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RESEARCH ARTICLE

Process and outcome in pluralistic Transactional Analysis counselling for long-term health conditions: A case series

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Abstract

Background: Many people experience living with a long-term health condition as highly stressful. The psychological impact of chronic illness can include anxiety, depression, post-traumatic stress disorder, and relationship difficulties. *Aims:* The present study used a case series to examine the process and outcome of pluralistically-informed Transactional Analysis counselling in three clients suffering major health problems. *Method:* A rich case record was assembled for each client, incorporating therapist notes, transcripts of sessions, scores on standard outcome measures, and a follow-up interview. These case materials were analysed to identify key helpful process within the therapy, and to determine the nature of the outcomes of the intervention. *Findings:* A set of core therapeutic tasks could be identified across all three cases, and clients reported high levels of satisfaction with outcome. *Conclusions:* Implications for practice and future research are discussed.

Keywords: case study; health; illness; pluralism; Transactional Analysis

Introduction

There exists a substantial literature on the psychological consequences of being diagnosed with a serious health condition. Edelman, Lemon and Kidman (2005) suggest that progress in the effectiveness of medical interventions means that patients live longer, with the result that there is a greater likelihood that they, and their families, will need to go through a process of coming to terms with a diagnosis of a serious health condition. Research studies that have followed up patients following diagnosis have reported significant short-term increases in anxiety, depression, and relationship difficulties (Sarafino, 2006). In some individuals, the diagnosis and other episodes associated with the onset of the illness are experienced as traumatic. Boulton, Boudioni, Mossman, Moynihan, Leydon, and Ramirez (2001) describe the typical sequence of crisis reaction as involving initial shock and disbelief, followed by anxiety, anger, guilt and depression. The

overall picture in relation to the psychological impact of being diagnosed with a long-term health condition is complex. Many patients are able to draw on their own resilience and coping strategies and deal effectively with the stress of their illness. However, for other people, the diagnosis represents an overwhelmingly negative turning point in their sense of self, relationships and well-being, and results in significant psychological problems.

There are a number of ways in which the psychological impact of long-term health conditions can be managed. Nichols (2003) argues that doctors, nurses and health professionals can play an important role in offering emotional and psychological support during the intensive phase of treatment immediately following a diagnosis. There exists a wide range of sources of help that may be utilised: self-help groups and websites; self-help books; meditation and yoga; relaxation training; psycho-educational stress management groups; and medication for anxiety and depression. Counselling and psychotherapy are of

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key significance within this range of options because they are uniquely oriented to the needs of each individual patient, and as a result are likely to be particularly relevant for patients who may remain symptomatic following other, lower-intensity interventions. However, reviews of studies of the effectiveness of counselling and psychotherapy for long-term health conditions present a complex and conflicting picture (Bottomley, 1998; Brown & MacHale, 2007; Lepore & Coyne, 2006). There is a broad consensus across these reviews that existing research has not yet identified the elements of therapy process, or curative factors that are most relevant for these clients. It is therefore necessary to turn to research strategies that are designed to make it possible to identify helpful and unhelpful aspects of therapy for this client population. One means of pursuing this form of inquiry is through qualitative research into the experiences of clients. Qualitative studies of the experience of therapy in clients with long-term health conditions, using in-depth interviews with clients, have identified a range of factors that clients reported as helpful, including: the therapeutic relationship; telling the story; expressing emotion; learning coping skills; normalisation; contact with other people with a similar condition; facing up to the meaning and possibility of death; a structured approach to therapy; and involvement of family members in therapy (Boulton et al., 2001; Bottomley, 1998; Edelman, Lemon, & Kidman, 2005; MacCormack et al., 2001; Robinson, Carroll, & Watson, 2005).

A further research strategy that is likely to be of value in this area is systematic case study research that critically examines the process and outcomes of therapy in the context of the lives of individual clients; the present study adopted this approach. The aim of the study was to contribute to an understanding of the role of specific therapeutic tasks and processes associated with the outcome of therapy with clients suffering from long-term, life-threatening illnesses.

Method

Case data were collected on three clients reporting long-term health conditions seen by one counsellor (the author); the clients were seen concurrently. No clients refused to take part in the study. Data were collected as part of the routine procedures of the counselling centre and assembled into a rich case record, which was independently analysed by two researchers. Clients were invited to comment on the analysis of their own case.

Data collection

The rich case record consisted of a range of sources of information:

- (a) Assessment interview. A research colleague (not the author) interviewed each client prior to commencement of counselling. This meeting was not audio recorded but detailed notes were taken.
- (b) Therapist session notes were collected on each case.
- (c) Transcripts were made of a number of sessions; not all sessions were recorded.
- (d) The Change Interview (Elliott, Slatick, & Urman, 2001) was used to elicit client perceptions of the outcomes of therapy. The Change Interview comprises a structured follow-up interview guide, designed to allow clients to report on the changes that occurred during therapy, and the factors in therapy that they had experienced as helpful or hindering. Change Interviews were audio recorded and transcribed.
- (e) Clients were invited to comment on the analysis of their case.
- (f) Additional information. One client received an additional mid-therapy interview, as part of another project. Two clients completed the CORE-OM (Barkham, Mellor-Clark, Connell, & Cahill, 2006) and a goals scale (Deane, Spicer, & Todd, 1997) at the start and end of counselling. One of these clients also completed the CORE-OM and goals scale on a weekly basis.

Participants

Clients were referred to the counselling centre by their General Practitioner (GP). The participants recruited to the case series were all female (ages 46, 52 and 55 at the start of counselling), and had been experiencing serious health problems (cancer, fibromyalgia, multiple sclerosis) for several years before being referred for counselling.

Ethical considerations

Participants were provided with a research information sheet at a pre-counselling meeting, and agreed that information could be collected on their therapy, for potential use in a case study. At the end of counselling, participants were asked again to consent

for data to be analysed. Participants were provided with a copy of their case summary, and asked to make any necessary alterations to ensure confidentiality and accuracy. Verbal consent was obtained on all occasions where audio recording took place, with the participant being informed that she could switch off the recorder at any point. These ethical procedures were approved by the National Health Service (NHS) Local Research Ethics Committee as part of the research protocol of the counselling centre. The actual names of clients and family members are not used in the case summaries – all names were chosen by the clients themselves.

Procedures

Potential clients were initially assessed for suitability for counselling by their GP, who sent a referral form to the counselling centre and provided the client with a leaflet about counselling. The client was contacted by the centre manager, and invited to attend an initial meeting to discuss what was involved in counselling and to decide whether they wanted to begin counselling. The meeting lasted for about one hour and encompassed: collecting information about the client's personal and family life, health status and social network; identifying the goals of counselling; discussing what was involved in counselling; discussing involvement in the research project; reviewing counselling preferences; explaining arrangements for appointment-making. The client was then given a first appointment with a counsellor within two weeks. On-going scheduling of further appointments was agreed between the counsellor and client. At the end of counselling, or at the end of approximately each year of counselling the client was invited to attend an additional session to be interviewed by a research assistant (not the counsellor) on their views of the counselling they had received (the Change Interview). Counselling took place in a community counselling clinic based in purpose-built premises (apart from occasional meetings in hospital and in the home of one client). Each counselling session was 55 minutes in duration. Clients did not pay for counselling.

Therapy intervention

The counselling delivered consisted of individual Transactional Analysis (TA) counselling (Stewart & Joines, 1987; Tudor & Widdowson, 2002). TA is an integrative approach to psychotherapy that incorpo-

rates a relational perspective on working with cognitive and behavioural change and the promotion of understanding and insight into the impact of early experience on current issues. TA may also include a psycho-educational component, where the client learns about TA theory. In terms of comparison between this study and therapy interventions reported in the literature as a whole, the therapy in each of the present cases included the use of person-centred core conditions of empathy, acceptance and congruence to establish and maintain a working alliance, the use of CBT-oriented techniques such as challenging automatic thoughts and irrational beliefs and behaviour change experiments conducted as homework assignments, the use of case formulation and contracting, and psychodynamically-oriented interpretation to stimulate insight into connections between past and present events. While based in a TA model, the counselling was also informed by a pluralistic perspective (Cooper & McLeod, 2011) that emphasised collaborative dialogue around the goals, tasks and methods of counselling, and a focus on client strengths and resources. In practice, what this meant was that clients were regularly invited to discuss their goals for counselling, and review the usefulness of the strategies that were being employed in pursuit of these goals. A pluralistic stance facilitated the judicious selection and application of the multiple therapeutic possibilities afforded by the TA tradition.

At the time of the study, no adherence measures were available that would have enabled the degree of concordance of therapist interventions with TA principles to be assessed. However, all three cases were regularly taken to supervision with a leading figure in the TA community professional community (Certified Transactional Analyst with Psychotherapy Speciality, European Association for Transactional Analysis; Teaching and Supervising Transactional Analyst with Psychotherapy Speciality, International Transactional Analysis Association). Counselling was carried out on a weekly open-ended basis, with regular reviews.

Data analysis

All available information from each case was assembled into a 'case book'. This material was subjected to hermeneutic analysis (Elliott, 2001, 2002) by the researcher and a colleague (an experienced counsellor and researcher) in order to (a) construct a case summary; (b) decide on whether the

case had a good or poor outcome; and (c) identify factors in the counselling that contributed to outcome. The aim of hermeneutic analysis of single case study data is to arrive at an agreed interpretation of the case that has emerged from rigorous examination of alternative readings or interpretation of specific observations within the case material. The analysis proceeded through a series of cycles, in which tentative conclusions were formulated, and then re-checked against the data. The final stage of the analysis involved inviting the clients to read and comment on the case summary.

Reflexive statement

I am a registered TA practitioner (Institute of Transactional Analysis) with 15 years experience as a counsellor and trainer, and previous training in person-centred counselling as well as an MSc in TA Counselling. My motivation to undertake this study developed when I was manager and counsellor at a community counselling research clinic based at the University of Abertay Dundee. We offered open-ended integrative/pluralistic counselling to patients referred by GPs in a city-centre practice. A significant proportion of our clients were people who were struggling to cope with the consequences of long-term health problems such as heart disease, chronic fatigue syndrome, multiple sclerosis, diabetes and cancer, and people living with agonising pain for which there was no cure. Although these clients were experiencing anxiety, depression and other psychological problems, the health issues that they were facing introduced a new level of complexity to the work. I became interested in learning more about how to respond to the needs of these clients.

An essential part of the process of learning was grounded in my own emotional response to the clients with whom I was working, for example fearfulness around the loss of control that a long-term health condition can bring. An important aspect of the therapeutic process, therefore, was involved with using supervision and personal therapy to explore and work through these counter-transference reactions. Although this dimension of the study is not explicitly discussed in the current paper, it is crucial to acknowledge that it would not have been possible to offer effective support to these clients if I had not been available to get it for myself. This need was particularly vital when one client expressed a wish to end her life. The clients reported in the present paper were the first three clients with

long-term health conditions with whom I had worked. Also, I had no previous personal experience of serious illness. At the outset, I wondered whether counselling would be useful for these individuals. My personal goal in writing this paper has been to find a way to allow my clients to tell their story, in a way that respected all of the different facets of their experience.

Results

This section reports on the analysis of the three cases, described in the order in which the clients were referred to the clinic. The first case is presented in more detail; for reasons of space, less information is provided on the other cases. Following the three case summaries, a cross-case analysis is offered, highlighting common themes across the case series as a whole.

Case 1. Isobel

Isobel was aged 55, married with two grown-up daughters and three young grandchildren. Up until five years ago she had worked as a personal assistant, but had to leave her job because of health reasons. Nine years ago she was diagnosed with multiple sclerosis (MS) and is now registered as disabled. At the initial pre-counselling assessment, Isobel described the following presenting problems:

- an inability to accept the reality of the MS;
- social anxiety due to MS symptoms – worry about how people will perceive her;
- depression, ‘feeling like I am in a deep dark hole’; she has cried every day for three months;
- not being able to say ‘no’ to other people.

She admitted that she did not see how counselling could help, but that it had been recommended by her GP and she viewed it as a last resort. She had previously tried a self-help group for people with MS, but found that it was very competitive around who had the worst story to tell, and made her feel worse.

The initial counselling contract was to meet for 12 sessions, with a review at session ten, with one-hour sessions each week. Isobel’s goals for counselling were to make positive changes in the way she felt about herself in relation to having MS, to accept the reality of the MS, and to allow family members to take care of her. The counselling intervention in this

initial phase of therapy consisted mainly of offering Isobel a facilitative relationship characterised by acceptance, empathy and genuineness. This allowed a basis of trust to be established, and also enabled Isobel to begin to be more self-accepting. At this point in the case study, a TA case formulation was constructed, which identified the 'drivers' ('be strong', 'be perfect' and 'please others'; Kahler, 1975) that supported her underlying script pattern (Berne, 1975) and which traced the source of her contaminated Adult beliefs (Berne, 1961).

Sessions 13–24 mainly focused on the task of challenging some of Isobel's beliefs, such as the idea that 'I don't exist unless I am perfect'. The therapist pointed out to Isobel that every time she wished for something she said 'touch wood' and her head, implying that she was stupid. She made the connection between these actions and her constant apologising to people, for needing or wanting anything, as if it is an apology for her existence. The therapist began to challenge Isobel every time that she touched her head or apologised. This was done with a great deal of humour on both sides. In TA terms, the counselling at this stage focused on how Isobel discounted her own ability to make Adult choices (Mellor & Schiff, 1975).

The next phase of counselling reflected TA themes around re-learning and making new decisions (Goulding & Goulding, 1979). Isobel took initiatives around telling her daughters and her husband about the effects of MS and becoming more willing to ask for help from other people. She became much clearer about what she could and could not do in terms of looking after the grandchildren. Much of this work consisted of Isobel taking time to reflect on interactions with key people in her life, decide on how she would prefer to relate to these individuals, identify what she needs to do differently, then trying out these new strategies between sessions and reporting back on how successful she had been.

Around six months into counselling, Isobel suffered a worsening of her MS symptoms and spent some time in hospital. Counselling continued in the hospital then in her home. She managed better than in earlier hospital periods, but at times felt in complete despair. The counselling at this point included discussions around her desire to live and do everything possible to make herself well, and a desire to die.

A recurring issue that was explored at various stages in the counselling concerned the relationship between Isobel and the medical staff who were treating her.

She discharged herself from the hospital outpatient MS clinic because she felt as though they were treating her 'like a guinea pig' – what they were doing wasn't helping her; it was more for their research. She provided some forceful feedback to her hospital consultant, and at a later point insisted on undergoing surgery that would enhance her quality of life. The final phase of counselling addressed difficulties in the relationship between Isobel and her husband. The overall length of counselling was 48 months.

At the end of therapy, Isobel was unequivocally positive about the impact of counselling on her life. In a Change Interview conducted at the end of counselling, Isobel reported that she had become an active advocate for counselling:

I have spoken to Dr X who is the chief neurologist and I told him that, in the end, I said to him all the drugs and all this and do you know what has helped me is counselling. (Change Interview)

Further evidence of the positive impact of counselling included the following statements made in the Change Interview:

... if I'd been referred to Julia say a month after my diagnosis, I would have handled it a lot differently, I would have handled it a lot better. Because in the while time I have been coming to see Julia, that's what's made me feel better, not the drugs.

...the counselling has helped me deal with other issues that I have had in my life that I never thought would come out. I mean everybody has skeletons, but I've sort of dealt with these as well. ... I still have bad days but know how to cope with it. ... my coping capacity is much better.

Alongside counselling, there were some additional sources of learning and support that Isobel identified as valuable. These included reading a book about one woman's experiences of MS, watching a TV programme about assisted suicide, and conversations with one particularly good friend. However, Isobel viewed counselling as the main source for the changes that she experienced (see Table I: ratings of likelihood of change without therapy). Counselling appeared to have an impact on the level of health and well-being that was experienced by Isobel. Prior to counselling, she had attempted to hide her illness from others, with the result that she did not ask for help when she needed it, and made herself ill by trying to do too much for other people (e.g. taking care of her grandchildren for

Table I. Change list – Isobel.

Area of change	Change was:	Without therapy:	Importance:
	1 – expected 3 – neither 5 – surprised by	1 – unlikely 3 – neither 5 – likely	1 – not at all 2 – slightly 3 – moderately 4 – very 5 – extremely
1. Counselling made me accept MS	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
2. Confidence increased 150%	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
3. Helped adjust to things as they come along	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
4. Deal with skeletons	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
5. Better coping strategies	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
6. More self-accepting – don't beat self up	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
7. Can choose who I have around me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
8. Able to focus on my strengths rather than limitations	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

long periods). As a result of counselling, she was able to ask for help, and able to monitor her own health status more effectively. She was also able to gain more enjoyment from being with other people, and to do this on a more frequent basis. She accepted that she did have something positive to offer to her friends and family, as a person who is good company, caring, and fun to be with.

Case 2. Ellie

Ellie was aged 52, married, and described herself as close to her family. She lived with her husband and two adult children. Ellie described herself as having good relationships with her parents and her identical twin sister, who she saw often. Ellie had previously been employed for several years in an administrative role at a city hospital but had been forced to leave the job following a diagnosis of fibromyalgia. At the point of entering counselling, Ellie was registered as disabled. She described herself as always putting a smile on things, as a worrier with emotions like a coiled spring inside. These emotions surfaced when she was alone. She reported that she felt depressed and cried a lot. Because of the fibromyalgia and other medical conditions, Ellie was constantly in physical pain. She was referred for counselling by her GP, on the basis of fibromyalgia, constant pain and stiffness, struggling to cope, low mood and feelings of frustration. The GP had prescribed ibuprofen, dihexicodine, paracetamol (all for pain), and Prozac (an anti-depressant).

At the initial pre-counselling meeting, Ellie described the following presenting problems:

- coping with pain;
- taking care of self;

- being over-emotional when alone;
- not being able to say 'no' to other people.

In the first counselling session, she described herself as fighting depression, because of a desire to be seen by others as a cheerful person. It was hard to be happy when she was in this amount of pain. She could not see how counselling could help. The initial counselling contract was to meet for 12 sessions, with a review at session ten, with one-hour sessions each week. Ellie identified two goals for counselling: 'Constant pain, I need relief from it' – rated 8 on a 9-point scale, and 'Depression, I cry a lot' – rated 7 on a 9-point scale. Ellie also agreed to complete the CORE outcome measure every week. Her initial score indicated a moderate level of symptoms.

In TA terms, Ellie could be understood as being driven by 'please others' and 'be strong' messages (Kahler, 1975), supported by an injunction 'don't feel (except in private)'. She also appeared to be involved in a symbiotic relationship with her twin (Schiff & Schiff, 1971). Early on, Ellie was really unsure of whether counselling would be of any use to her since she believed her unhappiness was caused by the physical pain. By session six, a final contract (Widdowson, 2010) was made:

- Exploring ways to lessen her pain. This goal involved learning to stop pleasing others by always saying 'yes', starting to put herself first, and not doing things that she knows will result in her ending up in more pain than usual.
- Instead of believing she must always present herself as 'fine' and able to take care of other people when she is not, she would talk to other people about how she was feeling and ask for help when she needed it.

These goals were explored in the context of the key relationships in Ellie's life. She reported that she loved her friends and family and would do anything for them. This often meant that she cleaned, ironed and ran family members about in the car even though these activities caused her enormous pain. Within counselling, Ellie examined these situations and was able to stop believing that it was wrong to acknowledge when she was in pain, and acceptable to refuse to do things. She expressed an enormous sense of loss at not working and coming to terms with the fact that her health was not going to get better.

As counselling proceeded, Ellie was increasingly able to act on her new awareness of herself and her relationships (Table II). She decided to become a Samaritan, an activity that would bring meaning into her life, and then to proceed to further accredited training in counselling skills. She also began to delegate tasks for the family to do. She reported that she was aware of feeling less pain when she was distracted and purposeful. She stopped several of the compulsive rituals she had used for over 40 years to control anxiety.

Ellie's CORE score reduced to the 'mild symptoms' range, and her goals ratings were 7 (pain; limited change) and 3 (depression/crying; clinically significant change).

Case 3. Sarah

On her first visit to the counselling centre, the image presented by Sarah was that of a fragile, self-contained woman, exceptionally thin because of her health. She was aged 46, single, having separated from her same-sex partner 18 months previously.

Sarah had one daughter and one granddaughter, and a difficult relationship with her mother and father. At the start of counselling she lived in a caravan in the garden of her daughter's house, and worked in a supermarket. Five years previously she had been diagnosed with breast cancer and had a double mastectomy. She also experienced a number of other health problems, including a compromised immune system, chest infections and heart disease, and was receiving multiple medications. Sarah had received counselling previously (ten sessions) but had not found it helpful because the counsellor 'just gave advice' rather than allowing her to explore issues.

The initial counselling contract was to meet for 12 sessions, with a review at session six, with one-hour sessions each week. Sarah's goals for counselling were to deal with:

- events and issues from past relationships are dominating my thoughts (rated 7 on 9-point scale);
- to come to terms with my health problems (rated 8 on 9-point scale).

Counselling focused on three main areas. First, the counsellor encouraged Sarah to develop more constructive coping strategies, such as being willing to ask for help when necessary, breaking down problems into manageable chunks, and not ruminating on issues. The second health-related area centred on Sarah's decision to leave her job and apply for disability benefit. Her doctors had strongly advised Sarah to stop work, on the grounds that she would kill herself if she continued. She was reluctant to take this step, for financial reasons and because of wanting to have a purpose to her life. The counsellor

Table II. Change list – Ellie.

Change	Change was: 1 – expected 3 – neither 5 – surprised by	Without therapy: 1 – unlikely 3 – neither 5 – likely	Importance:
			1 – not at all 2 – slightly 3 – moderately 4 – very 5 – extremely
1. Look at pain in a different way	1 2 3 4 <u>5</u>	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>
2. Taking better care of myself – doing less OCD	1 2 3 4 <u>5</u>	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>
3. Huge confidence now	1 2 3 4 <u>5</u>	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>
4. Accepted pain and limitations, accepted that I'm not 'superwoman'	1 2 3 4 <u>5</u>	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>
5. Allowing others to help	1 2 3 4 <u>5</u>	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>
6. Coming off antidepressants	1 2 3 4 <u>5</u>	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>
7. Coping strategies	1 2 3 4 <u>5</u>	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>
8. Changed outlook on life	1 2 3 4 <u>5</u>	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>

encouraged her to look at what she might like to do if she gave up work. She listed looking after her granddaughter and doing some voluntary work for people who have a diagnosis of breast cancer (she already did some telephone helpline work). Towards the end of her counselling she gave up work. The third area was around tests that had been carried out – Sarah imagined that the cancer had returned and had an expectation that she may only be given a short time to live. During counselling, Sarah was invited to reflect on the implications of living her life as if death was imminent.

Counselling around relationship issues encompassed exploring childhood experiences of sexual and physical and emotional abuse, and examining the ways that patterns of relating to other people had been established at that time. It also involved reflecting on current relationships, and trying out new ways of communicating with significant other people in her life. The main shifts that occurred in this area were:

- being able to develop a more honest relationship with her daughter, which included openly discussing the reasons for the absence of her daughter's father in her life, and allowing her daughter to see her vulnerability rather than Sarah being the one who took care;
- getting back in contact with her mother and developing a new relationship on her own terms;
- was able to have a meeting with her father, who was seriously ill;
- accepting that her relationship with her partner was over;
- moving into accommodation where she could be more autonomous and able to form new relationships.

The process of counselling was characterised by the development of a strong, caring relationship between Sarah and her counsellor. There were several episodes where Sarah was emotionally overwhelmed by the pain that was triggered by exploring past events, and would cancel subsequent counselling sessions. The counsellor kept Sarah's counselling appointment time open through these episodes, which made it possible for her to resume counselling when she felt ready.

Counselling continued for 18 months. The issues associated with learning to cope with health difficulties were largely resolved within the first three months, while the work around relationship issues continued to the end. On completion of counselling, Sarah was rating her problems as '2' on a 0–9 scale (where 9 indicated maximally troubling). At the end of counselling, Sarah's CORE score had shifted from the 'severe' to the 'normal/non-clinical' range. At the follow-up interview, Sarah reported that she was better able to deal with her health problems because she was more able to live in the 'here and now', and was now able to live life as she wanted to, not as other people wanted her to be.

Cross-case analysis

Taking the three cases together, there were a number of common themes identified:

- (1) These are all clear-cut good outcome cases, in which the client achieved the goals (verified by verbal report and therapist notes and in two cases by shifts in goals ratings recorded on a weekly basis) and did not report any areas of disappointment or ambivalence in the post-counselling Change Interview. Given that

Table III. Change list – Sarah.

Change	Change was:	Without therapy:	Importance:
	1 – expected 3 – neither 5 – surprised by	1 – unlikely 3 – neither 5 – likely	1 – not at all 2 – slightly 3 – moderately 4 – very 5 – extremely
1. Resolved issues with my mother	<u>1</u> 2 3 4 5	<u>1</u> 2 3 4 5	1 2 3 <u>4</u> 5
2. Take health problems more in my stride	1 2 <u>3</u> 4 5	<u>1</u> 2 3 4 5	1 2 3 <u>4</u> 5
3. Put problems in individual boxes not one huge box	1 2 <u>3</u> 4 5	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>
4. More able to be open with daughter	1 2 3 <u>4</u> 5	1 2 <u>3</u> 4 5	1 2 3 <u>4</u> 5
5. Taken on counsellor qualities	1 2 3 4 <u>5</u>	<u>1</u> 2 3 4 5	1 2 3 <u>4</u> 5
6. Not living my life through somebody else's	1 2 3 <u>4</u> 5	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>
7. Better coping strategies: 'don't dwell on things so much'	1 2 <u>3</u> 4 5	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>

- these were consecutive cases and that no similar cases (i.e. clients with long-term health problems) had been excluded from the study, the findings provide at least preliminary evidence that pluralistically-oriented TA counselling can be an effective intervention for clients experiencing long-term health conditions.
- (2) The quality of the client-therapist relationship was mentioned by each client as a central factor that contributed to change. Clients experienced the counsellor as being different from other health professionals with whom they had been in contact, in being unequivocally on their side and in being willing to listen. The counsellor was described as accepting and understanding and also as willing to challenge the client when necessary.
 - (3) It was important for each client to have sufficient time at the beginning of counselling to tell their story. This experience appeared to reinforce for the client the idea that they were being taken seriously, and that the complexity of their situation was being respected.
 - (4) The length of counselling seemed to be an important factor for clients. There were a sufficient number of sessions for the client to be able to explore the whole of the set of issues that were troubling them. The length of counselling also enabled the counsellor to accompany and support the client through health crises. This strengthened their relationship, and also allowed the counsellor to gain a closer understanding of the reality of the client's condition.
 - (5) In each case, the counselling addressed a range of issues. Even though the relative importance of each of these issues varied across cases, each of the clients needed to work on:
 - (i) the ways in which unresolved events from the past influenced their capacity to cope with current relationships;
 - (ii) developing cognitive and behavioural coping strategies for managing pain and fatigue;
 - (iii) learning to like themselves better, and move beyond a sense of worthlessness and low self-esteem that resulted from living with serious illness;
 - (iv) becoming more assertive in asking for help, and telling other people when they were tired or in pain;
 - (v) becoming more assertive in dealing with medical staff;
 - (vi) discovering and nurturing new sources of pleasure, satisfaction and meaning;
 - (vii) facing the prospect of death, and being able to talk about the meaning of dying.
 - (6) In each case, counselling was delivered in a flexible manner that took account of the health status of the client (for example, the counsellor visiting the client at home);
 - (7) The goals of counselling that were agreed between therapist and client did not imply that counselling would help the client to get better. Instead, counselling was represented as a process that would help the person to cope more effectively with the stress of their illness.
 - (8) The counselling was organised around mutually agreed goals, which were reviewed on a regular basis.
 - (9) Counselling involved encouraging clients to identify and make use of cultural resources, such as complementary therapies.
 - (10) The counsellor did not have a background in healthcare, and had no special knowledge of the conditions being described by clients – this did not seem to represent a problem for clients.
 - (11) The counselling environment was described by all three clients as welcoming and comfortable.

There did not appear to be any specific issues or processes that arose in one case that were distinctively or markedly different from the themes that were observed in other cases.

Discussion

The main finding to emerge from this case series was that pluralistic TA counselling was an effective intervention for clients experiencing emotional and relationship difficulties around coming to terms with long-term illness. The effectiveness of counselling appeared to be attributable to the adoption of a flexible, integrative approach that allowed clients sufficient time to explore different facets of the meaning of illness, in the context of a strong therapeutic relationship. The validity of these conclusions is supported by the fact that the clients comprised a naturalistic case series – no eligible cases were excluded from consideration. In addition,

a variety of different types of process and outcome data were collected on each case, from three sources: the therapist, the client, and two independent interviewers. Data were systematically analysed in a way that critically considered alternative interpretations. Finally, the clients were clear and unequivocal in their testimony about the helpfulness of the therapy they had received.

Limitations of the study

It is not possible to generalise from a case series with a small sample: it may be that other clients receiving the same type of therapy would respond in a different manner. The study is based on the work of one counsellor, and it may be that she had a special affinity for this client group, was particularly acceptable to these clients on account of similarities in age, gender and ethnicity, or was generally more effective in her work than other counsellors. It is important to consider the characteristics of the sample of clients included in this study; all three clients were women in their 40s or 50s who had been living with a debilitating health condition for many years. It may be that different results might be found with male clients, those in different age groups, those at different stages of their illness trajectory, or with people from different cultural backgrounds.

The present study made use of a research protocol designed to accommodate clients with a wide range of presenting problems. As a result, no specific health-related measures were included. In future case study research with clients with long-term health conditions, it would be useful to include measures of health status, such as daily pain ratings, healthcare utilisation (e.g. GP and hospital visits) and quality of life. The use of such measures would make it possible to (a) make more direct comparisons with other groups of patients, and (b) carry out a more detailed analysis of the links between therapy process and health outcomes.

In respect of the interpretation of case evidence around the process and outcome of counselling, it is important to consider the potential impact of extra-therapy factors that occurred in all three cases, such as the use of complementary therapies, changes in living situation and development of interests. However, detailed analysis of case material indicated that all three clients were unequivocal in their attribution of change to counselling, rather than other factors. In addition, for all clients, changes were recorded in advance of the occurrence of extra-therapy events,

and clients attributed an enhanced capacity to take advantage of new opportunities as a consequence of counselling.

At the start of counselling, all three clients exhibited a tendency to wish to please other people, and deny their own needs. It is possible, therefore, that the positive accounts recorded in the Change Interview and outcome measures may have resulted from a wish to please the counsellor and/or the person conducting the interview. On balance, however, this interpretation was not supported by detailed analysis of the case material, on two grounds. First, over the course of counselling, each client demonstrated a marked shift away from a 'please others' pattern, in the direction of greater assertiveness. Second, the Change Interview incorporates a set of probe questions that are designed to elicit evidence of compliance bias.

It could also be argued that the changes demonstrated by clients were the result of common factors, such as the instillation of hope, provision of a cognitive rationale, therapist modelling, or expression of emotion, rather than arising from the implementation of specific counselling interventions. The analysis of case data suggests that although common factors clearly played an important role in recovery, but that the operation of these factors was inextricably linked to the use of specific TA strategies. For example, conducting a TA diagnosis and subsequent contracting in the early stage of counselling functioned for all three clients as a marker of a shift from initial scepticism about the value of counselling, to a more hopeful stance that was grounded in a shared understanding of the nature of the problem and how it might be addressed.

Implications for practice

Aspects of therapy identified as helpful in previous research in this area (Boulton et al., 2001; Bottomley, 1998; Edelman, Lemon, & Kidman, 2005; MacCormack et al., 2001) are supported by the findings of the present study. However, clients in the present study did not highlight normalisation, or contact with fellow-sufferers, as significant for them. It may be that these particular factors are more relevant in group therapy rather than individual work. In addition, one client (Isobel) stated that she had actively disliked her experience of being in a group with fellow-sufferers. The results of the present study might challenge the conclusions drawn by Robinson, Carroll, and Watson (2005), which

characterised the families of people with long-term health conditions as supportive units that could be mobilised to help the ill person. In contrast, in the present study, the families of clients seemed to include a combination of members who were supportive or potentially supportive, and also other members who were not supportive because they found it hard to accept the illness and disability of someone on whom they had depended. As a consequence, a vital strand of the therapy focused on developing ways of understanding and practical strategies for coping with conflict with these family members. It may have been difficult for these ill clients to deal with these issues face-to-face with their family members, in the setting of a family therapy meeting.

The TA concept of 'driver' (Kahler, 1975) appeared to be highly relevant to understanding these clients' problems. All three of them exhibited 'be strong' and 'please others' patterns in which they suppressed their own neediness and vulnerability and continued to try to look after others. In all three cases, the development of client self-awareness around this pattern made a substantial contribution to positive change.

Counselling encouraged clients to acknowledge their strengths, and to find ways to channel these strengths in the form of activities that would be meaningful and satisfying. Also, each case could be described as an example of personal growth occurring in response to a major personal crisis. In addition, a common set of therapeutic tasks appeared to be central within each case. It may be that the list of therapy characteristics outlined in the section on 'cross-case analysis' could be used as the beginning of an integrative model of counselling/psychotherapy for long-term health conditions, which could be further tested and elaborated in studies of therapist training and supervision, and in studies of client outcomes and experiences of therapy.

Conclusion

This study can be seen as testing a particular model of counselling practice, which is integrative, collaborative and flexible. The positive findings from the three cases suggest that this model may represent an approach that is particularly appropriate for clients living with long-term health conditions. A therapy approach that limited the number of sessions available to clients might have made it impossible for

them to work through the range of issues that was apparent in each case. An approach that used only one model of change, such as CBT, person-centred or psychodynamic, would have run the risk of failing to give clients what they needed.

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Biography

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