CLINICAL COUNSELLING IN CONTEXT SERIES

Clinical Counselling in Medical Settings

Edited by Peter Thomas,
Susan Davison and
Christopher Rance

Clinical Counselling in Medical Settings

Counselling is offered more and more frequently in conjunction with traditional medical model treatments, yet can still attract both suspicion and exaggerated expectations from other professionals working in healthcare settings.

Clinical Counselling in Medical Settings offers an honest examination of the possibilities and limitations of counselling in a range of surroundings and patient groups, showing how each setting has unique features that influence the therapeutic process. Settings as diverse as a rehabilitation centre, a pain relief clinic, and a hospice, come under scrutiny, and the important issue of the counsellor's role with an interdisciplinary team is dealt with.

With numerous clinical examples, this book will prove essential reading not only for counsellors and psychotherapists but to all mental health professionals.

Peter Thomas is a senior counsellor and counselling consultant in a number of healthcare organisations including mental health, general practice and primary care groups. **Susan Davison** is a psychoanalyst and consultant psychotherapist to the South London and Maudsley Hospital NHS Trust. **Christopher Rance** is a management consultant, group analyst, psychotherapist and lecturer in organisational group analysis at London and Hertfordshire Universities.

Clinical Counselling in Context
Series Editor: John Lees

This series of key texts examines the unique nature of counselling in a wide range of clinical settings. Each book shows how the context in which counselling takes place has profound effects on the nature and outcome of the counselling practice, and encourages clinical debate and dialogue.

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Publisher's Note
The publisher has gone to great lengths to ensure the quality of this reprint but points out that some imperfections in the original may be apparent.

The editors would like to dedicate this volume to their parents, three of whom died during its preparation

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Contributors

Frances Birch is a psychodynamic counsellor in private practice. After qualifying in medicine at Cambridge she specialised in palliative medicine, becoming a consultant and hospice director. She has worked in general psychiatry at the Maudsley Hospital, London, where she is now an honorary clinical associate attached to the Psychotherapy Department.

Emma Coore BSC, MBBS, DROG is a general practitioner currently working in a central London practice. She developed her interest in counselling through co-ordinating the study of primary care counselling in south London while completing her general practice training at King's College and the Maudsley Hospitals in London

Alison Jesson RGN, BSC(HONS), MSC (Psychotherapy), has had over 27 years of working in the National Health Service. She originally qualified as a nurse and subsequently as a UKRC counsellor and a UKCP psychotherapist. She works part-time as a staff counsellor in a large London teaching hospital. She also runs her own private psychotherapy practice, teaches interpersonal and managerial skills to health service staff, and works for a national employee assistance programme (EAP).

Alison Lashwood works as a genetic counsellor within a clinical genetics team at Guy's Hospital in London. Her principal interests are pre-symptomatic testing for those at risk of Huntington's disease and prenatal diagnostic testing. More recently she has become affiliated to the Guy's and St Thomas Hospital Centre for re-implantation diagnosis.

Amanda Logan is a nurse counsellor in the renal unit at a leading London teaching hospital.

Simon Lovestone is senior lecturer in old age psychiatry and neuroscience at the Institute of Psychiatry, London University, and honorary consultant old age psychiatrist at the Maudsley Hospital, London.

Mando Meleagrou works in the psychotherapy consultation service for pregnant women at the Harris Birthright Research Centre for fetal medicine at King's College Hospital London.

Kate Pugh BMEDSCI, MBBS, MRCPSYCH is a consultant psychiatrist in psychotherapy, Gordon Hospital, London. She has experience in working with GP counsellors, running a Balint group for 5 years during senior registrar psychotherapy training at the Maudsley Hospital, and facilitating, with Dr Emma Coore, on outcome study of GP counselling. She is currently consulting to community mental health teams and GP practices in Pimlico, London.

Angela Taylor BA(HONS) has worked in the National Health Service as a rehabilitation counsellor for 6 years. She is currently the senior counsellor in rehabilitation medicine for a rehabilitation centre in south London. Much of her work has involved the theme of loss, particularly in healthcare.

Maureen Williams is a chartered clinical psychologist employed by the South London and Maudsley NHS Trust as a consultant psychologist to provide a clinical service to medical and surgical patients, both in- and out-patients at King's College Hospital London. For the past 18 years she has provided an assessment and treatment service to the King's pain relief unit. She has published research on pain patients, lectured at international conferences on the management of chronic pain patients and is honorary senior lecturer at the Institute of Psychiatry, University of London.

Editors

Susan Davison PHD, MBBS, MRCP, MRCPSYCH is a psychoanalyst and consultant psychotherapist to the South London and Maudsley Hospital NHS Trust.

Christopher Rance OSB (OBL PK), BSC, MBCS, MINST GA is a management consultant, group analyst, psychotherapist and lecturer in organisational group analysis at London and Hertfordshire Universities.

Peter Thomas MSC, RGN is a senior counsellor and counselling consultant in a number of healthcare organisations, including mental health, general practice and primary care groups.

Introduction

Susan Davison

In considering whom to invite to contribute to this book we became aware of the many counsellors known to us personally who are working in a wide variety of medical settings. It appears that an army of counsellors has sprung up from the dragon's teeth of modern technological medicine. The growth of this area of application of counselling has occurred without any central policy planning; rather the case for it has been made on the spot, by the professionals who identified the need for it.

Apart from genetic counselling, which is an exception, the story is of Trojan horses in the form of researchers or members of staff who also happen to have a training in psychotherapy and counselling. Almost universally the idea of having a person whose role it is to listen to what may not be spoken, to articulate what the client may be too frightened to accept, to acknowledge beliefs and feelings unacceptable to the staff as a whole, can be threatening. Why should this be? We have hypothesised that in general those who are committed to the effective application of sophisticated technology often find it difficult to accept that psychological interventions can also be an important contribution to the welfare of patients.

Our initial plan was to edit the contributions to this book in a way which would provide a consistency of style and structure. However, it became clear to us that the style of each contribution in itself reflected the way in which the context influenced the attitudes and approaches of each practitioner. We have therefore left the contributions in the style in which they were originally provided as being in itself a comment on the influence that context has on the mode of counselling.

Isabel Menzies Lyth is quoted again and again by our contributors, indicating the centrality of the link between the organisation of a human institution and the need of the staff to employ psychological defences in order to be able to perform their professional duties without unmanageable

emotional cost. It may have been realistic to combine the functions of physical care and good counsel when in truth there was little to be done other than let nature take its course. But today even hospice care of the dying has become increasingly technical.

Inherent in the medical settings described in this book is a tendency to let a rift form between the physical technical care and the psychological care of patients. This is not to criticise staff who must defend themselves from being overwhelmed by the emotional significance of what they do. The temptation to relegate psychological care to some less important realm, which at a pinch can be dispensed with, must be resisted. Counselling has made a utilitarian case for its inclusion in the multidisciplinary team. Patients appreciate it, and it takes a burden of care off the shoulders of the other healthcare professionals. It can feed back usefully into the way services are structured and delivered and it can point out the need for the care of the staff themselves. In this way the counsellor may contribute to the quality of service provided.

The ideal to which the multidisciplinary team aspires is that of creative collaboration between differentiated roles. This requires mutual respect, an understanding of each other's strengths and weaknesses, and good communication. A good team is one in which everyone feels valued for the contribution he or she makes. Good morale is the cornerstone of excellence of delivery of medical care. However, there always will be times when, for whatever reason, staff begin to feel persecuted, unappreciated, underfunded and overworked. This is fertile ground in which rifts can develop between professions. The counsellor, who is not within any of the existing hierarchies, may be sanctioned by the team to alert everyone to dips in morale and to recommend reflection on its causes so as to arrive at remedial action. However, there may also be a tendency to shoot the messenger.

Counselling in healthcare settings has grown so fast that regulatory organisations, such as the British Association of Counsellors and Psychotherapists (BACP), are struggling to keep up. Codes of practice and ethics, which were originally defined in relation to private practice, need to be re-examined in the context of multidisciplinary working. There is now a sufficient body of experience, partly drawn from counsellors in primary care, but now available from other medical settings as described here, from which to establish codes of practice for counsellors working with multidisciplinary teams. Issues of confidentiality in relation both to the clients' families and to the team, for example, need to be clarified in terms of optimising care on the one hand and protecting against paternalism on the other.

There is at present no formal training for counsellors in specialised medical settings. This has not proved to be a major handicap when counsellors are drawn from the ranks of the existing multidisciplinary teams. Their knowledge base with regards to the technical medical side of the service will be more than adequate. They will already be sensitised to the issues most likely to arise in the client population that uses the service, particularly if they had identified the need for counselling in the first place.

As the profession develops this will no longer necessarily be the case; appropriate training will need to be offered. Some form of accreditation will be required as a means of quality control. Suitable qualified professionals will not happily accept a situation in which they are seen as middle-class 'do-gooders' who don't really need an income. They will want, and should have, a proper career structure with appropriate pay scales and the benefits enjoyed by other healthcare professionals in the National Health Service (NHS).

With this raised professional profile and the attendant costs to the NHS budget, counsellors will need to demonstrate their value to the service. Genetic counselling, the most firmly established application in a medical setting, has begun to establish a methodology for evaluating its effect. Counselling is most readily legitimised when patients, in order to make informed decisions and to be able to co-operate fully with their care, need to understand the scientific basis of the advice being offered to them by their doctors. Genetic counselling most obviously conforms to this paradigm: an understanding of Mendelian inheritance and statistical probability are the basic tools with which to understand the chances of giving birth to offspring affected by genetic disease. The effect of a counselling intervention at this fundamental educational level could quite easily be measured.

This however is only the beginning as there are many obstacles to the assimilation of facts which have emotional significance. To be able to help a client and his or her family imagine the emotional consequences for them of the various outcomes and decisions ahead requires more than the ability to communicate complex ideas simply. It requires an understanding of psychological defences, for none of us can bear too much reality; it requires tolerance and patience and an awareness of different cultural and religious beliefs; it needs respect for the private beliefs and hidden meanings we all attribute to the fundamental processes of life and death. So much of the emotional work has to do with grief; clients and their families need to mourn the future they took for granted in order to be able to make a healthy adaptation to the reality of the condition and its often unpleasant treatments.

An effective counselling intervention should be able to be recognised, in terms of increased acceptance of reality, improved co-operation with treatment, better understanding of the danger signals of opting out of care, a more positive outlook on the future, and greater flexibility in adapting to disability. Suitable instruments to measure all these benefits have yet to be devised but this is an obvious area for properly co-ordinated, collaborative research of the type that has led to the development of the Clinical Outcomes in Routine Evaluation (CORE) instrument. It should also be recognised there can be no definition of benefit which does not involve a value judgement of some kind, one from which individual clients may dissent. Thus measurement of outcome of a process, which is intended to enhance the freedom of choice in the context of each individual's beliefs and values, can only ever be an approximate science.

An important role for the BACP, which already has some of the structures in place, will be to provide appropriate professional support to counsellors in medical settings. It is in a position to take the lead in developing professional standards and codes of practice, co-ordinating research and audit initiatives, negotiating appropriate terms and conditions for counsellors in the NHS, and laying down guidelines for supervision and care of staff. Not least, it can promote the cause of psychological care of patients and their families to those who determine policy and funding – our political masters. If counselling is to emerge as a new and valued profession in the health service it needs a professionally run body to represent it. Counsellors need to shake off the perception of some that they are from a voluntary army nourished by altruism rather than by a conviction of the importance of professional psychological care in the effective delivery of medical services.

The editors have not, as a matter of principle, sought to categorise counselling approaches according to particular theoretical or technical orientations. Some authors declare a particular category, others use eclectic integrative models. Our point is that the contexts both draw counsellors of certain theoretical inclinations to them and then influence the development of a particular style in that context.

Some case vignettes have been provided to illustrate counselling in action. All these vignettes have been anonymised so that not even the subjects could recognise them. If anyone thinks they do, then our major changes have resulted in an accidental correlation with someone unknown to us.

Chapter 1

A review

Emma Coore and Kate Pugh

Introduction

The remarkable growth of counselling in both the NHS and the voluntary sector signals a change in our culture over the past 20 years. General practitioners and their patients value highly the services of their practice counsellor, even when no measurable symptom reduction occurs (Hemmings 1999). Many hospital departments and clinics now employ counsellors to work as part of the multidisciplinary team so as to be able to take a more holistic approach to patient care. In a service where greater efficiency is being squeezed out of all health workers, the counsellor can offer a precious commodity – time. Time to listen; time to attend to questions that 'I didn't want to bother the doctor with'; time protected from the demands of emergencies and routines alike; time to assess how much a patient has understood about his or her condition, the treatment and the implications of it for his or her future and family.

Counsellors are being enlisted in increasing numbers to meet a need, perceived by healthcare workers and patients alike, to attend to the psychosocial aspects of modern medicine while the technocrats apply their amazing skills to the patient's condition. The ensuing chapters in this book will describe how counselling has been integrated into a number of different services, showing how the context and its conditions shape the counsellor's work and in turn how the counsellor can bring a new dimension to the service.

It has been argued that counselling is an indulgence, fostering dependence in patients whose unpleasant but probably self-limiting mental states should be born with stoicism (Persaud 1993). But this is to misunderstand the complexity of the problems which beset our patients. This chapter aims to set out, in general terms, the case for employing counsellors in medical settings and to outline the nature of the work involved.

There is a large amount of psychological adjustment needed in relation to many serious and non-serious medical conditions. Inevitably the degree to which this is necessary will vary from patient to patient. It is impossible to determine to what extent the problems are directly due to the illness and how much they are related to the patient's underlying psychological state. Similarly, when counsellors are working with psychiatric services or in general practice, distress may stem from many aspects of a patient's life, all of which may be worthy of counselling therapy if the patient's overall welfare is the aim.

There have been a large number of studies to determine the prevalence of psychological disorder amongst medical patients and these suggest that, compared to the general population prevalence of 9 per cent (Goldberg and Huxley 1980), the prevalence in hospital populations is around 30 per cent. For example, eighteen months following hysterectomy, 28 per cent (Gath *et al.* 1982); adjustment to haemodialysis: 53 per cent depression, 30 per cent anxiety (Kaplan de Nour 1981); psychological morbidity following stoma surgery over 50 per cent (Thomas *et al.* 1984). A general medical ward can be expected to contain 23 per cent (Maguire *et al.* 1974) to 29 per cent (Moffic and Paykel 1975) of patients with psychiatric morbidity, generally depression.

Counsellors in healthcare settings are often assisting patients to cope with some of life's potentially most challenging moments. Life events may have occurred which have been shown to play a significant role in the predisposition towards and onset of depression. Loss in some form or other may have occurred or be imminent. This need not relate just to death but to loss of mobility, independence, fertility or just future hopes, to name but a few (Murray-Parkes, 1976; Daniluk 1997):

> It is vital to understand the emotional reactions which grip people in these personal crises can have a crushing power. For some, the anguish of the emotional reaction is harder to bear than the illness itself.
>
> (Nichols 1984)

These reactions are faced by staff on a daily basis whilst working in hospices, renal units, infertility clinics and with any form of chronic illness or where conditions are not amenable to treatment.