The Personification of Chronic Physical Illness: Its Role in Adjustment and Implications for Psychotherapy Integration

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We propose the term illness personification (ILL-PERF) as an organizing theme shedding light on the ways individuals live with, under, and outside of chronic physical illness. Drawing from multiple theoretical sources—object relations theory, social-cognitive theory, existential phenomenology and neuroscience—as well as from our own research program on chronic pain and systemic lupus erythematosus (LSE), we argue that individual differences in the tendency to ascribe human characteristics to physical illness play an important risk/resilience role in illness-related disability and emotional distress. We then describe the way ILL-PERF might be incorporated into extant—and integrative—treatments of chronic physical illness.

Keywords: illness-personification, chronic-illness, psychotherapy, adjustment

Advances in medicine and technology have brought about an increase in life expectancy and longevity—inevitably accompanied by an increase in the number of people who live with chronic medical conditions. The latter might be defined as “illnesses that are prolonged, do not resolve spontaneously, and are rarely cured completely” (Centers for Disease Control and Prevention, 2009). It is estimated that more than 133 million Americans suffer from at least one chronic illness, accounting for 75% of health care costs, with 7 of 10 deaths being caused by it (Centers for Disease Control and Prevention, 2009). The most common medical conditions are cancer, cardiovascular disease, diabetes, and rheumatic diseases—although various forms of chronic pain also appear to play an ominous role in the devastating consequences of chronic illness (see Croft, Blyth, & Van der Windt, 2010; Dagenais, Caro, & Haldeman, 2008; Ranjan, 2001).

In addition to the huge medical and financial costs of chronic illness, it also carries severe psychological and psychiatric implications (Stanton, Revenson, & Tennen, 2007). Many individuals suffering from a chronic illness experience limitations in daily activity, significant emotional distress, a psychiatric diagnosis—particularly unipolar depression—and even suicidality (Davis, Affleck, Zautra, & Tennen, 2006; Hendin, 1999; Tang & Crane, 2006). At the same time, research is increasingly veering in the direction of focusing on patient resilience and positive adjustment (e.g., Sturgeon & Zautra, 2010). In this context, we propose illness personification (ILL-PERF) as an individual-difference dimension in (mal)adjustment in the context of chronic illness. Herein, we lay out the theoretical foundations for ILL-PERF, review the empirical research pertaining to it, and derive ramifications for treatment with chronic illness.

Theoretical Foundations

Chronic physical illness can be said to serve as prototype of chronic stress—itself a poorly understood condition (Miller, Chen, & Zhou, 2007). The theoretical basis for ILL-PERF thus emerges from our developing perspective on stress in general and chronic stress in particular. Working from an integrative/existential perspective (e.g., Davidson & Shahar, 2007; Shahar, 2011, 2012; Shahar & Davidson, 2009), we seek to conceptualize stress as a human experience. Specifically, we focus on intentionality.
Not only is this a human characteristic distinguishing *homo sapiens* from other species (Amati & Shallice, 2007; Iacoboni et al., 1999; Quirin et al., 2012)—and thus a constitutive building blocks of personality development (Austin & Vancouver, 1996; Shahar, 2004; Shahar, Cross, & Henrich, 2004)—but, as we shall explicate below, also serves as the experiential hallmark of human stress. In the words of Cooper (1990) in his treatise on existentialism, which so aptly describe our thesis:

...to quote Kierkegaard again, "an existing individual is constantly in the process of becoming." The same, you might say, is true of objects like acorns or clouds. But the difference is supposed to be this: At any given point in an acorn’s career, it is possible to give an exhaustive description of it in terms of the properties—color, molecular structure, and so forth—which belong to it at that moment. But no complete account can be given of a human being without reference to what he is in the process of becoming—without reference, that is, to the projects and intentions which he is on the way to realizing, and in terms of which sense is made of his present condition. As Heidegger puts it, the human being is always "ahead of himself," always *unterwegs* ("on the way"). (Cooper, 1990, p. 3; italics in the original)

The person is ahead of his/herself because s/he is attempting to catch up with what s/he might be. What might s/he be? Psychotherapy across all the “big schools” has historically labeled this the “realized self” (Horney, 1951), the “true self” (Winnicott, 1965), “self-actualization” (Maslow, 1943), or the “organismic self” (Rogers, 1961). Whatever term is used, one of the prerequisites for actualizing one’s potential is clearly goal-directed action—that is, behavior geared toward attaining short and long-term “projects” (Shahar, 2011, 2012).

Given this “projectual” nature of the individual, any and all situations and events thwarting or threatening “projectuality” engender human stress. Put differently, *eventuality* is an existential obstacle in the face of projectuality, the tension between the two constituting the noxious aspect of stressful events and situation. In fact, acute and chronic stress might be rank-ordered based on the extent to which it blocks a person’s ability to become what s/he might.

Consider, for instance, the occurrence of chronic illness during adolescence, an important developmental period in which self and identity take shape. Imagine a 16-year-old teenager struggling to figure out her sexual identity within a social matrix of ongoing tension between herself and her parents and herself and her peers, compounded by mounting pressure to excel in school and prepare for college. Now imagine this teen struggling with an onset of diabetes, cystic fibrosis, juvenile rheumatic arthritis, or irritable bowel disease (Cuneo & Schiaffino, 2002; Greenley et al., 2010; Luyckx et al., 2008; Pfeffer, Pfeffer, & Hodson, 2003). The demands these conditions will make on this hypothetical teen are formidable, and we can expect her physical and mental resources to be drained. This in turn will impede her ability to form—let alone pursue—coherent, self-related life goals. That so many adolescents do succeed is a testimony to the miraculous power of resilience (Masten, 2001).

We define stress personification in general—and ILL-PERF in particular—as an individual’s *tendency to ascribe human attributes to the stressful condition* (e.g., chronic illness)—*qualities particularly relevant to his or her self and identity.* For instance, when a husband of a chronically ill wife labels her fibromyalgia “the intruder” (Piburn, 1999), it probably reflects his feeling that her illness is invading the psychological territory they share. Put differently, labeling illness as “intrusive” reflects the construction of a narrative tying together self-and-illness—in the object relations sense of the word.

Personification, we argue, is potentially adaptive because of its *transformative* nature: it changes an event or situation from an external obstacle into an internal sense of purpose and meaning. In this sense, the *war against pain* (Fishman & Berger, 1999) turns all chronic pain patients into potentially brave soldiers. In contrast, when personification is construed along persecutory lines, being related to a feeble sense of self, it undermines rather than empowers. The personified situation (illness) becomes ominous, non-negotiable, and impenetrable, the self being experienced as crippled, submissive. Effective coping is damaged, potentially translating into psychological symptoms—including suicidality (e.g., Tang & Crane, 2006). Personification is thus construed here as a two-edge

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1 One of us (G.S.), is so fond of this quotation that he uses it, with permission, in other publications (e.g. Shahar, 2010, 2011). Our (my) apologies to the reader.
sword, amply and aptly capturing our previous theorization concerning the dialectics of risk and resilience—namely, that very few factors can be deemed as either risk-related or protective. Most are both (Shahar, 2008; Shahar, Elad-Strenger, & Henrich, 2012; Shahar & Priel, 2002; Shahar & Priel, 2003).

While we would expect the possible emergence of stress personification in the face of all types of stress, we posit that such personification is particularly likely to occur under chronic stress. Why? Precisely because of the latter’s chronic nature. Chronic stress is not temporary or transitory. Persistent and continuous, it is best dealt with by changing one’s attitude toward the stress it induces (Aldwin & Brustrom, 1997). This exactly is what the people are attempting to achieve via the act of personification. Moreover, like a protagonist in a close relationship, chronic stress is something (someone) we get to know well over the course of time, making it further amenable to personification. I know the course of my illness: I know the days when it “acts out,” raises its nasty head, doesn’t let me live and know that I have to lie low and pace myself. I might also believe that there is light at the end of the tunnel, that she (the illness) will back off and hide in a corner, awaiting her next strike. I must take advantage of these opportunities to take back my life and pursue the things important to me. In other words, I must become “projectual.”

**Pertinent Empirical Research**

Humans seem to possess a profound need to anthropomorphize or personify the world (Bering, 2006; Epley, Waytz, Akalis, & Cacioppo, 2008; Epley, Waytz, & Cacioppo, 2007; Kwan & Fiske, 2008; Waytz, Cacioppo, & Epley, 2010), individual differences in the tendency to anthropomorphize/personify appearing to impact vast areas of psychological functioning—including human/computer-interaction, business, and law (Waytz et al., 2010). Research on anthropomorphism not yet having permeated health psychology and behavioral medicine, the work cited here, including the present theorizing, may hopefully constitute a first step in this direction.

From a cognitive-linguistic point of view, personification or anthropomorphism might be construed as a special case of *metaphorical speech* (e.g., Fadaee, 2011). Since Susan Sontag’s landmark publication *Illness as Metaphor and AIDS and its Metaphors* (Sontag, 1978), both social science and medical literature have begun paying the metaphorical framing of various medical conditions serious attention, due in large part to the stigmatization associated with AIDS (e.g., Barroso & Powell-Cope, 2000; Rollins, 2002; Rosenman, 2008; Sherwin, 2001). The metaphorizing of illness is not necessarily linked to negative images, however. It can carry definite advantages. One study demonstrates that breast cancer patients who view their disease as a “challenge” or “value” exhibit lower levels of depression and anxiety and a higher quality of life than women who regard it an “enemy,” “loss,” or “punishment” (Degner, Hack, O’Neil, & Kristjansdottir, 2003).

In the case of depression, metaphors taken from art and literature have become an integral part of its diagnostic concept, influencing both treatment and research (Rosenman, 2008). Metaphors can be employed in therapeutic interventions—as in self-management courses, for example, which have shown that their use facilitated emotional expression among individuals suffering from chronic illnesses (McFarland, Barlow, & Turner, 2009). In general, metaphors play a significant role in influencing and creating moral, ethical, and political values—particularly in the context of illness (Rollins, 2002; Sherwin, 2001). Juxtaposed with this line of inquiry, the theory of stress personification adduced above suggests that personifying—not just metaphorizing—illness imbues this stressful condition with a self-based meaning. In other words, basic developmental and personological themes are attributed to it by sufferers, thereby becoming a cornerstone in illness narratives.³

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² Anthropomorphism and personification appear to be very similar—arguably identical—in nature. See, for example, http://lynleystace.wordpress.com/2011/10/03/anthropomorphism-vs-personification/

³ Although embodied cognition—a term referring to the impact of bodily processes on cognitive ones—is also relevant in the context of illness personification, in our view embodied cognition works in an inverse fashion to ILL-PERF. Whereas the latter focuses on a bodily state—illness—and narrates it in human (personal) terms, the former “reduces” cognitive processes to bodily actions (e.g., Borghi & Cimatti, 2010).
To gain a better appreciation of this process, we studied ILL-PERF in two serious chronic medical conditions—systemic lupus erythematosus (SLE) and chronic physical pain. SLE is an autoimmune disease that can potentially affect tissue anywhere in the body, including the skin, internal organs, and central nervous system. Disease activity fluctuates, with patients usually experiencing disease flares and periods of remission throughout their life. The manifestation of the disease also displays great variability among patients (Borchers, Naguwa, Shoenfeld, & Gershwin, 2010). Employing in-depth qualitative analyses of narrative accounts of 15 women with chronic SLE, Schattner, Shahar, and Abu-Shakra (2008) found that they personified this illness along two major themes: (a) persecution, the self being a victim; and (b) combat, the self being a warrior-hero fighting an enemy (Schattner et al., 2008). In other words, over time their disease had become a mental representation endowed with the capacity to influence their emotional and physical well-being.

To the extent that illness is personified as persecutory it is defined as invasive. Indeed, *illness intrusiveness* (Devins, 1994) — operationalized as the extent to which illness interfered with valued activities and interests — was shown to generate considerable psychological distress (Devins, 2010). In another study emanating from the aforementioned qualitative research, we (Schattner, Shahar, Lerman, & Abu-Shakra, 2010) found that illness intrusiveness prospectively predicted an increase in depression over time. It is interesting to note that this study also found that depression predicted an increase in illness intrusiveness, suggesting a reciprocal longitudinal relationship (Schattner et al., 2010).

Physical pain pertains to an unpleasant experience associated with actual or potential tissue damage (Merskey & Bogduk, 1994). Whereas acute pain has a clear evolutionary purpose—to warn us of potential harm to our body—chronic pain (lasting at least 6 months) serves no such purpose (Banks & Kerns, 1996). It afflicts millions of patients globally (Croft et al., 2010), constituting a formidable health and economic burden (Mantyselka et al., 2001). The experience of pain includes both sensory and affective evaluative components (Merskey & Bogduk, 1994). The former refers to the intensity and location of pain and appears to be processed in the primary and secondary somatosensory cortices and thalamus (Hofbauer, Rainville, Duncan, & Bushnell, 2001). The latter refers to evaluative cognitive-affective processes (e.g., “pain is punishing”), being linked to heightened activation of the anterior cingulate cortex and insula (Hofbauer et al., 2001).

Our group has shown that the affective component is distinguishable from depressive symptoms (Lerman, Rudich, & Shahar, 2010), the latter being highly prevalent in chronic pain (Bair, Robinson, Katon, & Kroenke, 2003; Banks & Kerns, 1996; Breivik, Collett, Ventafridda, Cohen, & Gallacher, 2006; McWilliams, Cox, & Enns, 2003). We have also demonstrated that the affective component of pain—arguably indicative of pain personification—interacts with personality vulnerability. Specifically, chronic-pain patients with elevated levels of self-criticism reacted with an increase in depression, anxiety, and pain-related disability to elevated levels of affective—but not sensory—pain (Lerman, Shahar, Brill, & Rudich, 2012; Lerman, Shahar, & Rudich, 2012).

These findings prompted us to measure pain personification directly by using a novel self-report measure. Named the Pain Personification Questionnaire (PPQ), this assesses the personification of pain as a “bad” internal object. We found that pain personification predicted depression, illness intrusiveness, and pain-related distress—pointing to the importance of an object-relations approach for the understanding and treatment of depression in chronic illness (Schattner & Shahar, 2011).

**Implications for Psychotherapy (Integration) With Chronic-Illness Sufferers**

A number of interventions have been developed to help patients maintain quality of life despite chronic physical illness. Cognitive–behavioral therapy (CBT) features prominently among these, being found to reduce emotional distress in a number of medical conditions—such as chronic pain, cancer, heart disease, and diabetes (Greer et al., 2012; Gulliksson et al., 2011; Ismail et al., 2010; Lamb et al., 2010). Acceptance and commitment therapy (ACT), which grew out of CBT, sets its goal as promoting the acknowledgment of unwanted thoughts and feelings and encouraging engage-
ment in valued activities of life, frequently neglected because of avoidance of negative events or feelings (Hayes, 2004; Hayes, Luoma, Bond, Masuda, & Lillis, 2006). ACT-based interventions have been found to be affective in improving chronic pain patient’s quality of life and reducing their anxiety and depression (Johnston, Foster, Shennan, Starkey, & Johnson, 2010; McCracken & Gutierrez-Martinez, 2011). A number of studies have found hypnotic intervention to be effective in reducing pain in chronic-pain patients suffering from a variety of conditions (Elkins, Jensen, & Patterson, 2007).

Various forms of family therapy are often prescribed for couples and families living with chronic illness. These are usually behaviorally focused, attempting to improve communication and/or problem solving around the chronic illness and decrease relationship stress (e.g., Blanchard, Toseland, & McCallion, 1996; Ranjan, 2001; Szapocznik et al., 2004). A recent meta-analysis of randomized clinical trials testing these types of interventions yielded compelling support regarding their efficacy (Hartmann, Banzer, Wild, Eisler, & Herzog, 2010). With respect to psychodynamic therapy, some attempts have been undertaken to conceptualize an approach for the treatment of chronic pain (e.g., Basler, Grzesiak, & Dworkin, 2002). To date, we are unaware of any evidence base for these.

In Table 1, we outline ways in which the various psychosocial approaches for the treatment of chronic illness might rely on ILL-PERF — both in terms of case conceptualization and of treatment planning.

Thus, for example, when CBT is employed, the personification of chronic illness might derail adaptation (a) by activating negative automatic thoughts that instill hopelessness and helplessness and undermine effective coping (“this illness is a monster: how can I fight it?”) and (b) by prompting patients to become over-preoccupied with the illness rather than “living outside of it”; that is, participating in meaningful and enjoyable activities that shield against anhedonia and empower effective coping (Folkman, Moskowitz, Ozer, & Park, 1997). An ILL-PERF-sensitive CBT therapist might encourage patients to routinely monitor personifications, observe the way they unfold in response to events (both illness-related or unrelated), and then employ cognitive restructuring techniques to minimize the adverse effect of personifica-

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Relevance of Illness Personification (ILL-PERF) for the Major Approaches for the Treatment of Chronic Physical Illness</th>
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<tbody>
<tr>
<td><strong>Approach</strong></td>
<td><strong>Treatment plan</strong></td>
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<tr>
<td>CBT</td>
<td>Employ self-monitoring of personification; depersonify using cognitive restructuring; teach patients behavioral activation as a way of short-circuiting personification.</td>
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<tr>
<td>ACT</td>
<td>Teach acceptance and mindfulness.</td>
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<tr>
<td>Hypnosis</td>
<td>Metaphors including personification are used both as a way into the patient’s frame of thought and can be a powerful tool for altering thought, behavior, or sensation via hypnotic suggestion.</td>
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<tr>
<td>Family therapy</td>
<td>Link ILL-PERF to ongoing communication and inquire into its ramifications. Educate family members about ILL-PERF and define it as a problem to be solved.</td>
</tr>
<tr>
<td>Psychodynamic therapy</td>
<td>Explore life history with patient, work through conflicts with early (parental) figures, and help patients differentiate between object relations and illness representations.</td>
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*Note.* CBT = cognitive–behavioral therapy; ACT = acceptance and commitment therapy.
tion-related negative automatic thoughts ("chronic illness is scary, but it is not a monster. It is a clearly defined stressful situation for which effective coping skills exist and can be successfully implemented"). Behavioral activation might also be employed to help patients "live outside the personification," distracting them from ruminating over their illness ("person") by engaging in meaningful and enjoyable activities.

With respect to ACT, ILL-PERF could be conceptualized as interfering with acceptance and constituting a nonmindful, catastrophic state of mind. The remedy is straightforward: Patients would be taught to assume a collaborative stance ("I am not hurrying to recover, I can live with this situation"), receiving training in decentering and mindfulness techniques that are cognitively incompatible with the ruminating and repetitive nature of illness personification.

Regarding hypnosis, ILL-PERF could be adopted as a type of negative metaphor illustrative of the way in which patients view their condition. Utilization of this personal metaphor might promote self-reflection, increase motivation, and allow for a reframing of the problem (Hammond, 1990). A therapist using hypnosis in therapy could use ILL-PERF to understand the manner in which patients conceptualize their condition and employ this type of metaphor to engage the patient in treatment and promote change. Via hypnotic suggestion, personification could be a powerful tool to help alter thought, behavior, or sensation. If a patient sees his pain as an evil dragon roaring and flaming fire, hypnosis might assist him in visualizing himself as the dragon slayer dousing the flames with water—and thus reduce his physical pain.

Respecting family therapy, the personification of chronic illness might serve as an obstacle to adaptive communication between patients and spouses and/or other family members. Fearing the illness to be a monster, patients might refrain from describing it to family members for fear of "spooking" them. This, in turn, might lead to isolation and symptom concealment, the latter having been shown to contribute to distress in chronic illness (Druley, Stephens, & Coyne, 1997; Schattner et al., 2010). Alternatively, the distress and agitation brought about by illness personification might generate interpersonal stress, thereby exacerbating the course of illness. Family therapists might combat these iatrogenic processes by educating patients and family members regarding the tendency to personify the illness and its consequences and defining ILL-PERF as a problem in need of a relational solution. Spouses and other family members might then be trained to help the patient identify the points at which they personify the illness and collaborate with them either to "deconstruct" negative personifications ("remember, it is an illness, not a monster, and we are in it together") or to come up with empowering positive personifications—for both the patients themselves and their family ("not only is this illness not a monster but it is actually a wise teacher: it teaches us that now is the time to unite and come together as a family").

In the context of psychodynamic psychotherapy, ILL-PERF might be linked to a malevolent mental representation (an "introject") within the patient’s inner world. This could be detected if, for instance—in response to a patient’s statement that "my fibromyalgia is a monster"—a therapist inquires about other "monsters" of which the patient is aware, including people close to him/her. Clinical experience teaches us that the monster has frequently been there from the outset—in the presence of an abusive parent who, during childhood, has been internalized as a dormant, yet highly pervasive, "bad object" which then exacerbates the overwhelming effects and adverse consequences of the chronic illness. An exploration into the links between the illness as "monster" and the "monstrous" nature of the patient’s upbringing serves to portray her as an historical agent with a life story, clarifying—for patient and therapist alike—the intense manner in which she is reacting to her illness. It might also enable exploratory work into the patient’s past traumas—work that might shed light on, and establish narrative continuity with, the way patients deal with their current predicament. In this context, the patient’s previous strategies for dealing with past traumas might be highlighted, with an encouragement to utilize them for coping in the present ("you survived a physically abusive father by immersing yourself in swimming. You might do the same with your chronic back pain").

Finally, in the course of psychodynamic psychotherapy illness personifications might pervade the therapeutic relationship, leading—particularly at difficult times—to the patient
experiencing the therapist as unsympathetic to the illness. Thus, for example, a therapist’s failure to fully understand the pain (a quite natural phenomenon, it should be noted) might be experienced as persecutory—in a similar manner to the persecutory character of the illness. Here, a delicate and sensitive examination of transference-countertransference exchanges is called for (Shahar, 2004), not only by way of managing impasse but also to arrive at a deeper understanding of the patient’s history of personifications, mental representations, personal projects, and related coping strategies.

Ultimately, however, the psychological treatment of chronic physical illness requires the employment of more than a single approach. The above therapeutic modalities might be thought of as “modules” more—or less—salient at various stages of treatment. As chronic illness unfolds, as its severity waxes and wanes, and as patients’ developmental tasks and goals change (Shahar, 2001; Shahar & Davidson, 2009), a cognitive—behavioral focus on illness personifications might pave the way to a psychodynamic one. Family-related events complicating the picture even further, a more systemic intervention capable of short-circuiting the deleterious effect of personifications on the family and building alternative family related personifications is required. Thus, the prism of personifications permits us to understand that psychotherapy with people suffering from chronic physical illness must be integrative.

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