Review

What are the theoretical concepts that can be applied in therapeutic counselling?∗

A. Lacroix

3, boulevard des promenades CH-1227 Carouge, Genève, Switzerland

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Abstract

The therapeutic counselling of chronically ill patients has been undergoing developments over the last 20 years. From an intuitive and empirical base, it has now achieved a system of standardisation that can serve as a guarantee of effectiveness. Training facilities for this specific mode of healing accept many types of practitioners who have chosen to work in this field. The most widespread theoretical constructs are essentially derived from psychopedagogical models that tend to encourage the development of knowledge and training of how to dispense treatment, while ignoring the clinical type of approach that is based on relationships. This report presents a critical assessment of the most frequently used clinical models as well as some of the more innovative approaches.

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1. Introduction

Starting from early attempts to provide patients with essential information, the notion of counselling has been developed to where it now involves a variety of methods, sometimes based on implicit choices or models and sometimes on case-by-case variations. The first practitioners of patient counselling began by distributing medical information focusing on the disorder before they realised that what was more important for these patients was learning how to manage their own treatment.

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E-mail address: anne.lacroix8@wanadoo.fr.

Providing an exhaustive overview of the numerous counselling methods currently in practice or exploring their underlying conceptual foundations is beyond the scope of this report. Instead, I will discuss the main practices in terms of their most relevant aspects and the efficacy with which they are claimed to work.

The major conceptual turning point in the mid-twentieth century was the emergence of the biopsychosocial model [1] in medicine in contrast to the organic/functional model. This meant that, where previously patients had been treated only for specific disorders, treatment and assistance were now dispensed in a more open-ended context.

To provide patients with the necessary information required to manage their own treatment, patient counselling had to rely on teaching. From this grew two different disciplines:
the case of, say, the HbA1c rate. Also, what about the time factor framework of a prescription, which can be most demanding in established facts (in diabetes, for example) and keeping to the selling patients — negotiation is the primary mode, although authoritative in nature; in the domain that concerns us — counsel of determination. In the context of a school, determination is for passive learning. such that a form of transmissive pedagogy can act as a remedy psychology (from Piaget, among others)[3], the objectives are advantages as, in the light of the experience gained from practical criticism of the language used.

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Reintroducing action into learning methods has some advantages as, in the light of the experience gained from practical psychology (from Piaget, among others) [3], the objectives are such that a form of transmissive pedagogy can act as a remedy for passive learning.

However, one limitation of “objective pedagogy” is the mode of determination. In the context of a school, determination is authoritative in nature; in the domain that concerns us — counselling patients — negotiation is the primary mode, although the medical authority here fixes the limits by referring to well-established facts (in diabetes, for example) and keeping to the framework of a prescription, which can be most demanding in the case of, say, the HbA1c rate. Also, what about the time factor in objective pedagogy? It is clearly limited in a school environment whereas, in patient counselling, it takes on an entirely different dimension.

2. The objectives

Inspired by behaviourists and cognitivists, a type of “objective pedagogy”, which aimed to replace the traditional “contents pedagogy” [2], was developed in the United States. It adopted a functional perspective by setting up objective procedures of evaluation.

Like all pedagogical innovations, these objectives were tremendously appealing, appearing to be a miraculous solution. Undoubtedly, pedagogical objectives constitute an interesting operational attempt to exhort pedagogues to have clear intentions and to transform them into precise, pragmatic targets capable of being evaluated. However, in the drive for clarity, they favoured criticism of the language used.

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3. Motivation as a concept

Pedagogy can be defined as a relational practice because there are two categories of players, each with his own expectations. It is destined to function in dual uncertainty, which is the dynamic basis of any relationship. Motivation appears to be another important factor. Faced with the resistance to change expressed by a substantial number of patients, motivational interviewing [4] is considered a suitable means through which the professional carer can encourage the patient to modify his behaviour.

Those in favour of such an approach prefer contact without being judgemental. They focus principally on behaviour and not on the person. Their target is to assess what the patient would like to do, regardless of his state of health. They assume that, if the patient is able to project himself into a desirable future, he will modify his habits and maintain his day-to-day efforts. The change has a greater chance of occurring if the patient feels he is able to succeed; thus, throughout the interview, any intention that expresses his ability to achieve his goal is reinforced.

This approach is inspired by the behaviouristic idea of the stimulus-response that relies on the following presupposition: repetition of or, indeed, reformulation of the desired behaviour will lead to a reward by evoking satisfaction linked to the desired goal.

In fact, this strategy is more focused on the role of the practitioner than on the patient’s. The purpose is to modify the thoughts that limit a change in behaviour thanks to an enquiry that is aimed at cognitive reconstruction, a reprocessing of the idea that is the source of the problem. Based on how the patient takes in the information, this approach is the equivalent of cognitive reprocessing, which enables a change in behaviour.

My reticence concerning this technique comes from the fact that, by applying such a reasoned approach, there is a risk of reducing the person to his behavioural patterns. Yet, the individual is governed by both reason and the unconscious. The human being is trapped in his own contradictions; as a rational subject, he will submit himself to the standards of those who seek to do him good but, as a living individual, he will seek to evade the health injunctions that are proposed. Dietitians frequently complain that they spend all their time balancing food intake (diets) while their patients disregard these efforts and play with their own lives [5].

It then becomes difficult for the health professional to abandon the role of “he-who-knows-what-is-best-for-the-patient”. When confronted with a chronic situation, the health professional has to adapt to a new treatment approach that acknowledges that tools and technique are not the only solutions. The new position has to lie somewhere between feelings of helplessness and the risk of domination.

4. Communication in relationships

This leads us to the concept of communication as a factor in the relationship. Whether it is a one-to-one or a group situation or an interview with the patient or with those closest to him, learning sequences or any form of help — sensitivity, availability and other factors — can introduce misunderstandings. The numerous health professional–patient interviews are not mere conversations. Here, common sense and goodwill are clearly not only insufficient, but can even have perverse effects.

The works of Porter [6] and Rogers [7], which are widely used to train social workers, can be transposed into medical situations and provide medical teams with some know-how of the different response mechanisms in relational situations.
In social psychology, what is called “attitude” is a way to internalise, inducing a certain predisposition to action. Such attitudes are acquired and not innate. According to Porter, there are six categories of attitude that correspond to different ways of responding to a request or complaint. These responses are immediate or non-reflective reactions and can lead to effects that do not facilitate understanding and mutual trust.

For communication to be established, it is essential to let the other player know that he has been heard by reformulating what he has said. However, reformulation is not a spontaneous reaction. It is, in fact, a communication strategy for care–help relationships that is neither a conversation nor an interrogation. For Carl Rogers, the understanding attitude, which can be defined as empathic reformulation, is the pillar of his theory and practice.

Well before the motivational interview was described as the missing link in therapeutic counselling, recognition of reactive attitudes and training in how to listen to the other were fundamental elements in relationship communication.

5. Representations

Among the obstacles to patient adaptation, the role of representations is frequently mentioned. Here again, at least two tendencies can be seen in both anthropology and pedagogy.

Anthropology is based on the fundamental assumptions of its discipline, the first of which is an ethical dimension and the other, a refusal to cast any judgements in the understanding of the factors underlying any modes of behaviour. Anthropology concentrates on the discourse and behaviour of the person involved – for example, how the patient perceives the cause of his disease and the logic that determines his treatment.

For the anthropologist, an understanding of individual practices inevitably involves the context in which they appear [8]. Consequently, the conditions surrounding the maintenance or improvement in the state of health of the patient cannot be reduced to an attempt to modify individual behaviours without taking into account the social reality in which the individual has evolved. The anthropologist does not aim to change these behaviours even if they are pernicious but, instead, attempts to throw light on the behaviours by analysing the social, ethical and even religious background.

As for pedagogy, it is concerned with promoting learning reflexes and know-how. Research in the context of a school has shown that thought processes do not function like a passive recording system. Representations — preexisting images of reality that are unconsciously fixed in the mind — will resist any attempts to introduce objective reality.

Didactic research has shown the importance of knowing that representations need to be expressed to make them evolve. Rather than be considered as errors, they should serve as guidelines or indicators of the way the patient perceives things. Based on the experience gained from both the psychosocial group model and Piaget’s research in didactics, the next step is the cognitive conflict strategy [9].

Studies have demonstrated that the individual changes from the moment he creates a conflict between his own point of view and that of the other. In any group activity, the role of the teacher or instructor is to maintain the interactions and to regulate confrontations. Therapeutic counselling is mainly a group activity because of practical reasons and, more and more so, because it is based on the effects produced by interaction and confrontation.

Yet, regarding the knowledge and beliefs of the person himself, as in the case of learning about his disease, a number of questions remain unanswered. How are emotional factors, social pressure and values interacted with and combined, and articulated to produce representations? At what level of consciousness (or unconsciousness) does the elaboration of these representations take place [10]? Are representations alone the source of these behaviours? In the meantime, these are the targets of discourse and educational practices.

6. The psychological reality

During my collaboration with the Geneva team, where we worked a great deal on patient counselling, my fellow psychiatrists and I endeavoured to delineate the psychological reality of our patients. To enter into the disease process constitutes an event that is neither chosen nor desired. It can lead to having to face the thought of operations or even life-threatening events that, in turn, can have emotional repercussions that determine how a person adapts to the new situation.

This psychological dimension has been shown, in the clinical context to lie at the heart of the patient’s experience of disease. I have attempted to describe two distinct paths in relation to the mourning process, based on the Freudian psychodynamic model [11]. One path is characterised by the patient’s process of psychological integration of the loss of health, while the other involves a distancing process to such an extent that the patient’s reality is obscured, thanks to defence mechanisms set up by the ego, which feels threatened. Sometimes, there need to be a time lag between the onset of disease and the ability of the patient to consent to the necessary constraints that the condition demands. In fact, I have realised that a great number of patients waiver between refusal, denial and adapting to their chronic condition. What is involved is not the deliberate choice between one strategy or another, but an ambivalence when faced with the tension surrounding what is prescribed and what has been achieved; this results in the repetitive fixity of certain behaviours.

Caregivers generally understand how difficult it is to be afflicted with a chronic disease, but they feel at a loss when faced with attitudes of negligence or non-compliance that show that the patient is fed up or having to deal with events other than the disease itself. This, then, is considered the field of the psychiatrist. However, the patients themselves do not necessarily feel the need to see a psychiatrist. In the process of training for patient counselling, relatively little time is devoted to the dynamic psychological approach to patients, and few of us are developing this field. Indeed, this aspect is not seriously taken into account except for cancer patients (now considered a chronic disease) [12].

Within the framework of the patients’ follow-up, medical teams should also benefit from support where contact with the patients can be developed in a sharing environment where pro-
fessional activity can be supervised [13]. This clearly requires time and the presence of a third party, conditions which go against the increasing pressure of work based on rapid turnover. Nevertheless, although these demands might appear excessive, they are essential for optimizing goals and actions when confronting the overall approach to chronic patient care.

7. The concept of coping

Another point of view, which comes from the US, targets the role of stressful events and strategies to confront them — in other words, coping. Compared with the US, only moderate interest has been shown in France for this point of view.

Behaviours to confront the disease are defined as the cognitive, behavioural and emotional efforts that the individual deploys to master, tolerate and reduce internal and external demands, as well as the conflicts that can occur between these two kinds of demands. Are the different ways to react sparked by the situation or by the personality of the person experiencing the situation? Furthermore, at what level of psychic functioning are these ways of reacting and evolving situated?

The initial assessment is the cognitive process by which an event is experienced, according to the situation and personal resources at stake. As for the efforts made to confront the issues, this is about coping centred either on the problem or the emotions [14]. The cognitive aspect of the coping mechanism has reduced the problem to a solution to the problem. Yet, faced with an ordeal or some difficulty in which the events accumulate and multiply, the person reacts according to his background, values and psychosocial resources.

This notion of coping is placed within a logical context that does not accurately define the complexity of the process where a potentially serious disease is concerned, where the issue surrounding adaptation is uncertain as the disease is experienced not only as a deterioration in well-being, but also in emotional state.

8. The choice of conceptual models

There are certainly many complementary reading references to help in understanding the attitudes of patients. I should mention the Health Belief Model [15], the notion of the Health Locus of Control [16] or the comprehensive model of change by Prochaska and Di Clemente [17]. Each viewpoint reveals a breakdown of an object by analysing it according to a theoretical reference model.

Every school for patient counselling chooses its training models on the basis of certain values or to follow in the footsteps of the initial training it was inclined to prefer, using such and such theoretical guidelines.

As for doctors, on what elements do they base their professional roles during their medical studies and hospital training? The most widely developed and highly esteemed models depend on evidence-based medicine, including diagnostic investigations, treatments and specific operations. These elements are at the heart of professional ideals, linked to the motivations behind becoming a doctor. The first period in his professional life involves being efficient in crisis management. In this context, the responsibility is to cure or, if not, then to repair the damage.

Efficiency and power progressively determine professional identity, which is centred on direct intervention and control of a situation. This efficient, technical and scientific identity proceeds from modern medicine with the full assurance of its power over disease. Yet, the patients who benefit from this idea are not the majority, given the increasing number of chronic complaints that represent another challenge to the whole of medicine.

What happens to these professional identities that are based on performance when confronted with long-term diseases marked by risks and uncertainty?

Alongside cases and situations that can be solved thanks to basic knowledge, we discover, little by little, problems for which we were not prepared — a kind of deficiency where questions remain unanswered. The organic/functionalists are faced here with the survival of chronically ill patients, and in this context the need for supplementary training with a different focus arises. To become a patient counsellor while remaining a health professional implies the acquisition of new knowledge and behaviours that are able to bring about a change in personality. It involves three aspects, in practice:

- change in how the patient is perceived by considering his life story and background, and not only his organs;
- change in the relationship with the other — the patient — as someone who is to be encountered before counselling;
- change in logical and rational thinking, leading to a change in language to adapt to the other.

Training sessions in patient counselling should accentuate these changes or, at least, the desire for these changes to be made.

Yet, it seems that the expected changes involve, above all, changes in the patients themselves so that they become more aware, more willing to modify their pernicious habits and more willing to accept that it is in their own interest to become the true managers of their own states of health.

Teaching methods and modern psychology provide the approaches and the methodologies that are supposed to ensure efficient counselling practices. A vast number of strategies that are considered operational are intended to help the patient comply with his treatment, but can counselling be reduced to strategies?

9. Innovative perspectives

There are other strategies emerging today that are inspired by a clinical approach that tends to establish a relationship based on equality between partners. A Quebec-based experience — the PRIFAM [18] — is a family-linked programme that is part of the post-modern transformational paradigm. It proposes a holistic and systemic process in which the players, families, patients and professionals are synchronously interdependent in their development through reciprocity and power-sharing. The values, beliefs and connections of the members are recognised.
and taken into account in the intervention, along with those of the health professionals. Resources and the potential of each person are mutually pooled.

The major principles of this experience that enable transformation are reciprocity and mutuality. In other words, we need others — the patients — to accomplish our own transformations as health professionals.

We should welcome this new perspective — in the form of a narrative approach — as a universal human activity. How we speak about ourselves corresponds to the way in which we communicate our identity. The first doctors to have integrated this narrative approach into clinical practice were family-guidance workers.

Today, this approach could be part of the medical consultation, as the narrative then appears self-evident, particularly when trauma is involved. The basic theories in favour of the narrative approach derive from several branches of the humanities: philosophy, psychology, ethnology-anthropology and medical sociology. The narrative approach encourages us to think about the power element in relationships between patients and the medical team. One potential goal would be to aim for a better understanding of what affects identity, as the unexpected arrival of a chronic disease that alters the biological self brings about activation of the identity process, the expression of which is indicated by a narrative response to questioning.

In France, we owe the notion of narrative identity to philosopher Paul Ricoeur [19], whose concept of identity led to a questioning of the role of narration in the context of therapy. In addition, anglophone contributors such as John Launer [20] and Michael Rothschild [21] have concentrated on the narrative approach during consultation, without rejecting the role of technical expert.

Each patient who seeks help does not always have explicit expectations. Each patient has feelings linked to his particular problem, including fears. To understand the expectations, feelings and fears specific to each patient, and to enter into the world of each given patient, is a difficult art.

The key to a patient-orientated approach is to be able to move around in the patient’s narrative itself. In other words, it is the patient who inspires us, and the right word can indeed be the one that surprises us. I am specifically referring to J.B. Pontalis [21], who said: “Clinical practice-the source of thinking”. He did not use the word “theory”.

10. Conclusion

It was in response to the needs of chronically ill patients that “patient education” was developed. First of all, the word “education” is problematic, as it means “to raise or to interfere with the development” of a subject — in this case, any programmes and educational methods are selected by the healers. The strategies that are considered operational come from a prescriptive logic. Some models advise beginning patient education with an educative diagnosis, then to establish an educational contract to render the patient faithful. The appearance of a chronic disease is unpredictable as it depends on the subject’s personality — his psychological resources, his personal history, the moment in life he is now living; it also depends on the disease in question and the way the patient sees it, not forgetting the values to which he is attached. Without taking into account all these elements, the effects of education itself may also be totally unpredictable.

In photography, the solution which allows the invisible image to appear is called the revelatory. With people, an event such as a disease can serve as a revelatory of the patient’s capacities or difficulties in facing it, with the use of personal, familial or social resources, and reveal the value ascribed to specific life choices that function as essential landmarks such as professional achievements, self-esteem or enjoyment of life.

The patient’s needs appear to be of an existential nature which cannot be defined without an open-minded approach that requires acceptance of the unspeakable: fear of change and anxiety over the end.

The clinical approach (and why not narrative as well) offers a singular co-creation, the first steps in the formation of a link between the way a patient lives with disease and how he views the whole of his life to reestablish its threatened harmony.

References