

2004

Chronic medical illness : the counselor's role

Diana J. Cira
University of Northern Iowa

Copyright ©2004 Diana J. Cira

Follow this and additional works at: <https://scholarworks.uni.edu/grp>

 Part of the [Counseling Commons](#), and the [Therapeutics Commons](#)

Let us know how access to this document benefits you

Recommended Citation

Cira, Diana J., "Chronic medical illness : the counselor's role" (2004). *Graduate Research Papers*. 525.
<https://scholarworks.uni.edu/grp/525>

This Open Access Graduate Research Paper is brought to you for free and open access by the Graduate College at UNI ScholarWorks. It has been accepted for inclusion in Graduate Research Papers by an authorized administrator of UNI ScholarWorks. For more information, please contact scholarworks@uni.edu.

Chronic medical illness : the counselor's role

Abstract

In the next few decades, the number of chronically medically ill individuals in the United States will increase dramatically. To implement necessary interventions to improve their care, the United States health care system must make changes in the approaches used for these individuals. Counselors can play a critical role in these changes. By incorporating counselors in the care of individuals with chronic medical illnesses, the health care system will be better able to provide interventions that aid in effectively coping with the illnesses and the many psychosocial ramifications of the illnesses.

CHRONIC MEDICAL ILLNESS: THE COUNSELOR'S ROLE

A Research Paper

Presented to

The Department of Educational Leadership,
Counseling, and Post Secondary Education

University of Northern Iowa

In Partial Fulfillment

Of the Requirements for the Degree

Master of Arts

by

Diana J. Cira

May 2004

This Research Paper by: Diana J. Cira

Entitled: CHRONIC MEDICAL ILLNESS: THE COUNSELOR'S ROLE

has been approved as meeting the research requirement for the Degree of Master
of Arts.

3-9-04

Date Approved

Duane Halber

Advisor/Director of Research Paper

3-10-04

Date Received

William P. Callahan

Head, Department of Educational Leadership,
Counseling, and Postsecondary Education

Abstract

In the next few decades, the number of chronically medically ill individuals in the United States will increase dramatically. Delivery of health care for individuals with chronic medical illnesses is developing into a major health care challenge facing the United States. Individuals who have been diagnosed with a chronic medical illness are confronted with many obstacles that challenge their ability to maintain self-management strategies for their chronic illness. All self-management strategies involve the ability to remain motivated and consistent. Whether the individual with a chronic medical illness is a child or an adult, the reality of the daily struggles can become overwhelming. The impact of a chronic physical illness on the mental and psychological well being of an individual may lead to depression. Not only do individuals with a chronic physical illness become affected by the daily management stresses, but family members and caregivers as well experience great mental and psychological distress. With early intervention to address the stress and life changing impact of the illness among individuals with a chronic physical illness, their families, and their caregivers, prevention of severe depression and a worsening of the chronic illness may be avoided. To implement necessary interventions to improve the care of chronically medically ill individuals, the United States health care system must make changes in the approaches used to care for these individuals. Counselors can play a critical role in these changes. By incorporating counselors in the care of

individuals with chronic medical illnesses the health care system will be better able to provide interventions that aid these individuals in effectively coping with their illnesses and the many psychosocial ramifications of the illnesses.

Chronic Medical Illness: The Counselor's Role

As the population ages over the next two to three decades, the number of chronically medically ill individuals in the United States is expected to increase dramatically (Friedman, Myers, Sobel, Caudill, & Benson, 1995). In addition to a growing number of elderly with multiple chronic illnesses, the health care system has seen an increase in other serious chronic illnesses among much younger individuals as well. Diabetes, AIDS, hepatitis C infection, cystic fibrosis, multiple sclerosis, cancer, asthma, and chronic back pain are examples of chronic medical illnesses impacting young as well as older individuals. Though not considered a chronic illness, hearing impairment among the elderly is associated with significantly more depressive symptoms, low sense of mastery, increased sense of loneliness, and a reduced social network (Kramer, Kapteyn, Kuik, & Deeg, 2002). Because of the increased risk for psychosocial distress, hearing impairment in the elderly should not be minimized. Glasgow, McKay, Piette, and Reynolds (2001) suggest that "care of patients with chronic illnesses is arguably the major health care challenge for the next century" (p. 119).

Several factors appear to have impact on the long-term management of chronic illness. Certainly knowledge about the illness, knowledge about ways to manage the illness, the individual's personal lifestyle, and outlook on management of the illness have significant impact (Roth & Robinson, 1992).

Several researchers, Kerr (2001), Roberts, Kiselica, and Fredrickson (2002), and

Gagnon and Patten (2002) also propose that the presence of chronic medical illness is consistently associated with an increased prevalence of depressive symptoms and disorders. Simon (2001), Burke and Elliott (1999), and Clark, Cook, and Snow (1998) further contend that the presence of depression significantly increases and complicates the care as well as diminishes the quality of life for patients with chronic medical conditions.

Counselors, utilizing skills and interventions that empower an individual to incorporate knowledge about the chronic illness with a personal lifestyle management plan, can be valuable assets to the medical treatment team. One of the functions of counseling for individuals with a chronic medical illness is to activate the individual's coping mechanisms and reinforce and affirm the individual's strengths. By tapping these inner resources, psychological distress and physical symptoms are reduced, and individuals are more able to face the psychosocial challenges of the illness (Roberts, Kiselica, & Fredrickson, 2002).

Prevalence of Depression Among Chronically Ill Individuals

According to Remien and Rabkin (2001) depression is "the most common psychiatric disorder observed among HIV-positive patients" (p. 332). The existence of depression in the presence of HIV infection has been linked to poorer health outcomes, increased risk taking and maladaptive behaviors (Remien & Rabkin, 2001). In the study by Black, Goodwin, and Markides (1998), findings suggest that a cluster of illnesses, diabetes, stroke with residual speech problems,

arthritis, cancer, and kidney disease were associated with the presence of high levels of depressive symptoms. Clark et al. (1998) agree with other researchers that between 30-50% of primary care medical patients experience significant depressive symptoms compared to 9-20% of the general population.

Additionally, the prevalence of high levels of depressive symptoms increases with the number of chronic conditions experienced (Black, Goodwin, & Markides, 1998).

The prevalence of depression associated with the diagnosis of a chronic illness is not limited to adults. Burke and Elliott (1999) suggest that depression is a significant complication of chronic illness and its management for children and adolescents with a chronic illness. Stein, Westbrook, and Silver (1998) concluded that their research supports the findings of previous research implicating chronic health conditions with increased adjustment difficulties in children experiencing chronic medical illness. Adolescent females with diabetes have a risk of recurrent depression approximately nine times greater than the risk of adolescent males with diabetes (Burke & Elliott, 1999).

Another consideration in the long-term management of children with a chronic illness is the impact on the family and caregivers. The results of the research conducted by Ireys, Chernoff, DeVet, and Kim (2001) indicate that in the nearly ten million American families who have a child with a chronic medical

illness, primary guardians, often the mothers, are at risk for secondary mental health problems.

Caregiver strain has been recognized as a mental health problem associated with the care of adults with chronic medical illness as well. Gender of the caregiver may increase the likelihood of psychological distress. The implications of study results by Hagedoorn, Sanderman, Ranchor, Brilman, Kempen, and Ormel (2001) are that when a female spouse is the caregiver for an individual with a chronic illness, there may be an association between the woman's psychological distress and both her own and the spouse's health condition. Whereas a man's psychological distress was associated only with his own health condition. Adjustment issues such as these just mentioned, faced by the chronically medically ill and their families, can be predictable, anticipated, understood, and prepared for in advance and yet, within the health care system are not well addressed (Roberts, Kiselica, & Fredrickson, 2002).

Over the past century, the traditional medical model of care has been utilized throughout our health care system. This Western medicine model awards little attention to the psychological well-being of individuals with a chronic illness. In the traditional medical model the psychological, emotional, and spiritual impact of a chronic illness on the individual or his/her family is not addressed. Fortunately, new research is addressing the needs of the chronically medically ill and suggesting a new paradigm, one that Roberts, Kiselica, and

Fredrickson (2002) describe as a “biopsychosocial model of health and well-being emphasizing reciprocal interactions among biological, psychological, social, and spiritual dimensions that influence health” (p 422).

In the biopsychosocial model, psychological counseling is an integral part of routine chronic disease management. A variety of counseling strategies and interventions were identified within the literature pertaining to chronic disease management. These include addressing the individual’s sense of loss of control, self-efficacy issues, and coping skills. Cognitive behavioral approaches, motivational interviewing, and medical crisis management, family therapy interventions, as well as biofeedback, relaxation training, and bibliotherapy have also been utilized therapeutically in chronic illness counseling (Folkman & Greer, 2000).

Personal Impact of a Chronic Medical Illness

The diagnosis of a chronic illness disrupts a person’s sense of self and dramatically alters that person’s sense of control (Williams & Koocher, 1998). Roberts, Kiselica, and Fredrickson (2002) suggest that the sense of powerlessness and helplessness that accompanies loss of control is an important issue for people with a chronic illness. A sense of control also relates to one’s feeling of self-efficacy, or belief that one can exercise some strategy to bring about a desired outcome. As with other aspects related to depression, gender awareness may be beneficial for counselors working with an individual experiencing difficulties

related to sense of control. Men may be more likely to experience increased sense of loss of control and emotional distress, especially in a hospital setting (Williams & Koocher, 1998).

Alteration of self-image occurs when an individual receives a diagnosis of chronic illness. The individual must abandon previously held beliefs about self and begin to make peace with the altered self and circumstances (Roberts, Kiselica, & Fredrickson, 2002). Reconstructing positive self-conceptions is a major task for individuals with a chronic illness. In her study on infertility, Daniluk (2001) noted that the ability to construct a positive self-image, for individuals and couples, developed from a renewed commitment to and valuing of self that was greater than and separate from their inability to procreate. Self-image is also a salient factor in the emotional and psychological development of teenagers. For those teenagers with a chronic medical illness, addressing the issue of self-image becomes of paramount importance. Neinstein (2001) states, "developmental processes involved in adolescence have a complex and bi-directional interaction with chronic illness such that a chronic disease can alter development and vice versa" (p. 294).

Additional fears arise from increasing emotional and social stresses. Fears include loss of previously valued roles, isolation, abandonment, dependency on others, and death. Chronic illness often results in a loss of role or changes in the ability to function in a previous role or roles. If a role is highly valued, loss of the

role may result in additional reduction of self-esteem (Vilhjalmsson, 1998).

Psychosocial issues, especially family relationships, connectedness, and support have greater influence on a sense of well-being for teens than the chronic illness itself (Neinstein, 2001).

Chronic illness can also have a significant impact on financial resources. Reduced income is often experienced by medically chronically ill individuals due to unemployment, fewer working hours or periodic loss of work hours due to illness, and the additional financial burden of the cost of treatment. Lack of financial resources may lead to increased sense of loss of control, increased fear of dependency, reduced self-esteem, and increased interpersonal strain (Vilhjalmsson, 1998). Roberts, Kiselica, and Fredrickson (2002) argue that the inner resources of any psychologically healthy individual are spread beyond their limits when faced with the social and psychological challenges of a chronic medical illness. The stretching of inner resources may lead to depression in a significant number of individuals with chronic illness.

Evidence to Address Psychological and Social Needs of Medically Chronically Ill

Van Eijk and de Haan (1998) agree with others studying the management of chronic illness that a diagnosis of a chronic illness influences everything in the individual's life for the rest of that person's life. For that reason it is important that the individual learns an acceptance of the illness as part of their new self-

image. Thorne and Paterson (2001) suggest that the acceptance of an illness and the resultant ability to self-manage the illness involves shifting beyond compliance to medical advice to one of developing personal meaning, understanding, and experiential logic regarding self-care and medical information utilization.

In some cases, such as Parkinson's disease, hypothyroidism, cerebrovascular diseases, and multiple sclerosis, depression appears to be a direct biological effect of the illness and/or treatment. However, behavioral mechanisms appear to be associated with depression in many other chronic illnesses, especially those in which the activity limitations of the illness lead to the individual gradually withdrawing from rewarding activities (Simon, 2001). Chronic physical illnesses may be both directly and indirectly associated with depression. Roberts, Kiselica, and Fredrickson (2002) and Cuijpers (1998) estimate that from 36% to 50% of individuals with a chronic medical condition experience depression and that depression occurring during the recovery period of a life-threatening illness predicted a much poorer outcome.

Early mortality and increased morbidity appear to be related to the presence of depression. Depression increases the risk for myocardial infarction and is a predictor of a poorer outcome after a myocardial event (Frasure-Smith, Lesperance, & Talajic, 1995). Osborn (2001) argues that the established link between depressive symptoms and increased mortality and morbidity establishes

depression as a major lethal burden yet to be intensively researched. In addition to the direct personal impact of depression and its association with medical illness, the financial cost to the health care system is immense.

Individuals with symptoms of depression seek care from general practitioners for physical complaints at a much greater rate than individuals who do not have symptoms of depression. Friedman, Sobel, Myers, Caudill, and Benson (1995) estimate that about 60-75% of health care visits to HMO's are made by the "worried well" and that in the cases of unknown and unconfirmed etiology it was likely that psychological factors were responsible for symptoms. Primary care physician visits driven by psychological status rather than an actual medical need drive up the cost of health care (Koocher, Curtiss, Pollin, & Patton, 2001). Additionally, research in diabetes management indicates that the presence of depression negatively impacts the adherence to a diabetes treatment plan and increases complication rates, thus increasing the cost of health care (Resnicow, Dilorio, Soet, Borrelli, Hecht, & Ernst, (2002). Simon (2001) estimates that depression is associated with a 50%-100% increase in the use and cost of health services.

The financial cost to the health care system is increased when a dependent individual, such as a child develops a chronic medical illness and caregiver psychological and social needs are not met. The cost to the system is two-fold, first direct impact from the decline in mental and physical health of the caregiver

which may result in increased utilization of services for the caregiver. Secondly, unmet psychological and social needs of the caregiver result in decreased ability to cope with the responsibilities of care which result in less effective care giving and increased rates of complications and utilization of the health care system for the individual with the chronic illness (Thyen, Terres, Yazdgerdi, & Perrin, 1998).

Diabetes mellitus, both Type 1 and Type 2, demand enormous personal energy investment for management of the illness. Type 1 diabetes results from an autoimmune process that causes the destruction of the insulin producing cells of the pancreas and most often occurs in children. Type 2 diabetes occurs more gradually as a result of resistance to insulin working and progression to a state of decreased insulin production, often diagnosed at middle age. Though the mechanism of disease is different, the mental, physical, and emotional investment by the individual to maintain a near normal blood glucose level can be overwhelming. Because Type 1 diabetes occurs in children, this illness has a tremendous psychological impact on the parents and other caregivers of the child.

The results from research in management of children with Type 1 diabetes have revealed that many parents caring for children with Type 1 diabetes meet the criteria for posttraumatic stress disorder (PTSD). Landolt, Ribl, Laimbacher, Vollrath, Gnehm, and Sennhauser (2002) found that 24% of the mothers and 22% of the fathers of children with Type 1 diabetes in their study met full diagnostic criteria for PTSD. Additionally, 51% of the mothers and 41% of fathers met

criteria for subclinical PTSD. The psychological impact of a diagnosis of chronic illness of a child on the adult caretaker appears to be very significant. Addressing both caregiver needs and the needs of the individual with a chronic illness should be incorporated into the treatment plan of individuals with chronic medical illness.

Support for Counseling Interventions In the Care of Medically Ill Individuals

Roberts, Kiselica, and Fredrickson (2002) suggest that growing scientific evidence supports the rationale for the incorporation of counseling into the treatment plan of care for individuals with a chronic medical illness. They point to the growing mind-body research indicating the facilitation of physical healing through mental processes and improved outcomes when a more integrated approach addresses a multiplicity of issues (biopsychosocial model). A number of clinical trials support the efficacy of biofeedback in treating chronically painful conditions (Haythornthwaite & Benrud-Larson, 2000). Remien and Rabkin, (2001) indicate that cognitive behavioral therapy and interpersonal therapy have shown positive effects in alleviating depression in HIV-positive individuals.

Penninx, Tilburg, Boeke, Deeg, Kriegsman, and van Eijk (1998) found evidence that both social support and personal coping resources in the presence of a chronic illness decrease depressive symptoms in elderly individuals. Results of randomized controlled studies give some evidence that cognitive behavioral and behavioral therapy are effective treatments for chronic back pain and chronic

fatigue syndrome and that improvements in pain management were sustained at one year follow up visits (Raine, Haines, Sensky, Hutchings, Larkin, & Black, 2002). Additionally, their research indicated that the effect of cognitive behavioral therapy continues to improve over time. Because individuals with chronic pain often have symptoms for many years, they are frequent utilizers of the health care system.

Lustman (1998) found that using a combination of cognitive behavioral therapy with diabetes education was effective in treating major depression among patients with Type 2 diabetes. A significant finding in this study was that at six-month follow up individuals receiving cognitive behavioral therapy had significant improvement in average blood glucose levels. If a lower blood glucose level is maintained over time, significant reduction in complications from diabetes can be anticipated. Cognitive behavioral therapy could have tremendous cost savings and prove to be extremely cost effective as a treatment intervention with some chronic illnesses.

White (2001) contends that a cognitive therapy framework is well suited to address the difficulties associated with a chronic illness and its management. Three primary factors were identified by White (2001): 1) chronic medical illnesses are often associated with mood disorders and fatigue, two psychological problems for which research indicates cognitive therapy has efficacy, 2) the active self-management and collaborative approach necessary for management of a

chronic illness fit with the philosophy of cognitive therapy, and 3) the emphasis in the cognitive therapy model on learning many skills for the management of psychological problems can be readily applied to skills for chronic illness self-management.

Haythornthwaite and Benrud-Larson (2000) contend that the presence of pain is associated with significant reduction in mood and physical and social functioning which results in significantly poorer coping and adjustment. They suggest also that depression and poor coping skills are associated with greater pain severity while psychological interventions such as cognitive behavioral therapy, biofeedback, hypnosis, and operant behavioral therapy appear to significantly reduce pain and improve social role functioning. Cognitive behavioral therapy produced significant positive changes in measures of pain, mood, cognitive coping, and social role functioning in a study conducted by Morley, Eccleston, and Williams (1999) as well.

In the view of Friedman et al. (1995) formal "behavior modification programs make sense both clinically and economically because systematic efforts at changing behavior have been shown to be more successful than informal unsystematic efforts" (p 511). Glasgow, McKay, Piette, and Reynolds (2001) further suggest that to be cost effective and have an impact on large segments of the population for chronic illness management, group therapies rather than one on one contact will be necessary. Earlier studies support the benefits of group

counseling with women coping with physical illness. Roth and Robinson (1992) suggested that for female clients with a chronic illness, individual, couple, and group counseling can enhance pain management, stress management, and coping ability of the woman and her family. In their view, group counseling was a very powerful and supportive intervention.

Two relatively new approaches to counseling individuals with chronic illness are Medical Crisis Counseling (MCC) and Motivational Interviewing (MI). Both approaches place the counselor in a facilitative role as problem identifier, problem solver, change agent, and coach in a solution-focused, client-centered orientation (Resnicow, et al., 2002; Koocher, et al., 2001). According to Resnicow et al. (2002), the goal of Motivational Interviewing is to help clients work through their ambivalence about behavior change and accept the chronic nature of their illness. The goal of Medical Crisis Counseling is to integrate psychosocial interventions with medical care delivery and assist clients in problem-solving key issues related to coping with the chronic illness (Koocher et al., 2001).

The approach by Folkman and Greer (2000) is very similar in concept to MI and MCC. They recommend three key components for a therapeutic approach to assist individuals with chronic medical illness to maintain psychological well-being; 1) creating the conditions for challenge, 2) encouraging behaviors to achieve goals, and 3) maintaining background positive mood. Like MI and MCC,

the approach by Folkman and Greer stresses the importance of finding out what matters to the individual with the chronic illness and establishing goals related to the meaning of the illness to him/her. And, as in MI and MCC, the emphasis is on personal control. Results of the research on MI and MCC indicate that these well-focused interventions can reduce client distress, increase a sense of personal control, and enhance a sense of well-being in the face of chronic illness while potentially eliminating the need for costly mental health services later.

Barriers to Early Counseling Intervention

Though preliminary indications suggest that assisting clients to regain a sense of control early in their treatment reduces anxiety and depression (Williams & Koocher, 1998), the medical health system does not have an organized approach to addressing this major concern. Many barriers exist within the medical care model that interfere with early psychosocial intervention for the individual with a chronic medical illness. Such barriers include the beliefs of the Western medicine health care model, beliefs of clients, their families and health care providers, time, fragmented care, and limited research to indicate beneficial interventions.

Van Eijk and de Haan (1998) point out that a major hindrance to early referral is the belief system of the Western medical health care model. The paternalistic and exclusive orientation of this model of care often excludes the client in decision making regarding his or her own care. However, involvement

of the client in decision making has a positive impact on the doctor-client relationship and the willingness of clients to engage in self-care (van Eijk & de Haan, 1998). Lindsey (1997) further suggests that because the focus of the Western medicine model has been acute care with a curative mentality, the complex and long-term issues of chronic disease management often leave health care providers feeling inadequate, powerless, and unable to meet the needs of individuals with chronic illness.

Clients, their families, and health care providers often hold the belief that the client is supposed to be depressed when faced with a situation such as a chronic medical illness. The client, families, and providers may also hold the belief that the client will move beyond the negative feelings, emotions, and moods without help, the notion of “just get over it”. There also continues to be a stigma perceived by clients and their families when mental health services are utilized (Roberts, Kiselica, & Fredrickson, 2002).

The Western medical model also presents organizational challenges for many clients because of fragmented care. Clients with a chronic illness frequently receive care from several different health care providers, none of whom they know well, and therefore, may not feel comfortable enough with to discuss psychological issues. Additionally, health care providers have many demands on their time. With time limitations, providers are unable to address the social and psychological needs of a client who also has many urgent physical

problems (van Eijk & de Haan, 1998). Attempts to fully integrate a counseling strategy that assists clients in behavior change that would benefit long-term management of chronic illness has also been hampered by reimbursement policies and health care contracts that exclude many mental health and behavioral modification programs (Friedman et al., 1995).

Importantly, because psychological symptoms and somatic complaints often occur together, physicians have difficulty diagnosing depression when somatic symptoms are a client's major complaints (Kerr, 2001). Identification of client distress or depression is the first step in referral to mental health professionals. Remien and Rabkin (2001) argue that a primary task of the health care provider is to "identify the presence, duration, and severity of distress and depression" (p. 335) and refer the client to appropriate resources. However, Kerr (2001) contends that less than half of people affected by depression are accurately diagnosed even with tools that have been highly researched. Very little research has been undertaken to identify clients in medical crisis with corresponding psychological and social distress who may not meet the diagnostic criteria for depression but who clearly would benefit from mental health interventions (Kerr, 2001). It appears that a more systematic method of referral for clients with a chronic medical condition to mental health professionals would assist in identifying or preventing depressive symptoms.

Role of the Mental Health Counselor

Though research has indicated that utilizing mental health professionals to address the psychological and social needs of chronically ill individuals reduces health care costs, the national health care reform agenda has taken a short-sited approach to cost containment. Friedman et al. (1995) give convincing evidence that psychosocial interventions in the medical setting effectively address the true needs of individuals with chronic illness and maximize efficiency, therefore, having an impact on escalating health care costs. Counselors and other mental health professionals do have clear roles in the care and treatment of individuals, adults and children, with chronic medical illness.

The health care system is in need of a paradigm shift, one that is holistic and views the needs of all clients not from a paternalistic curative mind-set but from an inclusive, supportive, and integrated perspective (Roberts et al., 2002). Lindsey (1997) suggests that there is a very significant role for health care professionals, including mental health professionals, in supporting and facilitating different health and healing practices for the chronically medically ill. Mental health professionals are well trained to be active change agents. Counselors and other mental health professionals must first be facilitators within the health care delivery system to provide a closer linkage of medical care with psychosocial interventions that address the principal needs of the client (Koocher et al., 2001).

Mental health counselors play a vital role in assisting clients to regain a sense of control in their own care and management of a chronic illness. As Williams and Koocher (1998) point out, counselors are in a unique position to assist clients in determining what is controllable and what is not and then facilitating reordering of their priorities to maximize a sense of control and enjoyment in life. The mental health counselor can also provide the present missing ingredient of care in our medical health care model, that of listener and confidant for a client unwilling to discuss psychological concerns with a medical health professional not well known by the client or not able to take the time to listen to the client.

A critical counselor function is to facilitate change within a constructive and supportive relationship. The change facilitation assists clients to begin to explore new beliefs about chronic illness, what the illness means to the individual, and new possibilities for chronic disease management (Roberts, Kiselica, & Fredrickson, 2002). Counselors can then assist clients to set meaningful and achievable goals which in turn increase the client's self-esteem and sense of mastery. With increased personal coping resources of self-esteem and mastery, clients are less likely to develop depressive symptoms (Penninx et al., 1998).

Mental health counselors can also assist clients in learning new assertive and collaborative behaviors to use when working with medical health care providers. As van Eijk and de Haan (1998) and Lindsey (1997) indicate, clients

are often intimidated by the Western medical model of care and become less empowered, relinquishing control to the “medical experts.” Individuals with a chronic illness benefit from a more collaborative relationship with their health care providers and mental health counselors can help clients learn new behaviors that facilitate better communication and interaction with health care providers. The act of initiating the counseling process and the setting of mutually arrived at therapeutic goals can be an opportunity to remind clients that there are still things that remain under their control (Roberts, Kiselica, & Fredrickson, 2002).

Counselors have a role in research in the field of chronic illness management. The literature related to an integrative approach in chronic illness management that incorporates mental health counseling is growing but needs increased active involvement by mental health professionals (Folkman & Greer, 1999; Friedman et al., 1995; Roberts, Kiselica, & Fredrickson, 2002). Penninx et al. (1998) suggest that more research is needed to clarify what models of intervention are most effective with different chronic diseases. In their view, as well as in the view of Vilhjalmsson (1998), new research is needed to address which psychosocial interventions are most helpful, with whom, under what circumstances, and with which medical conditions. Other researchers stress that improved diagnostic and outcome tools are needed for early identification of depression and the evaluation of effectiveness of treatment among individuals with a chronic illness (Raine et al., 2002; Chaturvedi & Venugopal, 2001).

As Roth and Robinson (1992) state, "Because the physical and psychological aspects of chronic disease do not exist in isolation, neither can their treatment" (p. 64). Mental health professionals can play a critical role in helping clients, families, and medical health care providers to recognize the many factors involved in learning to manage a chronic illness while maintaining a sense of well-being. Folkman and Greer (2000) stress that it is imminently important to focus on the psychological well-being and the coping processes that support individuals with chronic illness as a complement to the traditional focus of medical care. When clients with chronic medical illness are beneficiaries of this holistic approach, they not only survive with their chronic illness but also thrive in the face of that chronic illness.

Conclusion

Chronic illness management is a growing health problem in the United States. Statistics indicate that the financial burden on the health care system due to escalating health care costs of an aging population and increasing number of chronic health conditions threatens to bankrupt the United States health care system. Several research studies point to the association between chronic medical illness and increased rates of depression. The presence of depression in individuals with a chronic illness is associated with greater morbidity and mortality.

Individuals who have been diagnosed with a chronic illness are confronted with many obstacles that challenge their ability to learn and maintain self-management strategies for their chronic illness. The psychological and social challenges of chronic illness can become overwhelming for these individuals. The sense of overwhelming loss of control in many aspects of their lives contributes to symptoms of depression. At this time, the Western medical model of care employed by the United States health care system does not have a systematic or holistic approach to the treatment and management of chronic medical illnesses.

The US health care system must make changes in its approaches to management of chronic illness. One important change will be to involve clients more in their own care, teaching clients how to live with a chronic illness and have less dependence on the medical system. A critical factor in this strategy will be the involvement of mental health professionals in the care of chronically ill individuals from the onset of an illness through the many stages of its progression.

Cognitive Behavioral Therapy has been effectively utilized in many studies related to chronic medical illness management. Strategies utilized within the cognitive approaches appear to have beneficial effect because they help clients gain control over psychological and physical symptoms. Other approaches, such as Motivational Interviewing and Medical Crisis Counseling, also show promise as helpful intervention strategies for individuals with chronic medical illness.

Counselors must begin to advocate a chronic disease management model that includes a strong psychosocial component, one that addresses the many complex needs of an individual struggling to learn ways to cope with a chronic illness that impacts every aspect of his or her life.

Future research involving mental health professionals must address the benefits of early intervention, different models of therapy that are effective for different types of chronic illness, effective tools to identify psychological distress in individuals with chronic illness, and the development of a holistic and yet systematic approach to the effective management of chronic illness. A collaborative model of care that includes client, physician, and counselor can assist individuals with a chronic illness to regain control of their own care as they move toward regaining control in their lives.

References

- Black, S., Goodwin, & S., Markides, K. (1998). The association between chronic diseases and depression symptomatology in older Mexican Americans. Journal of Gerontology, *53A*, M188-M194.
- Burke, P., & Elliott, M. (1999). Depression in pediatric chronic illness: A diathesis-stress model. Psychosomatics, *40*, 5-17.
- Chaturvedi, S. K., & Venugopal, D. (2001). Depression in medical disorders. Journal of Indian Medical Association, *99*, 29-31, 44.
- Clark, D., Cook, A., & Snow, D. (1998). Depressive symptom differences in hospitalized, medically ill, depressed psychiatric inpatients and nonmedical controls. Journal of Abnormal Psychology, *107*, 38-48.
- Cuijpers, P. (1998). Prevention of depression in chronic general medical disorders: A pilot study. Psychological Reports, *82*, 735-738.
- Daniluk, J.C. (2001). Reconstructing their lives: A longitudinal, qualitative analysis of the transition to biological childlessness for infertile couples. Journal of Counseling & Development, *79*, 439-449.
- Folkman, S., & Greer, S. (2000). Promoting psychological well-being in the face of serious illness: When theory, research, and practice inform each other. Psycho-Oncology, *9*, 11-19.
- Frasure-Smith, N., Lesperance, R., & Talajic, M. (1995). Depression and 18-month prognosis after myocardial infarction. Circulation, *91*, 999-1005.

Frasure-Smith, N., Lesperance, R., & Talajic, M. (1995). Depression and 18-month prognosis after myocardial infarction. Circulation, *91*, 999-1005.

Friedman, R., Meyers, P., Sobel, D., Caudell, M., & Benson, H., (1995). Behavioral medicine, clinical health psychology, and cost offset. Health Psychology, *14*, 509-518.

Gagnon, L. M., & Patten, S. B., (2002). Major depression and its association with long-term medical conditions. The Canadian Journal of Psychiatry, *47*, 149-152.

Glasgow, R., McKay, H., Piette, J. D., & Reynolds, K. D. (2001). The RE-AIM framework for evaluating interventions: What can it tell us about approaches to chronic illness management? Patient Education and Counseling, *44*, 119-127.

Hagedoorn, M., Sanderman, R., Ranchor, A. V., Brilman, E. I., Kempen, G. I., Ormel, J., (2001). Chronic disease in elderly couples: Are women more responsive to their spouses' health condition than men? Journal of Psychosomatic Research, *51*, 693-696.

Haythornthwaite, J. A., & Benrud-Larson, L. M. (2000). Psychological aspects of neuropathic pain. The Clinical Journal of Pain, *16*, S101-105.

Ireys, H., Chernoff, R., DeVet, K. A., & Kim, Y. (2001). Archives of Pediatric and Adolescent Medicine, *155*, 771-777.

Kerr, L. K. (2001). Screening tools for depression in primary care. Western Journal of Medicine, *175*, 349-352.

Koocher, G. P., Curtiss, E. K., Pollin, I. S., & Patton, K. E. (2001).

Medical crisis counseling in a health maintenance organization: Preventive intervention. Professional Psychology Research and Practice, *32*, 52-58.

Kramer, S. E., Kapteyn, T. S., Kuik, D. J., & Deeg, D. J. (2002). The association of hearing impairment and chronic diseases with psychosocial health status in older age. Journal of Aging and Health, *14*, 122-137.

Landolt, M., Ribl, K., Laimbacher, J., Vollrath, M., Gnehm, H., & Sennhauser, F. (2002). Posttraumatic stress disorder in parents of children with newly diagnosed type 1 diabetes. Journal of Pediatric Psychology, *27*, 647-652.

Lindsey, E. (1997). Experiences of the chronically ill: A covert caring for the self. Journal of Holistic Nursing, *15*, 227-242.

Lustman, P. (1998). Cognitive therapy may improve glycemic control in diabetics with depression. Annals of Internal Medicine, *129*, 605-621.

Morley, S., Eccleston, C., & Williams, A. (1999). Systematic review and meta-analysis of randomized controlled trials of cognitive behaviour therapy and behaviour therapy for chronic pain in adults, excluding headache. Pain, *80*, 1-13.

Neinstein, L. (2001). The treatment of adolescents with a chronic illness. Western Journal of Medicine, *175*, 293-295.

Osborn, P. J. (2001). The poor physical health of people with mental illness. Western Journal of Medicine, *175*, 329-332.

Penninx, B. W., Tilburg, T., Boeke, A. J., Deeg, D. J., Kriegsman, D. M., & van Eijk, T.M. (1998). Effects of social support and personal coping resources on depressive symptoms: Different for various chronic diseases? Health Psychology, 17, 551-558.

Raine, R., Haines, A., Sensky, T., Hutchings, A., Larkin, K., & Black, N. (2002). Systematic review of mental health interventions for patients with common somatic symptoms: Can research evidence from secondary care be extrapolated to primary care? British Medical Journal, 325, 1082-1085.

Remien, R. H., & Rabkin, J. (2001). Psychological aspects of living with HIV disease: A primary care perspective. Western Journal of Medicine, 175, 332-335.

Resnicow, K., DiIorio, C., Soet, J. E., Borrelli, B., Hecht, J., & Ernst, D. (2002). Motivational interviewing in health promotion: It sounds like something is changing. Health Psychology, 21, 444-451.

Roberts, S. A., Kiselica, M. S., Fredrickson, S. A. (2002). Quality of life of persons with medical illnesses: Counseling's holistic contribution. Journal of Counseling and Development, 80, 422-432.

Roth, S., & Robinson, S. (1992). Chronic disease in women: The role of the mental health counselor. Journal of Mental Health Counseling, 14, 59-72.

Simon, G. E., (2001). Treating depression in patients with chronic disease. Western Journal of Medicine, 175, 292-293.

Stein, R. E., Westbrook, L. E., & Johnson-Silver, E. (1998). Comparison of adjustment of school-age children with and without chronic conditions: Results from community-based samples. Journal of Developmental and Behavioral Pediatrics, 19, 267-272.

Thorne, S. E., & Paterson, B. L. (2001). Health care professional support for self-care management in chronic illness: Insights from diabetes research. Patient Education and Counseling, 42, 81-90.

Thyen, U., Terres, N. M., Yazdgerdi, S. R., & Perrin, J. M. (1998). Impact of long-term care of children assisted by technology on maternal health. Developmental and behavioral Pediatrics, 19, 273-282.

Van Eijk, J. T., & de Haan, M. (1998). Care for the chronically ill: The future of health care professionals and their patients. Patient Education and Counseling, 35, 233-240.

Vilhjalmsson, R., (1998). Direct and indirect effects of chronic physical conditions on depression: A preliminary investigation. Social Science and Medicine, 47, 603-611.

White, C. (2001). Cognitive behavioral principles in managing chronic disease. Western Journal of Medicine, 175, 338-342.

Williams, J., & Koocher (1998). Addressing loss of control in chronic illness: Theory and practice. Psychotherapy, 35, 325-335.