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Bio statement:

Daniel Lancaster is an LCSW who works in private practice in addition to being the Director of Clinical Authorizations at Elevated Outcomes. Daniel received his undergraduate degree from Weber State University and his MSW from the University of Utah. Currently, Daniel is working on his PhD, studying a therapeutic method called logotherapy which focuses on helping clients develop depth of personal meaning in life. Throughout his career, Daniel has worked with medically complicated patients who suffer from both medical and mental illness. He launched his private practice in 2013 where he specializes in medically complex patients, trauma, grief, and professional wellness consulting.

Treating the Soul

Addressing emotional wellness after a diabetes diagnosis

Daniel Lancaster, LCSW

Psychotherapist at Insight Therapeutic Services, LLC

PhD Candidate, existential analysis

Who is this guy?

- LCSW
  - MSW from U of U
- Career in medical social work
  - UUMC ED
  - Huntsman Cancer Institute
  - Elevated Outcomes, LLC
- Private practice: Insight Therapeutic Services, LLC
  - Specializing in medically complex/comorbid mental health
  - Consulting for professional wellness
- PhD candidate, studying existential analysis (logotherapy)

Learning Objectives

1. Develop an understanding of the Fennell Four-Phase model and how to identify which phase a patient is in
2. Establish phase-based means of interacting with patients
3. Identify resources for ongoing patient needs and professional enrichment

The Big Picture

Approaching with a relevant paradigm

Imposed Change

- Powerlessness
  - Confronted by limitations
- Grief and a need to mourn
  - Suffering and exploration
  - Acceptance and meaning
- Chronicity
  - Grief will continually re-impose itself
- Cure seeking
  - Unrealistic at best, pathological at worst

Global Guidance

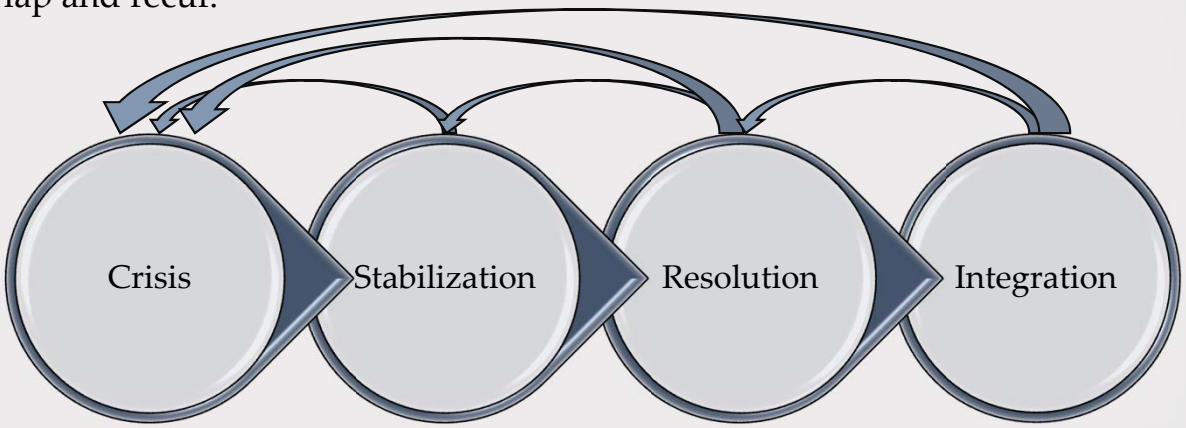
- Stick to your scope
  - From an emotionally supportive place
- People, not disease
  - Biopsychosocial & Transpersonal
- Balance emotional support with empowerment efforts
  - Avoid pathologizing their psychology
  - Avoid over-pathologizing their pathology
    - (i.e. victimizing via disease)

Four-Phase Approach

A non-pathologizing, de-mystifying, and empowering approach to understanding the impacts of chronic illness

Four-Phase Overview

- Flexible framework
  - "Employs the term *phase* rather than *stage* because it does not regard the phases as discrete entities . . ."
  - Phases can overlap and recur.



  - "The overall goal of the Four-Phase Model is integration of the illness into the patient's life, not a cure in the traditional sense. . . Chronic illness patients never leave the phases. The process of maintaining themselves, ideally in the integration phase, is ongoing."

Fennell, P. A. (2003)

Four Phases, Three Domains

1. Physical-Behavioral
   - Biological state of their disease and what they do or don't do about it and other areas of life
2. Social-Interactive
   - Relationships and other social environments such as employment
3. Psychological-Transpersonal
   - Thoughts, beliefs, emotions, life philosophy, and other aspects of one's internal world

Patient Experience in Crisis Phase

- Physical-Behavioral
  - Disease onset
  - May be gradual or emergent
- Social-Relational
  - Suspicion to support continuum
  - Shock, disbelief, and vicarious trauma
- Psychological-Transpersonal
  - Urgency
    - Fix it now!
  - Locus of treatment outside self
    - I can't help me; only others can
  - Self-pathologizing/Blame
    - Feeling simultaneously out of control yet totally responsible
  - Intrusive ideations
    - Unwanted, repetitive negative ideations of limitations and death
  - Ego Loss
    - Self-esteem diminished by reduced capacity
  - Low tolerance for ambiguity
    - Unknown is unmanageable; thus rejected

Grasping for control

"Patients in Phase 1 are typically overwhelmed by a sense of diagnostic and treatment urgency. They want to be fixed immediately, to have their painful condition removed as quickly as possible. Their sense of urgency usually includes and overwhelming need to identify their condition and what caused it. They desperately want to name the problem under the assumption that this will provide some degree of control over it."

Fennell, 2003, p. 99

Crisis Phase Based Care

Overall goal

- Trauma and crisis management
  1. Containment
  2. Allowance of suffering

Ya, but how?

- Establish a relationship
  - Warm, candid, and egalitarian
- Affirm illness and trauma
  - Willingness to listen and really hear
  - Validate traumatic experience, not minimize
- Normalize what's normal!
  - Education to scope-relevant information
  - Confront "emotional passing"
- Assert positive values
  - Personal worth, self-compassion, humor

Patient Experience in Stabilization Phase

- Physical-Behavioral
  - Plateau of symptoms
  - Stabilization to basic compliance
  - Seeking behavior
    - Other patients
    - Other providers/cures
- Social-Relational
  - Normalization failure
    - Symptoms controlled, but unable to return to "normal" life
- Psychological-Transpersonal
  - Slow return of internal locus
    - Increased (marginally) self-efficacy
  - Low tolerance of chronicity
    - Increased awareness but intolerant
  - Reduced self-pathologizing
    - Less blaming for their condition
  - Reduced intrusive ideations
    - Troubling thoughts diminish or become familiar, thus, less difficult

Better . . .but not "good enough"

"When patients reach a plateau of symptoms, they generally believe that they are on the way to a cure and that they shortly, if not immediately, should be able to resume their former life and activities. Their family, friends, and coworkers share these expectations. . . [However], at best, they can accomplish activities by trading off other activities. This failure to normalize and the ambiguity of their condition generate a new kind of suffering"

- Fennell, 2003, p. 188-189

Stabilization Phase Based Care

Overall Goal

- Restructuring life to fit limitations
  1. Balance
  2. Meet suffering with compassion

Ya, but how?

- Acknowledge and allow grief
  - Don't "fix" grief; compassionately allow it
  - Encourage expression
- Restructure coaching
  - Personal Energy Process (PEP)
    - Four areas: **1)** ALD's/self-care, **2)** personal enrichment, **3)** social/family, **4)** employment
- Self-observation
  - Data collection and journals
  - Reflection on wants and expectations
- Avoid "stabilization trap"
  - There is more than just being stable

Patient Experience in Resolution Phase

- **NOTE: Mixture of phases**
- Physical-Behavioral
  - Improvement
  - Continued plateau
- Social-Relational
  - Breaking silence
    - Confronting stigma
  - Selection of social support
    - Integration of support, separation from non-support
- Psychological-Transpersonal
  - Increased awareness and differentiation
    - No longer internalize others opinions/reactions
  - Increased self-esteem
    - Less self-pathologizing
    - Increased self-efficacy, internal locus of control
  - Increased tolerance
    - To both chronicity and ambiguity
  - Respect for self and suffering
    - "they are now standing with themselves rather than fighting against an alien self that the sickness has made them"
    - Creative process

Fennell, 2003, p. 258

The imperative of meaning

"The single most important intervention activity with Phase 3 patients concerns the development of meaning. In Phase 2, patients expanded and refined the insight into their illness and activities they began in Phase 1. This is an essential kind of insight . . . But even this kind of insight is not enough to sustain them for the long haul. Patients also need to place their lives in a wider context of meaning, first about the illness experience that has been imposed on them, but more importantly about what makes a life, even one as constrained as theirs, worth living."

Fennell, 2003, p. 253

Resolution Phase Based Care

Overall Goal

- Personal meaning and a new self
  1. Develop meaning
  2. Meet suffering with respect

Ya, but how?

- Maintain insight gains
  - Especially PEP and activity thresholds
  - Recognize and accept permanent losses
- Deep grief for lost self
  - Dark night of the soul
    - Failure to navigate results on phase regression, depression, suicide, etc.
  - Defining precrisis self → contrasting → phoenix
- Authenticity
  - Standing with actual thoughts and emotions, not "shoulds"
- Parallel process

Patient Experience in Integration Phase

- Physical-Behavioral
  - Integration as a cure
    - Full engagement in disease management
  - Relapse cycling
    - Relapse/stabilization/integration
- Social-Relational
  - Integrated supporters
    - Reconstructed relationships
  - Alternative vocational focus/activities
    - Reconstructed roles
- Psychological-Transpersonal
  - Comprehensive but growing phase understanding
  - Integration/alignment of pre- and post-crisis self
    - Discarded/grieved aspects
    - Hold on/integrated valued aspects
    - Process of "new" personal best
  - Quest for a full life
    - Broadened and deep sense of meaning
    - Continued emotional/spiritual/philosophical development

Living graciously

"Phase 4 patients integrate their illness into a whole and meaningful life. They no longer live merely as an illness write large, but as individuals with a variety of interests and engagements, despite how limited they may be physiologically. Their illness is just one aspect of their being. . . They manage to live graciously despite the rigors of both life and their chronic illness. . . Even when the effort is very difficult, they attribute high value to the sheer process, which in turn nurtures a renewed sense of self-esteem."

- Fennell, 2003, p. 315-316

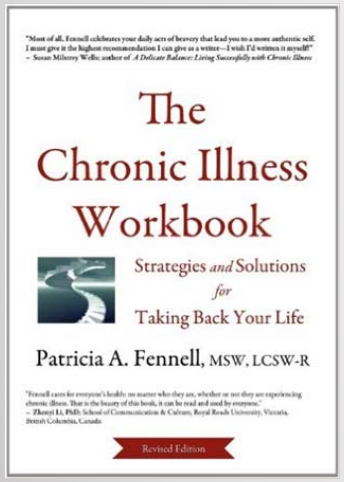
Integration Phase Based Care

Overall Goal

- Illness integration into a larger life
  1. Transcendence
  2. Integration of suffering

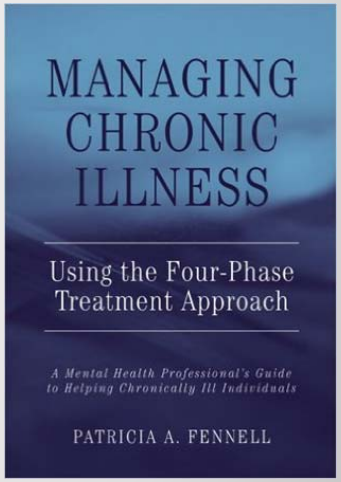
Ya, but how?

- Maintenance of new self
  - Simple encouragement and support
    - Less a patient, more a colleague in their care
- Free will
  - Every day they must make a choice to commit to the phase process; to what they have learned
  - Approach setbacks with mindfulness
- Continued meaning development
  - Evolving narrative



Resources & Enrichment

Stuff to study, ponder, and refer to



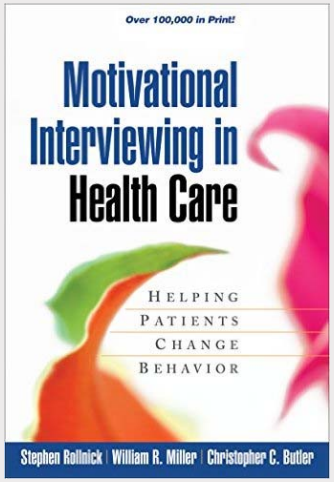
Biological-Behavioral

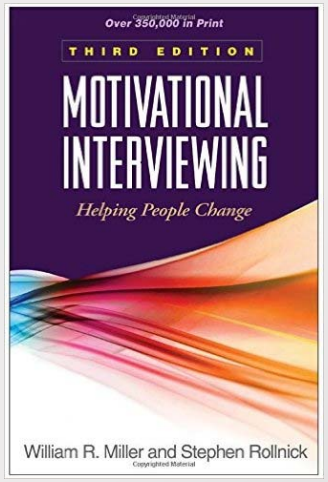
When to refer out

- Not engaging in treatment
- Relentless expressions of victimization
- If they ask

Professional enrichment

- Motivational Interviewing
  - Force multiplier: 10 – 15%
    - The "righting reflex"
    - Mining for "change talk"
    - Reflective listening





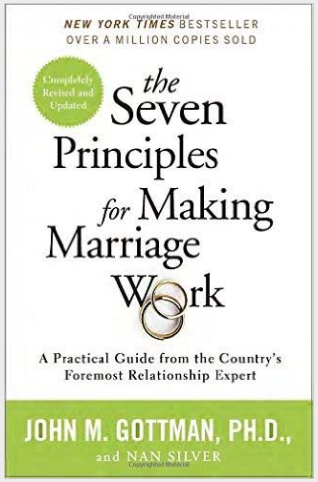
Social-Relational

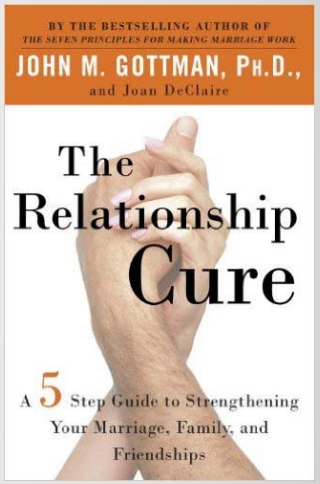
When to refer out

- Family conflict
- Relationships impacted by disease needs
- General lack of social support
- If they ask

Professional enrichment

- The Gottman Method
  - Best predictor of divorce: 96%!
  - Better relapse rate
    - "Four-horsemen"
    - Conflict management
    - Marital friendship
    - Shared meaning and goals

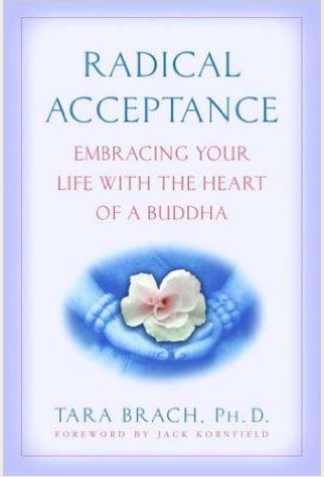




Psychological-Transpersonal

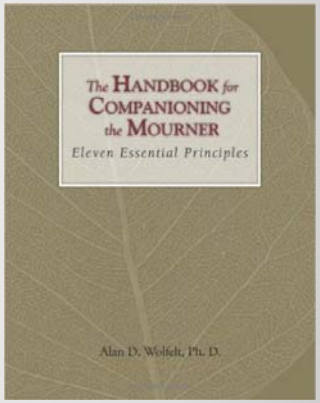
When to refer out

- Visceral or extended grief
- Depression, anxiety, panic attacks
- Hopelessness
- Religious/spiritual crisis
- If they ask

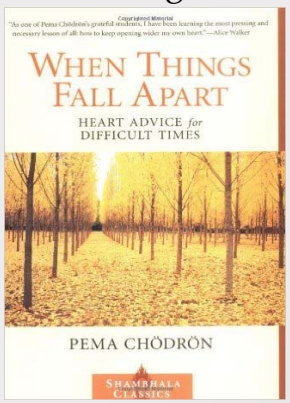


Professional enrichment

- "Companioning the Mourner"
  - Allan Wolfelt, PhD



- Mindfulness and Radical Acceptance
  - Relating to suffering



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Questions?

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