Managing the Psychological Side of Injury & Illness: Become a "Coping Coach"

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The individual who is clinically prepared as an athletic trainer, physical or occupational therapist assists their patient in managing the temporary and permanent physical impairments. The therapist/trainer also assumes a broader role as teacher and coach in applying the various therapeutic strategies. The personal interaction goes beyond the physical and becomes a critical part of the patient's efforts to psychologically cope with an injury, illness or chronic disease. This supportive relationship is no less important than the application of the various physical treatment modalities.

In too many cases, the emotional aspects of the injury or illness are ignored, discounted by the clinician. Clinical education programs fail to prepare the student to be comfortable with the emotional side of the medical predicament. This lack of attention is commonly generated by the clinicians' personal discomfort with the psychological side of the injury or illness. Likewise, the inability to confidently respond to a patient's expression of fear, anger or sadness reduces the opportunity to enhance the coping process.

To create an effective and practical "coping coach" model, the clinical specialist needs to become knowledgeable in three areas. They are:

1. Understand the nature of the psychological coping process
2. Apply a practical model that explains patient motivation
3. Develop effective interviewing skills that invite the client to safely express how he or she is dealing with the injury or illness

The Coping Process Injury, illness or chronic disease represent some degree of threat to the individual**.** The perceived threat elicits a corresponding level of anxiety and fear related to a real or perceived loss. This loss may be permanent or temporary. The impact can range from a mild inconvenience to a life altering event. The emotional response is based on the level of accurate assessment or cognitive appraisal of the event. If the threat is significantly disrupting, defense mechanisms, such as denial may come into play.

Various types of cognitive distortions or faulty thinking can exaggerate the emotional response. Such cognitive distortions as overgeneralization, premature conclusions or arbitrary inferences distort the reality of the event Understanding how the individual defines the nature, scope and degree of threat allows the clinician to accurately understand the emotional response. A common response to a loss is an acute sense of sadness or depression. Depression is an insidious barrier to the coping process. It reduces the physical and emotional energy, mental acuity, and performance focus. Alternatively, anger can be generated by a sense of unfairness and social isolation created by the event. An incongruent emotional response may be generated by a sense of secondary gain. Secondary gain suggests that something beneficial may be gained due to a loss. This may include meeting long term dependency needs, as well as receiving "permission" to disengage from certain stressful family or social relationships.

As the treatment process proceeds, the individual will participate in a continuous process of appraisal of the treatment outcomes, new clinical information and the relative gains and losses achieved during the rehabilitation process. The coping process will be driven by the degree of success in the restructuring of values, priorities and life styles to accommodate or adapt to the changes posed by the injury or illness. The person will have a natural tendency to regain a sense of autonomy, control and achieve a comfortable fit within his or her environment. This will become the fuel for the cognitive restructuring process.

The cognitive restructuring process or "thinking different" achieves a new or revised fit within various roles and functions post injury or illness. The restructuring process is comparable to gaining new skills and can be coached. There are several key steps to consider in this coaching process. They are:

- Assist the individual to align and affirm their belief system
- Encourage Self Talk that guides and reinforces positive outcomes
- Create options to assert control within the context of the impairment
- Initiate skills (new behaviors) to control and influence the immediate and future environment
- Apply behaviors in incremental fashions
- Assess outcomes accurately
- Reinforce outcomes and repeat

Motivation: Motivation is not a singular concept. There is no motivation switch that is mysteriously turned on or off. It is important to understand the drivers that may power an individual's efforts to reengage in work, competition, social events or a recommended treatment program. Motivation appears to be a function of key behavioral and cognitive processes. They are:

- The value or utility of the activity (V)
- The perceived chances of (Pos) successfully resuming the desired activity
- The real and perceived cost of re-engaging in the activity (C)

Figure 1 illustrates this functional relationship.

Figure 1
Elements of Motivation

$$\text{Motivation} \quad f \quad \frac{V + Pos}{C}$$

The value (V) of an activity may vary by the success a person has achieved, as well as the degree of satisfaction and reinforcing quality of the activity. For example, the onset of impairment within various career stages and job performance levels may generate differences in return to work motivation. Correspondingly, the degree of prior competitive sports success may play a role in the observed level of motivation to return to competition.

Early on in an injury or illness the individual makes an informal assessment as to what the impact will be and what will it take to adapt. Past coping success coupled with a wide range of other past experiences will begin to define their notion of the probability of success (Pos) they will have in managing this injury or illness. The greater sense of success can lead to increased observable motivation. The lower degree of success will reduce the willingness to engage in positive efforts. The "coping coach" can assist in the development of the skills that will enhance the probability of success.

Each person will also make a judgment as to the cost (C) of re-engaging in the pre-injury or illness activity. This cost may be economic. They may gain or lose financially. The perceived cost may be in increased pain or discomfort. The cost may be silently determined that if I go

back to work or competition, “It will literally kill me!” Such an assessment typically reduces both interest and energy to move forward.

Correspondingly, the person may exhibit differing levels of expected effort for a particular activity. The expectation is on the observers' part and may include the therapist, coach, team mates, work colleagues, friends or family members. The less than expected effort can be easily misinterpreted as malingering, laziness or a slacker's pace to resume former responsibilities. “Poor” motivation may be an artifact of depression, fear or simply misinformation on current or future capacity. These cognitive distortions are quite common and present important influences in cases of chronic pain and a Functional Somatic Syndrome, such as Fibromyalgia.

Engage in the Discussion: The ability to engage the individual in a useful discussion of the emotional facets of their post injury experience is a critical skill. The following key issues frame the interview process as presented by Miller and Rollnick (2003) in their text, Motivational Interviewing. It is valuable to:

- Understand that change is natural
- Significant degrees of quick change are the threat
- Focus on working with the natural change process
- Incremental change is the goal
- Faith, hope and realistic expectations facilitate the perception and capacity for success
- Be aware of the individual’s readiness to change

The silent saboteur in the coping process is “Ambivalence”. Ambivalence is the middle ground between perceived costs and benefits to change. The result is a sense of being emotionally stuck. Being stuck can be interpreted in many ways by the outside observers. To begin the change, or getting unstuck process, the following themes need to be addressed. They are:

Collaborate - Do not become an authority, punishing or judging the person. Collaboration is not being a cheerleader, but an invitation to explore the feelings being generated as the person adjusts and adapts to new, unknown or fearful situations.

Evocate – The interview is not an interrogation efficiently gathering data. Nor is it a platform for imparting a particular point of view. It is eliciting or finding the nature of experiences within the person and drawing them out. The key outcome is to understand, “What is it like to be this person in this predicament?”

Autonomy Change is within the person. Change requires options coupled with a sense of freedom to move. The goal is to increase the intrinsic value of the personal responsibility to move forward. The client must present and understand the rationale and support for change.

The key principles of Motivational Interviewing are:

- **Express empathy** Reflective listening offers a sense of understanding and acceptance of the person's feelings and perspective. There is no judgment, blame or criticizing. This is not an agreement or endorsement of how the person feels but only recognition that this is how it is for that person.
- **Develop Discrepancy** The coaching interview is intentionally directive, directed toward the ambivalence to change. It is not a test of strength or wits. A critical goal is to assist the person to become unstuck. There needs to be recognition that a discrepancy exists between the present state of affairs and how the person wants the future to be. A common lament can be heard… "things will never be the same – I want to go back to the way it was before….". To what degree this may be true or even desirable becomes a source of discussion.
- **Roll with resistance** All too often the individual will offer a vigorous and vocal argument against change and adaptation**.** There is no winning an argument for change. It is desirable to offer differing options in relation to the resistance presented. Correspondingly, silence can offer a significant and effective resistance. Silence, may be construed to be a passive aggressive response. More practically, the person may not have the vocabulary to describe what they are experiencing or simply is embarrassed to feel the way they do. Silence requires both patience and commitment to listen to what is not being said.
- **Support Self-Efficacy** A critical part of the coping discussion leads to understanding and eventually support of the person's belief in her or his ability to carry out the task of change. The ability to cope with the events becomes self–fulfilling with the development of a successful image of empowerment. Incremental success builds the sense of personal control.

The capacity to become a "coping coach" offers both the clinician and the individual a mutually beneficial relationship beyond the application of physical modalities. The clinician is in a better position to understand and support the individual's efforts to adjust. The individual has a partner to assist in building emotional resilience. Emotional resilience is the capacity to manage repeated physical and emotional threats and insults generated by the injury, illness or chronic disease. Emotional resilience can be learned, developed and strengthened. Emotional resilience becomes the counter balance to the inevitable physical and psychological fatigue that reduces our ability to contain the impact of the injury or illness. Here in lies the essence of coping with an injury, illness or chronic disease.