Helping clients who have health issues

Julia McLeod, Mhairi Thurston and Kate Smith

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McLeod, Julia; Thurston, Mhairi; Smith, Kate

Chapter 21 Helping clients who have health issues

Aim

The aim of this chapter is to consider how a pluralistic approach to therapy can be used to support people who are living with long-term health problems

Overview

This chapter discusses therapeutic goals, tasks and methods that are associated with the use of counselling by people who are experiencing long-term health difficulties. The key topics addressed in the chapter are:

- The types of emotional and relationship issues reported by individuals with serious health problems
- Practical challenges arising from working with this client group
- Therapeutic methods that are particularly relevant in this area of practice
- Therapist issues and self-awareness.

A brief introduction to the issues faced by people with long-term health conditions

The term 'long-term condition' refers to a wide range of diagnoses, such as Hypertension, Depression, Asthma, Diabetes, Coronary Heart Disease, Chronic Kidney Disease, Hypothyroidism, Stroke, Cancer, Mental Health, Heart Failure, Epilepsy and Dementia (DOH, 2012). Other long-term health conditions which have a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities can additionally be categorised as disabilities, such as severe sight loss, HIV and MS (Equality Act, 2010). All these issues differ a great deal in terms of severity, aspects of everyday functioning that are affected, and ultimate prognosis. Nevertheless, from a psychological perspective, all of these conditions share some important characteristics. They have an impact on the way a person feels about himself or herself. They place restrictions on what a person can and cannot do, within their everyday life. They can lead to tensions in relationships with friends, family members and work colleague. They necessitate regular interaction with physicians, nurses and other health professionals. Finally, these conditions may be associated with financial hardship. Although the present chapter considers the domain of long-term health conditions as a whole, it is essential, when working with clients, to keep a focus on the unique and distinctive characteristics of the specific condition or conditions with which they are seeking to cope. It is also important to be sensitive to the needs of individuals whose health problems fall outside, or between, diagnostic categories (Creed, Hennington and Fink, 2011).

There exists a substantial amount of research into the emotional impact of long-term health issues. On the whole, the evidence suggests that physical health conditions tend to generate significant levels of psychological distress, emotional pain, and relationship difficulties (see, for example, Burmedi et al., 2002). There is also evidence that positive well-being supports

good health outcomes (Robertson et al., 2012). It is valuable for pluralistic therapists to become familiar with aspects of this research literature that are relevant to clients with whom they are working, as a means of sensitising themselves to the types of issues that may arise in therapy. There are two types of evidence that are particularly useful. Large-scale studies, that invite patients to complete standardised symptom measures, provide an overview of the extent and severity of psychological problems that might be encountered with a client group, and the ways in which these difficulties change over the course of a disorder. In-depth qualitative studies and case reports, based on interviews with patients and carers, provide an understanding of what it means to live with a health condition (for example, Nyman et al., 2012).

Up to now, the field of counselling and psychotherapy for people with long-term health conditions has been dominated by concepts and methods drawn from cognitive-behavioural, psychodynamic and bio-psycho-social perspectives. Cognitive-behavioural protocols for therapy for stress, anxiety and depression, can be readily adapted when these issues occur within the context of long-term health problems. In addition, CBT provides a range of therapeutic strategies in relation to the management of chronic pain. Psychodynamic theory and practice is particularly relevant to an understanding of such questions as the unconscious or underlying meaning of illness for the person, the bodily experience of being ill, and shifts in patterns of relationships. Most practitioners who work in this field are influenced, to a greater or lesser extent, by a bio-psycho-social perspective that emphasise the necessity to take account of physical/biological and social dimensions of the experience of the person, alongside psychological factors (Gilbert, 2002).

While building on these important traditions, a pluralistic approach acknowledges a wider range of therapeutic tasks arising from long-term health conditions, and seeks to make use of the preferences, strengths and capabilities of clients. Compared to CBT, psychodynamic and bio-psycho-social models, a pluralistic framework strives to be more flexible and responsive, and to place a greater emphasis on client-therapist collaboration. In these respects, pluralistic therapy is consistent with current developments in medical care (Mulley, Trimble and Elwyn, 2012).

The nature of a pluralistic understanding of long-term health conditions is illustrated in a study by Omylinska-Thurston and Cooper (2014), based on interviews with people who had received counselling while they were receiving treatment for cancer. All of the individuals who were interviewed reported that they used counselling as means of coming to terms with overwhelming feelings, such as being vulnerable and frightened. They also wanted to talk about losses, fear of cancer recurrence, and longstanding issues that had been re-awakened by the experience of being ill. They also used therapy to explore practical matters, such going back to work, weight management, sleep problems, relaxation skills, and strategies for resolving family tensions.

Case example

Isobel was aged 54 at the point when she entered therapy. Nine years earlier, she had received a diagnosis of multiple sclerosis (MS). Having been advised by her GP to see a counsellor, she had little expectation that therapy would be helpful. At the first session, she described herself as unable to accept the reality of the MS, depressed, worried about how people perceived her, and often physically exhausted because she was unwilling to say ‘no’ to other people. Over the course of therapy, other issues emerged, such as connections between current difficulties and earlier life events and experiences, the possibility of death, issues

around sexuality, and anger at the way that she was treated by some doctors. A detailed account of how these issues unfolded and were resolved, can be found in McLeod (2014).

Practical issues

An essential element of a pluralistic framework for practice is attention to arrangements around how therapy is conducted. This is particularly important in work with people with who have long-term health conditions, whose health requirements may need to be taken into account when negotiating such factors as the location of therapy and the duration of sessions. For example, Isobel, the client mentioned above, became a wheelchair user, and needed to be seen in a counselling room that was wheelchair-accessible. At points in her illness when she suffered debilitating relapses, counselling took place at her home or in a hospital ward, or was carried out by telephone. Other clients who are ill, may not be able to predict whether they are well enough to attend therapy on any particular day, or know how long a session might last before they become too tired. For pluralistic practitioners, part of the preparation for working with this client group involves making decisions around what can be offered, in terms of flexible meeting patterns. In most situations, this kind of flexibility will be guided by the needs and preferences of individual clients. In other situations, it may be useful to build-in certain arrangements from the outset, which anticipates potential client requirements. For example, in designing therapy provision for individuals with longstanding and intractable issues around irritable bowel syndrome, Guthrie (1991) offered extended first meetings, of two hours or longer, as a means of reassuring clients that the complex reality of their problems was being taken seriously.

Other practical issues are associated with questions around who provides therapy, and who is involved in therapy. In many health-care systems, patients are only considered eligible for counselling or psychotherapy at the point where they have developed 'clinical' symptoms of anxiety or depression. This kind of procedure fails to offer support at the early stages of medical treatment. On the other hand, offering counselling to all patients at an early stage is costly, and will be viewed as unnecessary by individuals who enjoy good family or community support, or for whom the emotional 'point of impact' does not arrive until much later (Thurston, 2010). In some organisations, doctors, nurses and other health professionals may receive training and supervision in the use of counselling skills (see, for example, Weaks, Johansen, Wilkinson and McLeod, 2010). If this occurs, it may be possible for counsellor or psychotherapists to liaise with these front-line colleagues around ways of ensuring that service users receive the level and intensity of counselling that is most appropriate to their needs (McLeod and McLeod, 2014).

Some people with long-term health issues may require the support of carers, who may be members of their family or can be paid support workers. Attendance at counselling may only be possible with the involvement of carers, and on some occasions the primary client may wish their carer to be part of the process of counselling. In other circumstances, or at other points in therapy, clients may prefer to have an opportunity to share their feelings in a private meeting with the counsellor. In recognition of the intense demands of caring roles, it can also be valuable to consider separate counselling support for the carer (Elvish et al., 2013). Beyond the involvement of a specific named carer, there are some situations in which the emotional and practical issues experienced by a person with a long-term health condition have a ripple effect through their whole family network, or are exacerbated by tensions within the family. In such scenarios, it can be useful to explore the possibility of family-based work.

Case example

Silvia lost her sight late in life, following surgery for what had appeared to be a minor eye complaint. As a person who lived alone, she then needed to depend on assistance from a series of paid support workers. In counselling, one of the themes that emerged was Silvia's relationships with these support workers, and the difference in her mood according to which worker has been allocated to her during that particular week. Silvia was able to use counselling to develop a better understanding of her own reactions to different carers, and to devise strategies for making the best use of this resource. Further discussion about how this topic was addressed, alongside other issues that emerged in counselling, is available in Thurston, McLeod and Thurston (2013).

Methods that can contribute to enhanced well-being in individuals with long-term health conditions

The key principle of pluralistic counselling is that there are many things that can be helpful, and that it is therefore a good idea to ask the person what he or she think would make a difference to them. This is particularly important in therapy with individuals with long-term health conditions, because it may well be that the person has been exposed to many well-meaning, or even life-saving interventions that have been imposed by others. The willingness of the therapist to convey a genuine interest in their client's experience, and their knowledge of what has been or might be helpful, is a crucial strategy in its own right.

At the point of first involvement in counselling, it may be that a person with a long-term health condition has been immersed in medical and biological explanations and conversation around their problem, and has been engaged in a search for medical solutions. It may also be the case that he or she has a sense of being crushed or overwhelmed by the immensity of what has befallen them. In such a situation, an invitation to engage in a conversation around goals and tasks may provide a structure that allows the person to see that there may be some possible ways to begin to move forward again in their life. The list of generic counselling tasks outlined in Cooper and McLeod (2011) encompasses many different types of therapeutic activity, ranging from general exploratory conversation through to more tightly-focused decision-making and behaviour-change initiatives. If a counsellor specialises in working with a particular client group, they may be able to develop a list of therapeutic tasks that are specific to that group. For example, on the basis of her clinical experience and research, Weaks, McLeod and Wilkinson (2006) generated a set of therapeutic tasks that tended to occur in individuals who had received a diagnosis of dementia or Alzheimer's disease. (include list of these tasks if there is enough space). The availability of a task list sensitises the counsellor to potential topics that may be implicit or vaguely indicated in the way that a client is talking about his or her experience. Alternatively, it may be useful to construct a leaflet or video that explains these tasks, and invites the client to reflect on the extent to which they are relevant to them.

For many clients with long-term health conditions, the relationship with their counsellor may have a healing capacity. In an interview-based study of experiences of counselling in people with cancer, MacCormack et al. (2001) found that the theme that was mentioned most often was that the counsellor was 'someone who cared'. At a point in life when a person could easily see himself or herself as worthless and a burden, or as little more than a 'diagnosis', there is a lot to be said for knowing that there is someone who cares. This relationship can also become a reference point and resource in everyday life, as the client comes to use it to

anticipate and prepare himself or herself for difficult upcoming events, or to debrief following such events.

A collaborative stance, a capacity to break big unmanageable challenges into smaller do-able chunks, and a willingness to offer a caring relationship, are essential general elements of pluralistic counselling (and other models of counselling). A further generic aspect of therapy is *time.* There are several ways in which time can have a powerful impact on clients who are struggling to cope with states of ill-health. The health professionals with whom they are in contact may not be able to offer them enough time to talk, because of pressure of work. Members of their family, or friends, may be willing to spend time doing things, such as driving them to the shops, but less willing to take time to listen, because what needs to be said is hard for them to hear. Compared to these experiences, even short-term counselling allows enough time to talk about significant and painful issues. Another way in which time has a meaning is if counselling continues long enough for the therapist to accompany the person through phases of relapse or crisis. An additional way in which time can be helpful is through providing some structure to a day, or even a week.

Beyond these generally helpful aspects of counselling, there any many ways in which specific activities or methods that are used within counselling sessions, can make a difference to someone with a long-term health condition. For reasons of space, within this chapter it is possible to describe only a selection from the many methods and activities that have been found to be effective in this field of work.

Talking. Providing an opportunity to talk and express feelings can be facilitative in a number of ways. Living with a serious health condition is often associated with worry and rumination. Telling one's story, to a counsellor, offers a means of externalising these recurring thoughts, and reflecting on what they mean and what can be done. Within such a conversation, the client and counsellor can engage in a collaborative effort to understand and 'get a handle' on what is happening for the person. Appropriate use of counselling skills, such as reflecting emotional themes, challenging contradictions, and inviting consideration of the implicit meaning of images and metaphors, can enable the person to talk in more depth than would be possible with family members or health workers. Further exploration of the ways in which 'just talking' can be helpful, can be found in McLeod and McLeod (2011).

Writing. There are many situations in counselling where it can be valuable to invite a client to write about his or her experiences and feelings around their illness, or in relation to underlying pre-existing issues (such as loss, trauma or abuse) that are re-awakened by the stress of living with a long-term health condition. Clients may find it helpful to keep a diary or journal, write in a focused way about specific events and episodes, or write 'unsent' letters to key people in their lives. The work of James Pennebaker is a particularly useful resource, in combining creative ideas about different writing styles, along with research that analyses how and why writing can have significant health benefits (Pennebaker and Evans, 2014).

Reading. The experience of illness is frequently accompanied by an effort to understand the impact and implications of the condition, as a means of re-establishing some degree of control over one's life. Reading can also enable a person to realise that they are not alone in their suffering, which in turn can encourage the to reach out to other people. There are many fictional, autobiographical and research-based accounts of the experience of illness that offer useful perspectives. There are also many self-help texts and workbooks that offer practical guidance on how to cope with various illnesses, or with depression, anxiety, low self-esteem and other consequences of such conditions.

Case example

Donald had received a more health scare when he suddenly collapsed with brain haemorrhage, and was then told that he would need to be monitored on a regular basis for the rest of his life, as well as taking medication. Although he was soon able to resume all of his work and family activities, Donald continued to worry, and sought help from a counsellor. Alongside several other issues, he found himself wanting to talk about what death might mean, and how he could make sense of it. On the suggestion of his therapist, he started to read some of the work of Irving Yalom, and found that his book on mortality (Yalom, 2008) was extremely helpful in allowing him to gain a deeper perspective on this topic.

Assertiveness skills. A common theme in counselling with people who health issues, concerns the difficult task of asking other people for help and information. A person who is ill may lack energy or confidence in respect of standing up for their rights and wants. There can also be a sense of being dependent, and grateful for the help and assistance that is already offered by others. Nevertheless, there may well be occasions when a person who is unwell does need to be assertive, for example when their doctor is not listening to them, or a family member is ignoring their disability or fatigue level. The social skills, CBT and assertiveness training literature includes a wealth of ideas about how to support clients to be clearer and more forceful in negotiation with others. Typically, these strategies involve looking closely at how the person currently deals with such situations, then brainstorming and rehearsing alternative responses. These new responses are then tried out in everyday life, in the form of carefully-constructed homework exercises. The outcomes of these new initiatives are then reviewed at the next counselling session.

Stress management techniques. Living with a long-term health condition can be highly stressful. It can be hard to predict how well one will function from one day to the next. Everyday tasks may become problematic. There may background concerns about possible relapse or deterioration. Counselling interventions around stress management can therefore play a key role in counselling with such clients (REF to be added). Examples of relevant methods that can be used include cognitive interventions designed to reduce negative self-attributions, and various forms of relaxation and breathing training.

Cultural resources. The pluralistic tradition in counselling places a strong emphasis on the likelihood that clients will have knowledge and access to cultural resources that can contribute to the alleviation of life difficulties (Cooper and McLeod, 2011). Often, the most valuable cultural resources consist of activities that the person has utilised at earlier stages in their life, but have been allowed to lapse. These can be quite simple things. For example, low mood and social isolation can be reduced or transformed by walking in a park and meeting other people, or by finding opportunities to join with others in singing songs. In addition to these personal accomplishments, there are also many self-help groups and internet sites that have been developed specifically for people with health issues (Adamsen, 2002). In counselling, clients can be encouraged to identify cultural resources that may be relevant to them, and then supported through the process of engaging with these activities.

Therapist issues and self-awareness

Pluralistic counselling and psychotherapy is not merely a set of guidelines for working collaboratively and responsively with clients. Being a pluralistic therapist also involves being open to learning from clients. There are two main ways in which this commitment to learning with and from clients, plays a key role in counselling for long-term health conditions. It is important for counsellors to possess a sufficient level of knowledge about the health

condition(s) of their client, or to be willing to acquire such knowledge. This does not mean that counsellors need to be experts, or to have backgrounds in nursing or other health professions. What is necessary is for the counsellor to be able to join the client is conversations about their illness of health condition, at a level that is meaningful for that client. Qualitative research studies on patient experiences of specific illnesses offer a useful entry-point to relevant knowledge. Typically, such articles include a succinct summary of the main medical characteristics of the condition, before moving on to explore the personal experience of individuals.

Another significant dimension of therapist self-awareness is concerned with his or her attitude to illness. On the whole, people do not readily talk about such matters as their fear of cancer or dementia, or death, or their sense of what it would be like to depend on other to fulfil everyday needs. Yet, most people will have minimally processed childhood experiences of witnessing illness in family members, or hearing stories about such events. From a psychodynamic perspective, such experiences provide a basis for powerful unconscious counter-transference responses to clients who have serious health issues. This factor means that it is necessary for therapists who work with such clients to be willing to make appropriate use of personal therapy, supervision, and consultation with colleagues.

Summary of key points

Research has found that the experience of living with a long-term health condition is associated with psychological symptoms and distress, exhibited as anxiety and depression, in a significant proportion of patients. However, there are major individual differences in relation to the stage at which these effects occur, and the specific pattern of difficulties that is expressed. A pluralistic perspective provides a means of responding flexibly to the diversity of client needs.

- Practical issues around location and timing of therapy, and collaborative involvement of carers and other professionals, represent important topics for exploration with this group of clients.
- The collaborative structure adopted within pluralistic therapy, provides a valuable framework for establishing an alliance with the client, managing distress, and conveying hope.
- There exists a wide range of techniques and methods that can be helpful in work with clients with long-term health conditions.
- The emotional intensity of this kind of work means that it is essential for counsellors and psychotherapists to make effective use of supervision and consultative support.

Exercises/points for reflection

1. What is your own experience of having a health problem, or receiving a health intervention that was uncomfortable, painful, embarrassing or life limiting in some way? In what ways have these experiences enabled you to be open to the stories of clients with long-term conditions? In what ways might your own experiences lead you to be reluctant to hear certain stories?
2. A client, with whom you have a good therapeutic relationship, tells you that he cannot cope with what lies ahead, at a later stage of his illness, and has started to make inquiries about assisted suicide. How do you respond?

Further reading

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