

# Intuitive ways of coping with illness: Acute vs. chronic thinking

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*People's experience of physical illness is influenced by their understanding of acute versus chronic health conditions. An awareness of this helps our understanding of the range of presentations patients<sup>1</sup> and families display in the presence of health professionals when given or adjusting to a chronic health diagnosis. Such an understanding may enable health professionals to help patients shift their expectations towards learning to 'live well' with a chronic health condition. The role of Clinical Psychologists in this is discussed.*

**D**EPARTMENT of Health statistics (DOH, 2004) show that 6 in 10 adults report at least one chronic health condition (e.g. diabetes, osteoporosis, chronic obstructive pulmonary disease). Such chronic health conditions and their complications account for 60 per cent of hospital bed use, and 80 per cent of GP consultations (DOH, 2004). Eiser (1993) describes how 15–20 per cent of children have a chronic illness (e.g. diabetes, asthma, cystic fibrosis). Similarly, a more recent Canadian study shows that 30 per cent of 6–11 year olds have a chronic health condition (McDougall et al., 2004). Chronic health conditions are evident across the age range, with incidence increasing with age. The cost to the health system of managing patients with these conditions is immense. Interestingly, despite these figures, a recent UK survey of general health only indicated that between 19–21 per cent of adults rated their health as 'less than good' (Office for National Statistics, 2010). Clearly the presence of a chronic health condition alone is not enough for people to perceive themselves as in poor health. How people interpret and manage their health condition is all important to how they perceive their health and interact with health services and professionals.

## Learning to cope

Many factors influence the ways we learn to cope with illness and adversity. Previous

experience of illness and adversity plays a major role. This includes coping behaviour modelled to us by our parents' responses to illness and adversity (Evans et al., 2008), personal temperament (Chess & Thomas, 1995) and pre-existing mental health difficulties (Evans et al., 2008). Our own experience and judgement of the illness and the strategies we have used to cope also play a role. The quality of early attachments to caregivers can shape our sense of security, predictability of our environment, emotional regulation, and consequently influence coping and illness behaviour (Feeney, 2000; Scharfe & Eldredge, 2001). Plus, how we interpret the meaning of illness (Sullivan et al., 2001) and how we may be specifically taught 'coping strategies' will influence how illness is managed; this being the premise behind many psychological interventions, such as cognitive behaviour therapy.

Expectations about what it is to 'cope' might also be formed by exposure to popular media (TV hospital dramas, drug advertisements) as well as the real-life medical system itself; in which all too often emotions may be overlooked or neglected and the message of being 'brave' is to 'not make a fuss'.

## Intuitive coping behaviour

By far the most common experience of 'illness' in the general population is in rela-

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<sup>1</sup>The terminology 'patient' is familiar and well understood within the physical health settings this article focuses on, and is used throughout this article on this basis.

tion to acute health conditions such as viral illnesses (colds, flu), broken bones and acute pain due to injury or illness. Such illnesses are termed 'acute' because of their transient nature, rather than severity of symptoms. On the whole, these 'acute illnesses' with time and relevant intervention are able to resolve and leave a person in good health again. As a consequence of this belief, a particular way of coping or managing being ill under these circumstances has evolved. It also lends to a particular way of parents, carers, partners helping and caring for these patients.

With such an understanding, patients tend to resort to resting, seeking sympathy, recognition and support from others, avoiding things that may exacerbate the problem further (such as increased activity or demands), and seeking medical treatment (e.g. medication) to make things 'better'. Similarly, parents, carers and partners often resort to providing sympathy, reassurance and support, encouraging rest and recuperation, help by getting an 'expert' (usually medical professional) to solve the problem, and protecting them from further discomfort (such as reducing demands and expectations, and encouraging avoidance of potential 'exacerbation'). By and large, these strategies are helpful when dealing with acute illness.

In contrast to acute illnesses, we know that chronic illnesses are either long lasting or recurrent, and may have a tendency to slowly progress in severity and impact upon the body (e.g. asthma, diabetes, inflammatory bowel disease). The majority of chronic illnesses are not infectious, although there are exceptions (e.g. HIV). Because of the nature of chronic illness, the concept of what it is to 'get better' cannot equate to 'getting rid of illness'. Instead, a good outcome for patients with chronic illness includes good management of treatment regimens, increased well-being (physical, emotional and social), increased quality of life, and generally learning to 'live well' with the condition.

Perhaps counter-intuitively, in order to live a more 'normal life' patients must

accept that they have a chronic (long-term) illness in the first place. All too often there is the tendency to deny or try to ignore this. Such an adjustment to acceptance can take time, trial and error, and in some circumstances require further support (e.g. psychological intervention). Only through acceptance of their condition can a balance between quality of life and condition management take place. This also involves a change in perspective from short-term thinking about illness and health related goal setting to thinking more long-term.

For many patients and families the understanding of how acute and chronic illnesses differ will not be known. When it comes to managing chronic illness the strategies described above for dealing with acute illnesses are no less intuitive. Unfortunately, such strategies are no longer effective in managing the condition and conversely can act to reinforce, prolong and even exacerbate the problem.

Examples of how such behaviours can exacerbate chronic health problems are highlighted in the literature looking at family interactions and their influence upon paediatric pain. Blount et al. (1989, 1990) identified how parental 'distress promoting' behaviours (reassurance, empathy, apologising, criticising, catastrophising) can exacerbate child responses to painful procedures, and how 'coping promoting' behaviours (providing distraction, commands to engage in coping, encouragement of breathing techniques) did the opposite. Similarly, other studies (Peterson & Palermo, 2004; Walker et al., 2006) have also shown how parent behaviours of paying sympathetic attention to their child's pain and allowing avoidance of regular activities can exacerbate their child's experience of pain. These 'distress promoting' behaviours and 'paying sympathetic attention' represent many parents' best attempts at coping and managing children's pain and distress.

Such behaviours are also evident with adult patients and their families, and are not just specific to children. In addition to these behaviours, many families may fall into the trap of overcompensating by 'spoiling' fam-

ily members who are ill. This derives from the desire to take action to alleviate distress by pacifying, comforting and distracting with 'extra-special' attention and rewards. Again, such strategies can be helpful for short-term illness. When faced with long-term health conditions, they can foster incorrect and unhelpful expectations, over-reliance on others to alleviate distress and disengagement from finding their own strategies for managing illness. Coupled with this, the prospect of losing these and other 'secondary gains' (e.g. keeping families 'together' by having to care for the 'ill' person, time off work/education, financial assistance) may mean managing well becomes far less enticing.

When considering all of these unhelpful behaviours, we propose that such seemingly maladaptive strategies may stem from intuitive responses based upon an understanding and familiarity with acute illness, as described above.

### **Promoting coping**

Because chronic illnesses bring patients into regular contact with health services, health professionals are witness to the full range of coping strategies. Although understandable, all too often maladaptive coping strategies of being overly protective, sympathetic and 'needy' are negatively viewed by health professionals in exasperation, and with frustration, blame and admonishment. It is important to normalise patient and family behaviours as intuitive yet unhelpful responses to a chronic health condition, otherwise there is the danger that patients and their families may experience professionals to lack patience, understanding and empathy. This in turn may lead to poor engagement with services and treatment regimens, and an overall reduction in how they manage and view their health.

Instead it is essential that health professionals first understand the normal range and diversity of responses of patients and families to a diagnosis of chronic illness. Despite the growing body of literature, guidelines and initiatives promoting the involvement of psychological services in

physical health settings, the responsibility of socialising families into understanding the nature of chronic illness falls to all health professionals. The language we use to communicate this understanding can also be confusing. For example, the word 'chronic' is often understood to indicate severity of symptoms, as illustrated by comments such as 'my back hurts something chronic'.

A key role for clinical psychologists working in health settings is to educate and then support other professionals to remain mindful of 'acute illness behaviours or responses' that might initially emerge in the short-term when diagnosed with a chronic condition, and to then encourage a focus on long-term management and quality of life. Such education needs to articulate how some patients and their families may require more time from health professionals in the initial stages following diagnosis. By communicating such an understanding, helping educate about the difference between acute and chronic illness using everyday language, and normalising patient and family responses, we may improve patient care through better engagement with services. Only with patience, understanding and empathy can health professionals help promote a shift in thinking for patients and their families to longer-term goal setting and striking a balance between medical management and quality of life. Since seeking a 'cure' is impossible, only through learning to 'live well' despite having a chronic health condition can patients improve perception and management of their health which, in turn, will influence how they interact with health services.

Some patients and families will invariably become 'stuck' after engaging in acute illness responses, and may require therapeutic input from clinical psychologists. In these circumstances a simple explanation of the difference between acute and chronic illness and appropriate coping responses will not be enough. Therapeutic work often needs to address secondary gain issues; helping patients' and families to find different ways of meeting unfulfilled needs instead of

adopting a 'sick role'. Working to build confidence in managing treatment regimens and coming to terms with the permanent nature of their condition is also essential.

Often, the most important element to therapeutic involvement is in helping patients and families learn that living with unpleasant side effects or symptoms, instead of trying without success to rid themselves of these, can actually lead to better emotional well-being and quality of life in the long-run. Counter-intuitively, this may even reduce the experience of these symptoms on occasions too. Achieving this understanding with patients therapeutically is difficult, although acceptance and commitment therapy (ACT) and other 3rd wave cognitive-behavioural approaches show great utility and promise in this area (Prevedini et al., 2011; Veehof et al., 2011).

Overall, there is huge value in clinical psychologists working in physical health settings, both 'directly' (in seeing patients face-to-face) and 'indirectly' (through edu-

cating and intervening at systemic levels in organisations). The financial implications of this for the NHS in the current economical climate are immense. The more difficult challenge for our profession is to find ways of quantifying and measuring our impact and cost effectiveness in these environments in order to secure continued commissioning of posts.

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