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## A Model for Counselling Cancer Patients

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Ronna F. Jevne  
Cheryl L. Nekolaichuk  
F. Helen A. Williamson  
University of Alberta

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### Abstract

Cancer invades the lives of people from all walks of life. Every counsellor can expect to deal with people who face the challenges of this devastating, life-threatening illness. This paper describes a model for counselling cancer patients that integrates the unique features of the cancer experience within a basic counselling framework. This model combines a nine-step, problem-solving approach with a biopsychosocial perspective, placing greater emphasis on the person than the problem. Innovative questioning techniques and strategies, embedded within this framework, harness the illness experience as a creative force, carving a pathway to patient empowerment and wellness.

### Résumé

Le cancer touche la vie des gens de tous les horizons. Les conseillers peuvent tous s'attendre à avoir des clients devant faire face aux défis posés par cette maladie dévastante qui peut être mortelle. Cet article décrit un modèle pour le counseling des personnes atteintes de cancer intégrant au sein d'un cadre de counseling de base les aspects uniques qui caractérisent l'expérience du cancer. Ce modèle comprend une démarche de résolution de problèmes en neuf étapes dont la perspective est à la fois biologique, psychologique et sociale et qui met l'accent sur l'individu plutôt que sur la difficulté. Des méthodes et stratégies interrogatives innovatrices reposant sur ce cadre transforment l'expérience de maladie en une force qui incite à l'action et qui mène à la prise en main personnelle et au mieux-être du client.

The word "cancer" continues to strike fear into the hardest of souls. As psychologists working in a large urban cancer hospital, we were introduced to the fragility and sacredness of life. Each day, we strived to make a difference in the lives of patients and their families. It became evident that the difference lay in the means, not in the goals. The lived experience of our work taught us that the task was endless, the challenges relentless. At some deep level, it was necessary to be fully committed to caring, and to understand that life is a privilege.

Approximately one in three people will develop cancer at some point in their life time (National Cancer Institute of Canada, 1997). The invasive nature of this disease and its treatment produce distressing physical symptoms, such as pain, nausea, anorexia, and fatigue. Accompanying these physiological changes, people experience a wide range of psychological stressors (Farber, Weinerman, & Kuypers, 1985; Frank-Stromborg, Wright, Segalla, & Diekmann, 1984; Holland & Rowland, 1989; Nerenz, Leventhal, & Love, 1982; Peteet, 1979). Depression and anxiety are the most common forms of psychological distress amongst cancer patients (Massie & Holland, 1989; McDaniel, Musselmar, Porter,

Reed, & Nemeroff, 1995). Approximately 10 to 25% of cancer patients will develop a major depressive disorder, depending upon the degree of impairment, the stage of cancer, and the burden of symptoms, such as pain (Chochinov, 1994). Fears of death, disfigurement, dependence, disability, and role disruptions further contribute to a patient's level of psychological distress (Massie, 1989).

Cancer pervades many dimensions of an individual's life, reinforcing the need for a multidisciplinary treatment plan that focuses on the whole person. Given that the predominant approach in medicine is to identify and treat organic causes of disease, psychological interventions are rarely incorporated into a patient's treatment plan as proactive measures. The counsellor is often approached only after the patient or family members have experienced a crisis situation. In the health promotion literature, researchers have expressed dissatisfaction with the traditional biomedical model of health (Strachtchenko, 1990). The consideration of psychosocial factors that create distress, prompt health care utilization, and enhance adaptation to illness, can improve patients' quality of life and reshape medical care in a cost-efficient manner.

The therapeutic efficacy of psychological interventions for cancer patients is well-documented (Andersen, 1992; Pompe, Antoni, Visser, & Garssen, 1996; Spiegel, Bloom, Kraemer, & Gottheil, 1989; Trijsburg, van Knippenberg, & Rijpma, 1992). Many studies describe simple, safe, and relatively inexpensive interventions that can dramatically improve health outcomes and reduce the need for more expensive medical treatments (Sobel, 1995). Four major categories of psychosocial interventions most frequently described in the cancer literature include education, behavioural training, individual psychotherapy, and group interventions (Fawzy, Fawzy, Arndt, & Pasnau, 1995).

The purpose of this paper is to describe a specific psychological intervention, a model for counselling cancer patients,<sup>1</sup> based on our clinical experiences of working with this population. This model integrates a problem-solving approach within a biopsychosocial perspective (Engel, 1977), whereby the patient is the focal point.

Although this counselling model uses a step-wise problem-solving approach, its philosophical underpinnings (derived from the cancer experience) vary substantially from traditional frameworks. First, despite a wide variation in person-centred and pathology-oriented problem-solving approaches, this model unquestionably places greater emphasis on the person than on the problem. Second, counsellors adopting this framework view patients' problems as normal and healthy, rather than abnormal or pathological, components of the cancer experience. Counsellors create a hope-enhancing environment that is open to possibilities, rather than focusing on negative past experiences. Third, the counsellor adopts a collaborative, rather than prescriptive, stance by encouraging

patients to access inner resources and develop unique problem-solving skills. Fourth, given the potentially destructive nature and devastating assault of this illness upon a person's body and spirit, the ultimate goal of this approach is patient empowerment and reclaiming of self, rather than problem resolution. Counsellors encourage patients to develop unique problem-solving techniques, as opposed to dictating a single pathway to problem resolution that all patients must follow. In some cases, a patient's decision to not solve a problem is as therapeutic as problem resolution, and is to be encouraged.

The experience of living with a life-threatening illness fosters a unique shared partnership between the patient and the counsellor. The desired outcome of this partnership is to reestablish and maintain the patient's sense of self, in spite of an unpredictable and chaotic illness course. To frame this counselling approach within the cancer context, the nature of the cancer experience will be described followed by an in-depth description of the model, itself.

#### THE CANCER EXPERIENCE

##### *The Cancer Context*

The chronic, unpredictable nature of the cancer experience presents patients with unique challenges. Based on our clinical experiences, the following insidious and invasive features of cancer may increase the likelihood of psychological implications:

- (a) *a silent onset*: "If cancer can come unannounced, then it can return unannounced." The knowledge that cancer can return lingers even in patients where the prognosis is excellent.
- (b) *delayed diagnosis*: "If the medical profession didn't believe me once, maybe it will not believe me again." Undiagnosed malaise, resulting in test after test of "we found nothing," lowers trust in the science where patients look for treatment and survival.
- (c) *invasive, disfiguring treatment*: Cancer treatment is often demanding physically and emotionally. Patients dread the treatment as much as, if not more than, the disease itself, leading them to question both the process and outcome.
- (d) *multiple losses*: Body image or body function changes, loss of existential security, loss of predictability, loss of social acceptability, and role changes are among everyday losses of the cancer patient.
- (e) *association with death*: For many patients, a cancer diagnosis is a death sentence and may be their first encounter with mortality.
- (f) *chronic, unpredictable course*: Confronting the fear or the reality of the disease, and dealing with challenges over an extended period of time, deplete resources.

These clinical observations are supported by descriptions of psychological reactions to cancer in the literature. Despite excellent prognoses, cancer survivors may experience ongoing psychological problems, including anxiety, depression, altered body image, and fears of recurrence (Tross & Holland, 1989). With respect to the cancer diagnosis, itself,

Rowland (1989) identified five disruptions of illness, common to all patients regardless of their stage of development: *altered personal relationships, dependence-independence, achievement disruption, body-sexual image and integrity, and existential issues*. These disruptions are commonly referred to as "the five D's:" distance, dependence, disability, disfigurement, and death.

### *The Voice of the Patient*

Patients perceive cancer as an assault on the self (Moorey, 1991; Rowland, 1989). Life, as it was known, is no more. The sense of self is a narrative phenomenon (Stivers, 1993). When people seek counselling, they have a story to tell. Patients often feel that even their stories about physical symptoms have been "cut off" by hurried health care providers.

Some patients want assistance with (or at least support for) eliciting information and action from the health care system. Resources concerning the specifics of a particular cancer are often available through on-line computerized library searches. It can be useful for a counsellor to conduct a literature search to understand a patient's specific condition. The end purpose is for a counsellor to be well-informed, but not necessarily an instant expert. If possible, patients should also be encouraged to seek information regarding their condition directly from their doctor or library services. Some hospitals provide resource centres equipped to assist patients in searching and interpreting information.

Finally, patients and families want to deal with someone who is not afraid of cancer, someone who is willing to enter the trenches and to be there with them. Both patients and professionals carry personal assumptions about the meaning of cancer. It is especially useful to be aware of the challenges of cancer, the attitudes that many cancer patients have to counselling, and various helpful and unhelpful assumptions of counsellors.

### *The Voice of the Counsellor*

Death or the threat of death factors in a new dimension to our working assumptions with cancer patients. The question is not whether we hold these assumptions, but whether or not they are within our awareness. These assumptions influence the way we perceive people with cancer and their concerns. Some assumptions may be more helpful than others. The following assumptions are inherent in the approach described in this article. The reader is invited to agree or disagree with them.

Cancer may be viewed as a chronic, as opposed to curable, condition (Schipper, 1994). Thus, the primary focus of counselling cancer patients is the management of a chronic illness. The role of the counsellor is to maximize the existing system, not to change it. Differences in the support system are likely to occur, but structural change is not the specific intent

of counselling. This assumption is consistent with the view that most patients are socially "healthy" (albeit under stress) and with guidance can adjust to surrounding stressors. Increasing the confidence and skills of such individuals promotes health and makes economic sense.

The cancer population is a normal population with regard to psychiatric conditions (Chochinov, 1994; Rodin, 1995). Thus, we believe the reactions to cancer experiences are better described from a stress or coping paradigm than from a psychopathology model. With rare exceptions, patients either have, or can learn, strategies to increase their well-being and enhance their strengths. Information and insight gained from within and outside the patient's awareness is useful in the therapeutic process.

Cancer patients display wide variations in their reactions to stress associated with cancer (Moorey, 1991). An individual's personality influences the response to cancer diagnosis and treatment, and is a valuable strength if respected, understood, and assessed. It is our belief that patients are competent decision-makers and are doing their best at *any* given point in time, even when progress may seem puzzling or non-existent to the observer.

Based on our clinical experiences, the following commonly held counsellor assumptions may prove to be *unhelpful* with most cancer patients: (a) The patient must reach deep insights and be totally adjusted for counselling to be defined as successful; (b) Patients are psychologically fragile; (c) Solving practical matters is not counselling; (d) Denial and avoidance are unhelpful; (e) Depression and anxiety are negative; (f) Patients must go through certain adaptive phases; and, (g) Dying is the worst thing that could happen.

The assumptions described in this section are useful for working with most cancer patients. However, patients with an apparent psychiatric history, or with neurological damage, may require interventions based upon other assumptions.

#### A COUNSELLING MODEL

Our model for counselling cancer patients integrates a problem-solving approach within a person-centered, biopsychosocial framework. Unlike traditional prescriptive problem-oriented frameworks (D'Zurilla, 1986), this model focuses on the patient's experiences and resources. Consonant with a biopsychosocial perspective, it acknowledges the complex interactions of the biological, psychological, and social aspects of disease, with a primary emphasis on wellness as opposed to pathology. It provides patients with a mind set, that anchors them within the tumultuous experience of living with a life-threatening illness.

The model consists of nine phases: (a) exploration and enhancement of the patient's level of hope and commitment; (b) assessment of the

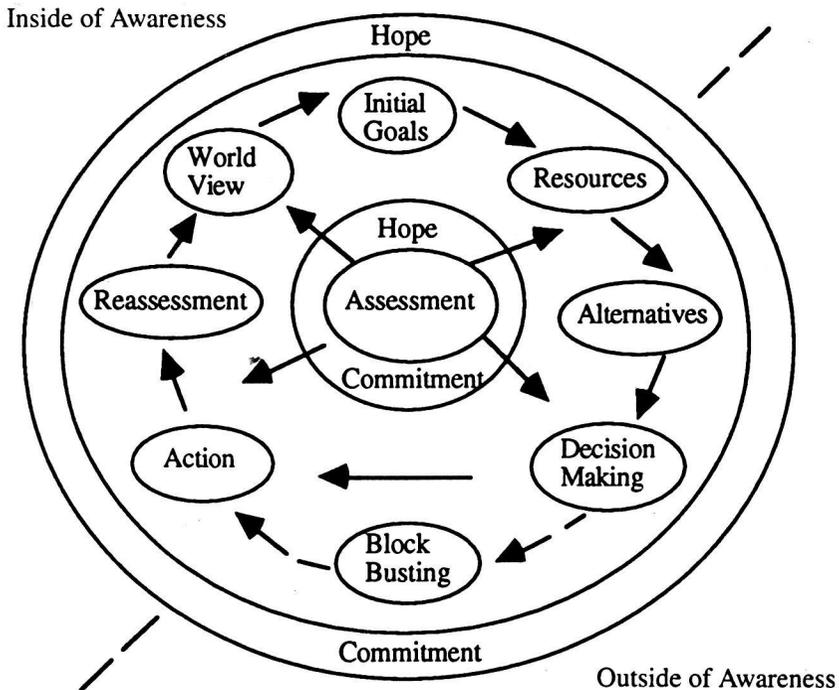


FIGURE 1

*A patient-centred counselling model within the context of cancer.*

patient's world view; (c) identification of initial goals; (d) compilation of a resource inventory; (e) development of a repertoire of alternatives; (f) decision-making; (g) block-busting; (h) action planning; and, (i) reassessment (see Figure 1). The following is a description of each phase of this model, highlighting its purpose, desired outcomes, and specific therapeutic strategies, where applicable. A summary of questions that may be helpful to guide the patient through these phases appears in Table 1.

TABLE 1

### *Questioning Guide for Counselling Cancer Patients*

#### *Phase 1. Hope Enhancement And Deepening Of Commitment*

- a. On a scale of one-to-ten, how committed do you feel you are to hope/health/getting better?
- b. How hopeful are you and for what do you hope?
- c. Are you concerned about how normal your reactions are to cancer?

*Phase 2. Assessment Of Patient's World View*

- a. *If you could identify the three things which most concern you, then what would they be?*
- b. *If you could draw your pain/anxiety/concern/frustration, then what would the picture be like? Would your wife/brother/doctor concur? What would they say?*
- c. *If someone filmed a video of your life's past ten years, then what would it look like? What would be the audience's reaction? What would be the title?*

*Phase 3. Initial Goal Identification*

- a. *What will your life be like if you are able to resolve this? If, by magic, this situation was the way you wanted it, then how would it be? What could be, at minimum, an acceptable solution?*
- b. *How are your desired outcomes similar to or different from others in your life at home or in hospital?*
- c. *How will you know when you are adequately managing the problem? How will others know?*
- d. *What is the most important aspect of this situation to be resolved?*
- e. *If you had to represent your present life situation as a game, then what would the object of the game be? What are the rules of the game? Who referees? Who keeps score? Who is in the bleachers? How is time kept? When is the game over?*

*Phase 4. Compilation Of A Resource Inventory*

- a. *In what way is this situation like others you have faced and what strengths, skills or resources have brought you through?*
- b. *In what way, if any, does this problem affect you financially?*
- c. *What do you see as your personal strengths? How effective are you at the following: decision making, setting priorities, communicating your needs and feelings to family and medical/nursing staff, or relaxing/staying cool when in a stressful situation?*
- d. *What do you see as the personal strengths of those around you? Who in your world is available to help? What is the nature of the help you can expect from them?*
- e. *What do you need to deal with this situation? How possible will it be for you to access these needs?*
- f. *What part has church or religion played in your life?*
- g. *What have been your experiences with the medical system?*

*Phase 5. Exploration Of Alternatives*

- a. *What have you already tried to solve the situation?*
- b. *Which concern(s) are you going to work on resolving today, this week, this month . . . ? What is one small thing you can do today? What is the smallest event that could make a difference?*
- c. *If you didn't have to consider anyone else's feelings, then how would you solve this?*

- d. What is the most important and helpful thing that could happen?
- e. What stressor can you get rid of? A change in which stressor would be most helpful in changing your experience? What stressor can you most influence?
- f. How many ways of coping with this can you think of creating?
- g. What would be the most absurd way to solve this?
- h. What would you advise someone else to do in this situation?
- i. If you awoke in the morning and something was better, then what would have happened overnight?

*Phase 6. Decision Making*

- a. What decision do you need to make today? If you could set a priority on one thing happening today, then what would it be? What would be the smallest decision you could make toward your goal today?
- b. If you could take charge of this situation, then what would you have to decide? What is going to be important to you in making the decision?
- c. If you could have permission for three things, then what would they be? Whose approval would feel especially good?
- d. How would a person whom you trust advise you in this matter? Whom in your world can you trust for advice? Whose, if anyone's, assistance would you like in this decision?
- e. If there are two sides of you struggling over the decision, then which side do you hope wins?

*Phase 7. Block-Busting*

- a. What is your sense of how you prevent yourself from achieving your goals? How are others blocking you from achieving your goals?
- b. If you were not sad/afraid/mad, then what do you think you would feel? What would you like to feel?
- c. There is a part of you that wants to go ahead and a part of you that holds back. Tell me about each side.
- d. If you could picture what is holding you back, then what would it look like—size, shape, color, texture? (It can be helpful to have the patient draw a picture of his/her block.)
- e. If stopping yourself from taking an action is somehow serving a purpose, then what is that purpose? What would you like us to understand about you that we seem to be missing? With which part of this experience is it the hardest to come to terms?
- f. If you could empower yourself to do one thing, then what would you want it to be? With regard to this situation, what is the thought you most often think? What do you wish you could think?

*Phase 8. Action Planning*

- a. What activities will you start or stop? When?
- b. Who can reinforce this?

*Phase 9. Reassessment*

- a. How successful do you feel? What do you need to do now, if anything?
- b. When will you reassess the situation? What will be the signs you need to reassess your situation?
- c. How will you monitor your ongoing success? Who can support your changes and play a part in monitoring your progress?
- d. Write a letter to yourself, indicating how you will feel in three months (as the counsellor offers to mail it to the patient at that time).
- e. Prepare a large poster, which includes a small calendar, that will remind you of your progress.

*Phase 1. Hope Enhancement and Deepening of Commitment*

This first phase, the enhancement of hope and deepening of commitment, grounds patients within a trusting environment and opens a window for exploration of possibilities. The enhancement of hope anchors patients within the turbulence of a life-threatening illness, while the deepening of commitment encourages patients to assume an active role in their care and recovery.

Hope is an intangible and "intangibles set the stage for medicine" (Cousins, 1989). The absence of hope reduces the power of the best medicine and health care professionals. Throughout the counselling process hope and commitment can be reinforced. The ultimate hope, of course, is to have patients assume responsibility for their own lives and maintain their self-integrity regardless of their health status. Several goals can be accomplished by having hope and commitment as essential threads which are woven throughout the counselling process. First, the patient begins to believe she or he is truly being heard. Second, the counsellor is able to assess the level and nature of both hope and commitment, as well as signs of discrepancies in the expressed (versus actual) commitment levels. Rather than label a patient as unwilling, noncompliant or resistant, the counsellor adopts the intentional goal of strengthening commitment and hope.

This phase of the framework consists of four preferred outcomes: (a) effective use of staff time and energy by gauging the most appropriate target and level of intervention; (b) patient recognition of the partnership nature of the helping relationship; (c) strengthened motivation; and (d) establishment of a "therapeutic" relationship.

*Strategies.* The patient's experience of being heard opens the door to hope and commitment. It is crucial to listen to the patient's whole story. If time is limited, then invite patients to record their stories in a journal, on video or audio tape, or in letters to a known or unknown person. If they are not writers, then they may be willing to draw a map or lifeline of their lives since the beginning of the illness. Keep asking yourself questions

during the patient's storytelling: What has brought this person to me and why now? How do they feel about coming? What are they committed to in their life and in their cancer experience? What in their life has been challenged by the diagnosis of cancer? What is the potential for success? How am I, and how are they, defining success?

People often feel they should be able to handle their cancer alone. By framing this period of time as unlike any past time and unlike any upcoming time, it conveys "permission" to disengage from the need to personally control everything. Introduce them to the idea of the "cancer roller coaster"—the sense of being in and out of control frequently—particularly during the initial stages of the illness. Encourage differentiating those aspects of life which are under, or potentially under, their control from those which are not. This helps to form the focus of realistic goals. Explore other situations in which the patient and/or family members have previously demonstrated hope and listen for metaphors suggested by previous experiences. For example, someone with a farming background may respond to references of life cycles, whereas a person with a military background may be more inclined to images or metaphors of battles. All metaphors can be useful in encouraging engagement.

Throughout this initial part of the patient-counsellor relationship, it is useful to indirectly suggest pleasantness, strength, calmness and feeling of connection, as well as how good it feels to have taken action and to have purpose. If "purpose" is not present, then endorse the search for purpose or "meaning" at their own pace: establish hope rituals, tell hope stories, have them describe their "hope" models, and listen for hope images.

### *Phase 2. Assessment of the Patient's World View*

This second phase focuses on assessing and understanding the cancer experience through the patient's world view, the lens (beliefs, thoughts, feelings, behaviors) through which the patient brings meaning to the experience. This assessment is ongoing and unfolds throughout the counselling process. If the initial assessment is hurried or incomplete, then information which is time-saving in the long run may be missed. Patients are more willing to reveal personal thoughts and feelings, within a trusting and respectful relationship. Thus, increased self-disclosure occurs as trust builds. The patient's experience of a "nonjudgmental" assessment phase can be therapeutic in itself. Within this phase, the counsellor has the potential to convey respect, inspire hope (regardless of disease stage), and affirm the patient's potential to manage. Assessment occurs while the patient's story is being told.

The goal of assessment is to gain an understanding of the patient's perceptions of many aspects of her/his life, including disease status (past, present, and future), and to explore strengths in nondisease

related areas. As a preferred outcome, the patient and counsellor become aware of aspects of the patient's life that were, are or could be positive. This realization can promote a shift in perspective when the cancer experience is recognized as a unique time of life and that his/her world need not be completely disease-oriented. As a result, areas of strengths can be identified and concerns prioritized.

*Strategies.* Inquire into the patient's understanding of his/her disease status, as well as fears and difficulties related to the disease. Seek permission to set discussions about the patient's cancer aside temporarily to inquire into the many other aspects of life, such as relationships, hobbies, or pets. Screen for depression and cognitive impairment. Inquire into life-style habits. If patients are capable and engaged in the process of change, then they often enjoy writing on 3 x 5 index cards a word or phrase reflective of the different aspects of life. On the back, they may also jot phrases indicating the past, present, and future status of these aspects. The cards can then be sorted from "area of lowest concern" to "area of highest concern" from which therapeutic conversations can be launched.

### *Phase 3. Initial Goal Identification*

Based on the information gathered within the second phase, Phase Three provides a focal point for discussion of possibilities through the selection of an initial goal(s). Patients do vary. Some prefer a global perspective, while others focus on the need for accomplishing specifics to assess the degree to which they are "getting better." By and large, the counsellor's own initial goals can be to identify criteria the patient or family will use to judge successful resolution of issues and, as a result, identify unrealistic criteria. Optimally, the counsellor would like to arrive at a negotiated consensus with the patient as to when the "problem" is considered resolved.

### *Phase 4. Compilation of a Resource Inventory*

Within Phase Four, patients are encouraged to compile a resource inventory that highlights both external and internal resources. In keeping with a wellness framework, the emphasis within this phase is on the patient's strengths as opposed to weaknesses or problems. To use resources effectively, one must be aware of them. In fact, it may be that awareness alone is helpful. Many patients have a narrow view of the concept of resources. Most think primarily of external resources (money and people) and a high proportion apologize for burdening others. Few people think of "managing" their resources. The counsellor's goal is to identify the wide range of personal, social, emotional, spiritual, financial and medical resources available in the situation. A desired outcome is the conscious

awareness of existing and needed resources and a negotiated consensus as to when the patient would consider the resources sufficient to the demands.

#### *Phase 5. Exploration of Alternatives*

This fifth phase offers patients an opportunity to expand and explore different possibilities for goal achievement. Ill patients often experience multiple losses, accompanied by a sense of fewer and fewer choices. By expanding the patient's perception of alternatives, a sense of control is enhanced. In every situation, the patient can be assisted to see if he or she is "choosing," perhaps among difficult alternatives, but still "choosing." At this point, the goal is to identify solutions without evaluation and generate as many options as possible—hopefully several creative ones. As a result, the patient gains an increased sense of choice within the limits of the available resources.

#### *Phase 6. Decision Making*

Within Phase Six, patients are encouraged to adopt an active stance through decision making. The decisions, themselves, are less important than the patients' experience of assuming a sense of control and actively participating in their care. Patients vary in their desire to make decisions about their own lives. The process to this point will have provided insight into the effectiveness of their decision-making ability. At this stage, it is now possible to emphasize to patients that they need not act on their decisions. Rather, it is simply interesting to explore situations by hypothesizing. You are looking for insight into the factors that influence their decision(s) and for the recognition (when valuable) that "no" is a valid decision. You want to reinforce a sense of control. As a result of this phase, the counsellor and patient will have explored a small step of action which can be taken. As well, the counsellor will have a clearer understanding of the patient's limits and potential for effective decision-making.

#### *Phase 7. Block-Busting*

This seventh phase focuses on blocks or barriers that prevent patients from taking action or following through on their preferred decisions. Blocks to action can be seen as resistance or information we do not yet understand. Often, much can be learned by understanding a block rather than assuming the need for its removal. A patient's block was originally put in place for a reason. We make no assumptions that someone other than the patient "knows best." When patients indicate a desire, yet an inability, to move beyond their blocks, the advanced skills of psychotherapy may be needed. The challenge is to first understand the

block. In so doing, patient resistance is often diminished. A willingness on the part of the patient to translate decision to action is the preferred outcome. Coming to awareness and coming to terms with the need to be blocked for awhile can also be important.

#### *Phase 8. Action Planning*

Within this phase, patients design a plan of action for following through on their previous decisions. This plan, which may be developed collaboratively with the counsellor, addresses the patient's unique needs and goals. The pursuit of action is not always a matter of action. Inaction may often be vital to the achievement of overall goals. The basic question is not, "What does the patient need to do?" but, "What is necessary to accomplish the particular goal(s)?" As often as not, decisions which need implementation involve choosing not to do parts of life that were everyday activities prior to illness. As an endpoint of this phase, the achievement of established goals is preferred. The counsellor must also self-assess by reflecting upon the following questions: What are my strengths and blocks as a helper? What am I actually going to do? What will the patient do? What is the smallest action to get started? How consistent is this with the patient's goals?

#### *Phase 9. Reassessment*

This final phase creates a space for reflection and reassessment. Patients may view this phase as a "time-out" to evaluate previous goals, decisions, and plans. Most lifestyle changes are subject to fatigue with time. By bringing this into the awareness of the patient, a monitoring process becomes a natural part of follow-up. It is like any other "recall" in a medical setting. The reassessment allows for confirmation of, or adjustment in, the strategies being used to manage treatment and disease.

### DISCUSSION

The counselling model described in this paper negotiates patients through a mine field of emotionally-charged experiences, by engaging them in a rational thought process leading to realistic solutions of their presenting concerns. A problem-solving approach is effective and appropriate for a large proportion of presenting concerns. It is a logical "first choice" intervention, since it is potentially within the skill level of most professionals. Use of this approach assumes the counsellor has basic counselling skills and the ability to perceive limitations and refer appropriately.

Although this model incorporates a problem-solving process, this model does not discount the affective component of the cancer experience. Rather, it facilitates effective problem resolution within an intense,

emotionally charged experience of living with a life-threatening illness. It is not a matter of denying or conquering fear or anger. It focuses on normalizing and, if possible, managing emotional responses, by asking the question, "How are you planning to manage the fear or the anger?" The normalization of emotions is, in itself, helpful. Patients are often relieved to know that it is normal to experience a myriad of feelings when life is disrupted by cancer.

The context of living with a life-threatening illness sets this model apart from traditional problem-solving approaches. Many problem-solving models are rooted in cognitive-behaviour therapy (Beck, 1976; Ellis, 1969). Research in this area predominantly revolves around the use of cognitive-behavioural approaches with psychiatric populations, such as depressed patients (Beck, Hollon, Young, Bedrosian, & Budenz, 1985). Most of these models focus on patients' thoughts, feelings, and behaviours, within a problem-oriented framework. Therapists using cognitive-behavioural approaches view problems as pathological and search for underlying cause-effect factors from the past. Using a prescriptive problem-solving approach, the therapist plays a primary role in structuring sessions, identifying problems, and applying specific strategies to solve the problem (D'Zurilla, 1986).

The philosophical underpinnings of this model parallel recent patient-oriented trends in health care and counselling. In the mid-70s, George Engel (1977) challenged his medical colleagues to consider an alternative to the traditional biomedical model, by advancing his belief in the need for an integrated biopsychosocial perspective. Recent visions of health for Canadians, that emphasize wellness and quality of life (Pederson, O'Neill, & Rootman, 1994), have helped champion Engel's cause. Other problem-solving approaches, grounded within person-centred and biopsychosocial frameworks (Schon, 1983; Sobel & Worden, 1982; Tuyn, 1992), further reinforce the need for counselling models that acknowledge the complex interactions between mind and body, illness and disease.

#### CONCLUSION

The intrinsic importance of the patient's unique experience to the quality of care has not figured prominently in shaping health care services and institutions. There is a need to deepen our understanding of the problems that people encounter in managing their illnesses and in maintaining a quality of living despite disability and suffering (Strauss, 1990). An issue today is that the choice of what is important may not be made by the patient. It is Feinstein's (1992) contention that no one other than the individual patient should determine the targets of health and quality of life. Patients and counsellors can be encouraged to look beyond the limitations of biomedical interventions and develop a better

appreciation of the role of patients as active partners in managing and promoting health (Sobel, 1995).

All too often, when those being counselled do not respond to a problem-solving method, they are labelled "difficult." Another possibility is that our assessments and choice of interventions are ineffective. There are limits to the problem-solving approach. The many challenges of illness and of facing mortality engender powerful feelings which must be heard—not banished by intellectual solutions. However, the possibility of taking charge of one's own life often requires working through, or transcending, these feelings. The journey to hope is not uncommonly a journey through pain. This counselling approach embraces the common elements of different roadmaps through which patients and their families navigate during difficult times.

### Note

<sup>1</sup> People living with cancer see themselves more as patients seeking help than as clients seeking counselling. Therefore, they will be referred to in this manuscript as patients.

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### About the Authors

Ronna F. Jevne is a Professor of Counselling in the Department of Educational Psychology, Faculty of Education, University of Alberta. As well, she is Program Director of the Hope Foundation of Alberta, an integrated research, counselling and training centre on the University of Alberta campus, established to study and enhance hope. She is interested in the role of hope in the helping relationship in health care and education contexts.

Cheryl L. Nikolaichuk is a counselling psychologist and Research Associate in the Department of Oncology at the University of Alberta. Her current research and clinical interests revolve around the biopsychosocial aspects of chronic and life-threatening illness, the experience of hope in palliative care, and health measurement and evaluation.

F. Helen A. Williamson is a clinical researcher in the Infant-Parent Program of the Hamilton Health Sciences Corporation through the Department of Psychiatry, McMaster University, Hamilton, Ontario. She graduated from the University of Alberta in counselling psychology. She is currently investigating group intervention for parents of high risk infants.

Address correspondence to: Ronna F. Jevne, Department of Educational Psychology, 6-102 Education North, Faculty of Education, University of Alberta, Edmonton, Alberta, Canada, T6G 2G5. Electronic mail may be sent via Internet to [ronna.jevne@ualberta.ca](mailto:ronna.jevne@ualberta.ca)