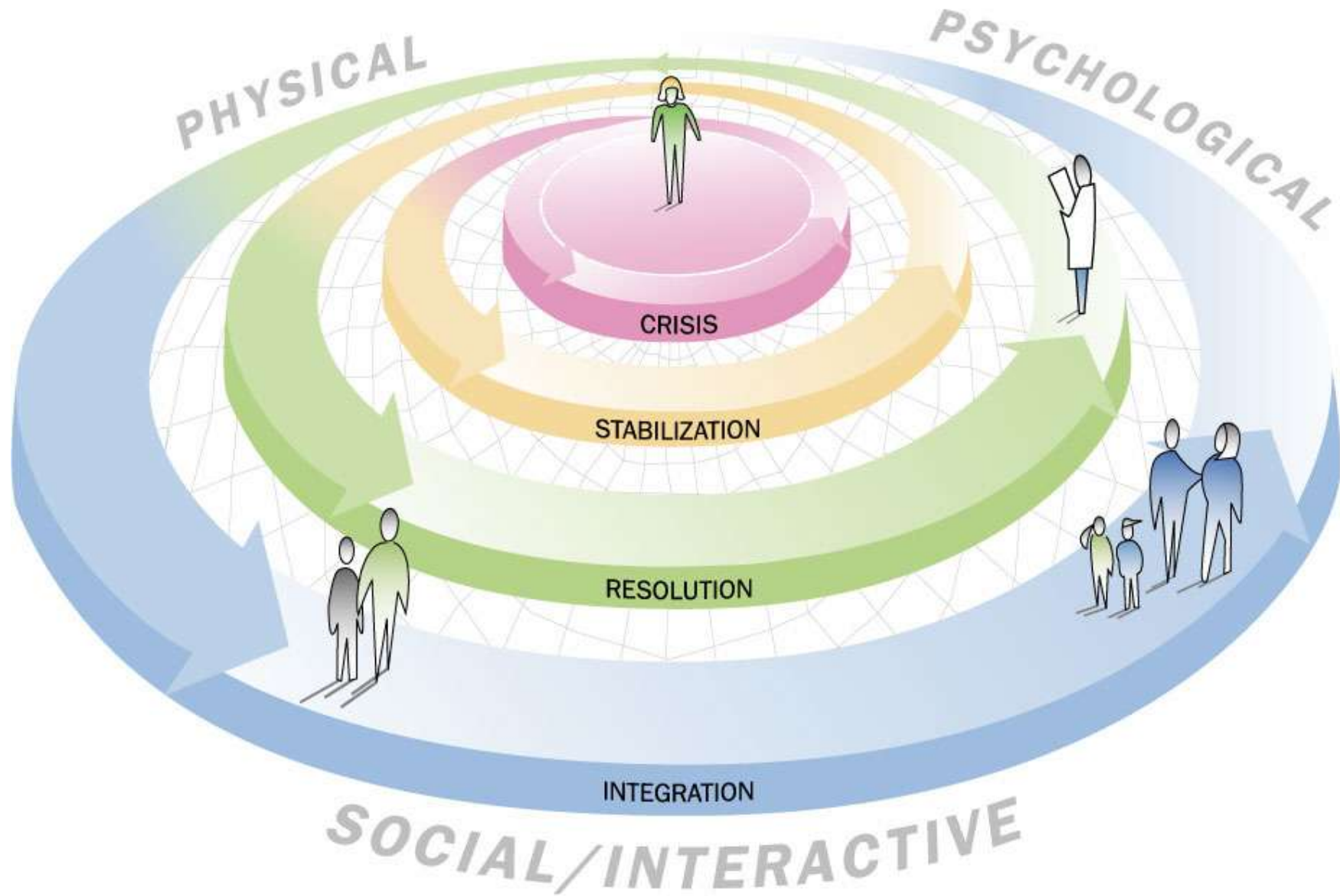
- Inadequate Language/ Models/ Metaphors
- Impact of Discourse
- Disease Maturity - Societal Acceptance

EFFECTS

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

From: Fennell, PA. Phase-Based Interventions. Chapter 22 in Jason, L.A.; Fennell, P.A.; Taylor, R. (editors), *Handbook of Chronic Fatigue Syndrome and Fatiguing Illnesses*. John Wiley and Sons Inc., New York, NY: 2003.

The Fennell Four Phase Model™



The Fennell Four-Phase Treatment for Chronic Illness

By Patricia A. Fennell, MSW, LCSW-R

The Challenge of Chronic Illness

Managing chronic illness is one of the greatest challenges facing our health care system today. There were 129 million people with chronic conditions in 2005; this number is expected to grow 32 percent to 171 million in 2030, according to Partnership for Solutions, a research cooperative led by Johns Hopkins University.¹ The costs of chronic illness to the U.S. are huge, accounting for at least 78 percent of all health care spending, or well over a trillion dollars per year.²

Patients with chronic conditions often fare poorly in the current primary care delivery environment, which is structured for acute, episodic care. Care is often delivered with little coordination across multiple settings, providers and treatments.³ Several variations of managed care have emerged in the past decade in an effort to improve care, reduce unnecessary service utilization and control spiraling costs. But the fragmented nature of services in the managed care market has not achieved the initial promise of truly coordinated care. Furthermore, managed care programs seldom address the complexity inherent in chronic conditions that may result in more frequent, rather than fewer, doctors' visits and hospitalizations. Chronic illnesses tend to affect several different body systems at the same time. In addition, 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 with the illness. The physical, psychological 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.

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.^{4, 5, 6, 7, 8, 9} The FFPT provides a framework 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.^{10, 11, 12, 13}

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 on the following page.¹⁴

Another promising approach is the Chronic Care Model (CCM), which provides a holistic framework and methodology for transforming a health care system so that patients receives coordinated care from a trained interdisciplinary health care team and planned follow up.¹⁵ What the CCM does not appear to consider in its approach to team-based treatment is the need to match medical interventions with the patient's Phase of Illness. This is important given the ebbs and flows of symptoms, and the cycles of relapse and remission that characterize many chronic conditions.

Case Management

As described previously, case management can be extremely complex in chronic illnesses because of the large number of medical professionals and treatments that can be involved. The FFPT can be used successfully as a chronic illness case management tool. The goals in case management run parallel to the clinical goals.

In **Phase 1**, the case management goal is to establish a case management focus. This includes restructuring the activities of daily living, engaging in family case management, assisting patients in navigating the health care system, intervening in the workplace if necessary, and acting as the patients' advocate.

In **Phase 2**, the case management goals are patient data collection and activity restructuring. With the help of the case manager, patients assess and restructure their activity levels and develop new parameters and norms. The case management continues to help with family case management, negotiation of the health care system, intervention with the employer, and patient advocacy.

In **Phase 3**, the case management goal is helping patients develop self-management skills. Patients learn to monitor their activities, coordinate their medical care, become their own health care advocates, and in general assume advocacy for themselves in the world at large. In **Phase 4**, the case management goal is to deepen patients' self-management skills.

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.

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

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 or gradual) to emergency period when the patient 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 (physical therapy, occupational therapy)	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 chronic illness limitations	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 treatments with “just living”
Phase Assessment & Intervention	Conduct psychosocial 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

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

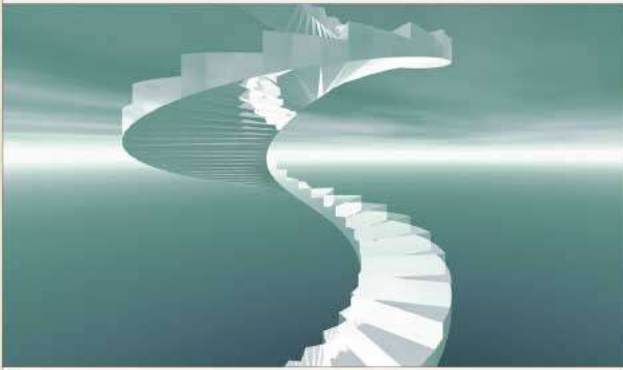
pursuing the ever-elusive cure, but integration of the illness into the patient's life. For patients and their families, the FFPT™ helps them to organize a narrative of their experience, essential for patient education and self-management.

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The Chronic Illness Workbook



STRATEGIES *and* SOLUTIONS
for TAKING BACK YOUR LIFE

Patricia A. Fennell, MSW, LCSW-R

The Chronic Illness Workbook brings clarity and order to what feels like an unmanageable and isolating experience. It shows both those who are ill and those who care for them how to live a full and meaningful life despite undeniable difficulties. Using her extensive experience with chronic illness patients, Patricia Fennell has created an original, comprehensive, research-validated approach that considers not only the physical aspects of chronic illness, but the psychological, social, and economic aspects as well.

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"*The Chronic Illness Workbook* is a valuable contribution that will be welcomed by the many sufferers of chronic diseases. It is of the greatest importance that patients learn to cope with the problems that cannot be remedied. Patricia Fennell's book provides an original and incisive approach to coping with chronic illness."

Noel R. Rose, M.D., Ph.D., Director of the Autoimmune Disease Research Center at the Johns Hopkins University School of Hygiene and Public Health

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