Counselling for patients with cancer

Lesley J Fallowfield

The recent tragedies at Bradford, Manchester Airport, Zeebrugge, Hungerford, and King's Cross have emphasised the value of counsellors, who may facilitate the healing of emotional wounds experienced by victims and their families long after physical problems have been resolved.¹ These large scale catastrophes have publicised the important counselling work that various agencies have been providing for years, such as Cruse in bereavement. Likewise, the current AIDS crisis has emphasised the need for counselling those people afflicted by other lifethreatening diseases such as cancer.

There are many studies reported in the medical press detailing the social disruption and emotional distress provoked by cancer. In one such multicentre study of 215 randomly assessed patients 101 had affective disorders of anxiety or depression, or both.² It is also clear that many distressed patients with cancer who might benefit from some psychological intervention go undiagnosed and therefore continue with their psychiatric morbidity untreated.³

What is counselling?

Few doctors receive much formal training in counselling skills, and it is therefore apposite to describe exactly what oncology counselling entails. Counselling is a special form of helping, and a person with cancer often requires this help to understand the way in which he or she feels and behaves as a result of the physical and psychological threats provoked by a diagnosis of cancer and its treatment. Patients may also need help with readjusting to changes in body image, lifestyle, and possibly a shortened life expectancy.

There are many different schools of counselling but most counselling techniques embody all or some of the following features. In *directive counselling* the counsellor acts prescriptively, directing the behaviour of the patient wanting help. *Informative counselling* entails providing information, giving help with decision making, and helping understanding. *Confrontational counselling* means challenging unhelpful thinking or coping strategies that are hindering the patient coming to terms with the problem and providing feedback to enable patients to adapt and recognise negative thinking themselves. *Cathartic counselling* is permitting the patient to express and release hidden thoughts, fears, and guilts in a safe, non-judgmental setting, so encouraging better self understanding. *Catalytic counselling* means being reflective and encouraging patients to establish their own, achievable goals, thus promoting a sense of control. *Supportive counselling* means providing acceptance, having empathy, and showing genuine concern for the patient and his or her fears and needs.

Most counselling models contain elements of all the components listed above, but eclectic counsellors use all forms of approach at different times with different patients. "Untrained," unskilled counsellors tend to

use too much directive counselling and sometimes dabble dangerously with confrontation and catharsis.

Counselling viewed in this way is a highly skilled and professional activity which demands a great deal of insight and emotional maturity on the part of the counsellor. Often substantial training is necessary to obtain these skills. Importantly, professional counsellors also see support and supervision for themselves as an integral part of their ability to counsel others.⁴ Very few counsellors currently working with patients with cancer appear to have had anything like the benefit of this training; nevertheless, plainly many are providing a valuable service born of their genuine concern for patients.

Who are the counsellors?

Growing awareness of the many psychosocial problems that confront patients with cancer has led to an increase in the number of people employed in some capacity as a "counsellor." It is therefore important to examine (a) who these counsellors are, (b) their working conditions and responsibilities, (c) their professional qualifications, (d) the therapeutic models that they are using, and (e) whether any supervision and support services are available to them. There is as yet no official professional counselling organisation in Britain and thus no common code of practice. No central register of oncology counsellors exists and anyone can call himself or herself a cancer counsellor. This is in stark contrast with the setting in other countries such as the United States, Canada, New Zealand, Australia, and other parts of Europe, where there are national organisations for counselling. Furthermore, most counsellors in those countries are certified professionals who have undertaken both academic and practical approved training courses.

In Britain counsellors may be paid by the NHS or from charitable funds; others provide a service voluntarily. Some work as full time counsellors, whereas many more are employed in another task such as teaching, fitting prostheses, or nursing but take on an additional counselling role. Some counsellors have degrees in psychology or have attended recognised or, better, accredited courses in counselling; others may have been appointed with no qualifications at all apart from "experience" with patients with cancer or a kindly manner when talking to them, which some people misguidedly believe are the sole requirements of counselling. Many may be entirely unsuitable as counsellors, especially if they are volunteers with cancer themselves who view helping others as a means of resolving their own emotional difficulties.⁵ The volunteer-victim counsellor may benefit by the distraction from his or her own problems which being concerned with another's traumas may provide. A thoughtful study of this particular issue has been called the "helper-therapy principle."⁶ A common difficulty is that unless the counsellor has considerable insight

and control of his or her own emotions, then these may be projected on to the patient being counselled.

A recent paper has also commented on the potential harm which volunteers without proper selection, support, and training can do to themselves as well as to the patients.⁷ Some volunteer-victim counsellors, for example, may overidentify with patients who then die. The volunteer may then rediscover fears of death, even though he or she had considered him/herself "cured" of cancer. Finally, volunteers frequently experience the emotional burn out reported so often among professional health workers in oncology.

Does counselling help?

Though many patients attest to the benefits of counselling, two comprehensive reviews of such psychological interventions have failed to provide unequivocal support for the positive effects of oncology counselling.^{8,9} There are research findings from studies of counselling in other medical settings, such as general practice,¹⁰ and of counselling families with physically or intellectually impaired children¹¹ which show a clear benefit not only to the patients but also to relatives or other members of the health care team, or both. Nevertheless, despite the lack of firm evidence from studies with patients with cancer it intuitively seems plausible that oncology counselling is valuable; indeed, the 1986 King's Fund consensus conference report stated that, so far as breast cancer was concerned, "It is essential that counselling is available."¹²

Some hospitals now employ specialist nurse counsellors for patients with stomas and breast cancer. Unfortunately, these counsellors may carry an enormous workload, providing at best only crisis counselling for patients with clearly identifiable problems. Usually they are unable to offer much prophylactic help or provide a proper follow up service. One paper has described how an initial burst of high commitment and enthusiasm is often followed by emotional exhaustion, depersonalisation, and low levels of personal efficacy.¹³ Even the best trained, most personally resourceful counsellors experience vast problems with their work. They frequently complain at meetings that they cannot cope with the workload, receive little support or recognition from other members of staff, and feel constantly stressed and isolated. This contrasts with professional counsellors in many other settings, who regularly meet with other counsellors. At these "supervision" meetings counsellors explore their own emotional needs, which inevitably affect any counselling relationship that they have with clients. This allows them to maintain a balanced perspective about what it is and is not possible to achieve with patients and also prevents emotional burn out.

The future for oncology counselling

Evaluation of the possible benefits of counselling is vital, but most efforts to date have failed owing to faulty methodology; poor definitions of the counselling role; lack of understanding of the need for research and cooperation by the counsellors and other health carers; evaluation of an essentially unqualified person; and, importantly, no explicit definition of the counselling methods being used. Furthermore, it is proving increasingly difficult to obtain the necessary research funds to conduct appropriate, well controlled trials of different counselling methods.

Awareness of the psychological problems produced by cancer and its treatment together with recognition by more doctors that some of these difficulties can be prevented or at least ameliorated by effective

counselling is encouraging. But counsellors need appropriate help, support, and training. It is not enough to choose the kindest nurse from the outpatient department who has had years of experience with patients with cancer and assume that she or he will automatically be an effective counsellor. Neither is it wise to assume that cancer victims will possess counselling skills merely by virtue of their experience of having the disease and treatment. It is imperative that these enthusiastic and often genuinely altruistic people should be interviewed carefully in order to establish not only their emotional stability but also their adjustment to their disease and general suitability as counsellors. Furthermore, the expectations and limits of responsibility accorded to non-professional counsellors should clearly be defined and supervised.

Other professional groups require training, supervision, monitoring of performance, and assessment or certification to maintain standards and some accountability of their performance. This protects not only the patients but the carers also. It is time for us to recognise a similar system for oncology counsellors. Doctors considering appointing a counsellor would be well advised to contact the British Association for Counselling, which publishes a directory of training courses¹⁴ and provides guidelines for the accreditation of counsellors working in medical settings.

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ANY QUESTIONS

What treatment is advised for local abdominal obesity in men?

Local abdominal obesity is usually a regional exaggeration of more general obesity and correction by dietary restriction and discipline is, therefore, the main treatment. This may leave local obesity of lesser severity which the patient may think is not worth surgical treatment.

Surgical alternatives are panniculectomy and liposuction. Panniculectomy, often called apronectomy when the adiposity is gross, is a cosmetic procedure which merely excises the localised obesity. It does have clinical benefit in relieving backache and psychiatric problems secondary to obesity when such problems are related. Liposuction is a relatively new procedure. Fat is aspirated using a high powered suction pump and large metal cannula, which is reamed forward and backwards until the localised adiposity is removed. As a technique it is more appropriate for lesser degrees of obesity.—R M BADDELEY, consultant surgeon, Birmingham