

Healing through meaning



Christopher Tovey challenges the medical model for counselling support and research with older people, and explains how finding meaning can be a valuable alternative

In 2020, at the age of 70, I began a four-year PhD narrative inquiry at Warwick University Centre for Lifelong Learning about how and why counselling can be valuable for older people such as myself. I wrote about my research proposal in the June 2020 edition of *Private Practice*.¹ My recently submitted PhD thesis explores the life course experiences of 14 counselling service users aged 65+ in various stages of growing older. A wide range of emotionally traumatic changes, transitions and problems in later life, had challenged each participant.

Recommendations for practice

When considering the appropriateness and effectiveness of any form of talking therapy, based on my research findings, I have seven key recommendations for therapists in achieving satisfactory therapeutic alliances with older people:

- 1 Don't view people through a medical model
- 2 Believe in growth and change at any stage of life
- 3 Be prepared to listen to life stories and be ready to talk about death
- 4 Don't objectify people with ageist stereotypes
- 5 Challenge social constructs
- 6 Adopt a nuanced, in-depth and contextual view of each client and identify what makes them unique, their specific strengths and potentials, and the personal meanings they attribute to their experiences
- 7 Cultivate curiosity about the concept of meaning, include it within organisational therapy protocols and explain its benefits to clients.

My research story

I initially had the idea of undertaking Langdridge's² 'Critical Narrative Analysis' of people's experiences of counselling in later life while working with service users at Age UK Warwickshire's Psychological Support. Talking to these clients in various later-life stages, I frequently encountered an attitude of needing to stoically meet any adversity life throws at you, combined with self-sufficiency, independent problem solving and emotional reticence. Many of the people I counselled were concerned not to be a burden to their loved ones and to continue to contribute to family and community wellbeing. I also found that supporting people to tell their stories, and find meaning in past, present and future existence, seemed to alleviate distress and enable my clients to maintain, or regain, their resilience, and adapt proactively to ongoing change and transition in their lives.^{1,3}

As Viktor Frankl³ argues in his explanation of 'logotherapy', the process of seeking 'personal meaning'⁴ for life experiences is unique for every client.³ Frankl drew on both psychoanalytic theories and existentialist ideas, such as 'being in the world',⁵ when he developed his revolutionary model in the 1930s as a form of existential psychiatry or 'healing through meaning'.³

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Post-traumatic growth

In my conversations with research participants, I observed in some of their later life stories, gradual, autonomous self-care processes of adjustment and recovery from traumatic distress, which were ultimately transformative. I've identified these participant experiences in my analysis as 'post-traumatic growth'. Researchers Calhoun and Tedeschi⁶ refer to the role of the therapist as an 'expert companion'.⁶ Stephen Joseph has written a valuable self-help guide to how people may recover from post-traumatic stress through post-traumatic growth.⁷ He writes: 'Most psychologists regard post-traumatic stress as symptomatic of disorder. But if we regard these cognitive processes from a perspective that encompasses their interaction with our assumptive world, we can understand them as steps in an adaptive process, rather than as symptoms of disorder.'⁷

REFERENCES

- 1 Tovey CR. Tales of transition. *Private Practice* 2020; June: 8-12.
- 2 Langdridge D. *Phenomenological psychology: theory, research and method*. London: Pearson/Prentice Hall; 2007.
- 3 Frankl VE. *The will to meaning: foundations and application of logotherapy*. New York, NY: Penguin; 1988.
- 4 Wong P. Personal meaning and successful aging. *Canadian Psychology* 1989; 30(3): 516.
- 5 Heidegger M. *Being and time*. New York, NY: Harper and Row; 1962.
- 6 Calhoun LG, Tedeschi RG. *Posttraumatic growth in clinical practice*. New York: Routledge; 2013.
- 7 Joseph S. *What doesn't kill us: a guide to overcoming adversity and moving forward*. London: Piatkus; 2013.

Joseph⁶ goes on to explain the importance of storytelling in the process of how people recover from trauma and distress. My reflexive approach to this 'narrative inquiry'⁸ with service users is influenced by personal experience and previous encounters with research and writing about the concept of post-traumatic growth.^{6,7}

Joseph's⁷ book gives useful perspectives on the importance and value of my biographical research with service users. I agree with his arguments. The following quotation serves to underpin my own approach to both psychotherapy practice and counselling research: 'Human beings are storytellers. It is human nature to make meaning of our lives by organising what happens to us into stories... We tell stories to understand what happens to us and to provide us with a framework to shape new experiences... Ultimately, we seek meaning in our experiences. Once we find it, meaning provides us with the strength to move forward.'⁷

I share Joseph's⁷ viewpoint that the stories we tell ourselves are the pathways through which we make sense of our lives, construct our identities, and establish why we choose to live our lives in one way and not another. Through storytelling, we create understanding that increases our voluntary control over our memories and resolves the tension between pre-existing assumptions and new, sometimes distressing, experiences.⁷

Joseph goes on to explain that when '...trauma creates a rupture in a person's life story', assumptions about ourselves, our place in the world and our expectations about it are shaken, even shattered. He adds that trauma may have the effect of rendering our life stories obsolete. And because we base our sense of who we are through the stories we tell; we feel that we are losing our very identity. Thus it is only through telling new stories that we can rebuild our sense of self and reconstruct an understanding of who we are, our place in the world, and our expectations of the world.⁷

Connecting with Frankl's³ contribution to psychotherapy, Matti Ameli⁹ is currently researching the significance of reason, meaning and resilience in the treatment of depression.⁹ Her innovative practitioner research links the importance of 'meaning' with developing and improving CBT and positive psychology practice.⁹

Medicalisation of distress

My thesis is critical of the currently favoured 'medical model' for talking therapy policy and counselling practice. In their recently published book, *People not Pathology*, Sanders and Tolan¹⁰ describe the cultural evolution of an increasingly dominant 'medicalised' and ideological narrative concerning counselling and psychotherapy policy and practice in the UK. They set the historical context for their concerns by describing the 'age of crises' and suggest that recent years have seen challenges to our way of life for many reasons. Since

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December 2019, we've been living in 'the age of COVID-19' with its particular and continually unfolding ramifications, which has impacted us all, as have other events, such as the wars in Ukraine and Gaza, and the cost-of-living crisis. They go on to say that medicalised talking therapy is the mainstream water we all swim in as counsellors.

Simply put, medicalised counselling assumes that psychological problems arise, at least in part, from changes to the brain. The best example of this is the tacit acceptance that depression is caused by a chemical imbalance in the brain. Medicalised counselling accepts the necessity and validity of psycho-diagnosis, and such diagnosis leads to the identification of a condition, illness or disorder, which in turn suggests or requires condition-appropriate interventions.

Problems concerning diagnosis of mental illness and the over-medicalisation of distress, are comprehensively discussed by Bentall,¹¹ Davies,¹² Boyle and Johnstone,¹³ Proctor¹⁴ and Johnstone.¹⁵ I also consider the example of the Power Threat Meaning Framework developed by the British Psychological Society as an alternative, non-medicalised approach to mental distress.¹³

Sanders and Tolan¹⁰ identify and compare a set of basic principles regarding mainstream practice that currently tends to accept the dominant 'medical model':

- It is reductionist and category-focused at heart, reducing people to lists of symptoms and categories determined by symptoms
- Non-medical approaches are observational, elaborative, educative or developmental
- It is symptom-driven, in vocabulary and practice and symptoms are the stock-in-trade
- Non-medical approaches do not trade in symptoms; rather, they adopt a phenomenological approach, taking the unedited experience of the client as uncategorisable
- Its process is curative, or correctional, with the quantitative outcome being symptom reduction or return to 'normality'
- Non-medical approaches have a growth, developmental, transcendent or restorative model of process, with a qualitatively measured and client-defined end of therapy, but not 'end of growth'.¹⁰

My biographical inquiry endeavours to question and challenge the currently favoured medical 'drug-metaphor' for counselling, and psychological support and research.^{16,17} This critique applies to people of all ages experiencing distress.

According to Bentall,¹¹ previous failures to adequately research the diverse social, economic and environmental determinants of psychiatric disorder, occurred, ironically, while the discipline of psychiatric epidemiology began to flourish.¹¹ Epidemiologists are interested in the way that disorders are distributed in the population and how these are related to social, economic and cultural factors. To this end, they have conducted surveys in which large representative samples from the population have been interviewed about psychiatric symptoms and their life histories and living circumstances.

Broadly speaking, environmental factors that play a role in mental ill health can be broken down into two types: factors that affect large groups of individuals, sometimes whole societies, and which vary little between people; and stressful and traumatic events that affect specific individuals. The former includes exposure to city environments, poverty, inequality, ethnic minority status and migration. The latter includes specific types of life events, such as childhood sexual and physical abuse, neglect by parents, bullying at school and in the workplace, and other kinds of victimisation.¹¹

Research participants

Talking about ageism, identity, belonging, finding meaning and purpose in life, feeling powerless, and significant experiences of attachment and loss, I vividly recall these perceptive contributions:

Jane talked about 'carrying many lenses' as we age and putting on different spectacles according to the contexts we're in: 'Our life experiences seem to create a kaleidoscope of different perceptions.'

Veronica responded defiantly to labelling and negative ageist stereotypes, asserting vehemently that we still have a role to play in older age and a need to feel we're still valued and contributing.

Maya described ageing as being 'like a map' determining what you should be able to be, say and do. We should not allow others to determine our response to age, she argued strongly.

Ruth used a powerful analogy of stereotypical social responses to people with disabilities tending to 'only see the wheelchair': 'As I get older, I'm the same person inside but all they see is this ageing face. They don't see me.' I loved her story about Pablo Casals, the famous cellist, still practising for four hours a day at the age of 92, because he felt he was still making progress; a great metaphor for just carrying on with life.

Karen faced an agonising dilemma as she approached retirement age, when her fulfilling professional identity as a therapist was threatened by the unexpected rejection of her vocational role by a seriously ill close friend and her family. This caused her to ask herself: Who am I becoming and where do I now belong?

Veronica vividly described her extremely unhappy childhood as a socially 'alienated' working-class girl in 1940s Britain. She movingly recounted the tragic story of her permanently fractured relationship with her mother and lifelong determination to find her biological father, as a possible explanation for why she felt so different from her family.

- 8 Clandinin DJ. *Engaging in narrative inquiry*. Abingdon: Routledge; 2016.
- 9 Ameli M. Reason, meaning and resilience in the treatment of depression: logotherapy as a bridge between cognitive behaviour therapy and positive psychology. In: Russo-Netzer P et al (eds) *Clinical perspectives on meaning*. Switzerland: Springer; 2016: 223-244.
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- 16 Orlinsky DE. Researchers' images of psychotherapy: their origins and influences on research. *Clinical Psychology Review* 1989; 9: 413-441.
- 17 Stiles WB, Shapiro DA. Abuse of the drug metaphor in psychotherapy process-outcome research. *Clinical Psychology Review* 1989; 9: 521-543.

She was also denied in childhood, as a working-class girl of her time, the kind of personally fulfilling educational experiences she had so passionately desired.

John had experienced the tragic loss of his wife to cancer during the COVID-19 pandemic and was also struggling with the additional traumatic effects of 'lockdown' limitations on both hospital visiting and funeral arrangements. He greatly appreciated the telephone counselling support he'd received from the Age UK Psychological Support Service at a time of crisis. He found himself opening in therapy about how terribly alone he now felt. He was also surprised to find himself recounting memories of his unsettled teenage years and what his working-class father had described as 'wasted opportunities' for a bright lad who had done well at school. His partnership had been a very happy and mutually supportive relationship for 50 years.

He movingly recalled how meeting his wife had been an extremely positive 'fateful moment' in his life, and a vitally important turning-point that had set him on the right track at that time.

John's sense of loss was profound. The acutely distressing circumstances of the COVID-19 lockdown measures had added to his grief, and had, by his own account, been a 'traumatic' experience. Even though limited to telephone support, the therapeutic counselling relationship had been both timely and expert from his perspective.

Conclusion

More qualitative biographical research is required to explore the serious social concerns and problems we're all facing, regardless of age. A broader societal perspective should acknowledge the need to shift our primary focus of attention urgently from individual mental health and psychopathology to our

social, cultural and historical contexts as significant causes of distress. Further quantitative research, such as epidemiology,¹¹ may throw light on the extent of the disastrous health impact of long-term austerity policies, rapidly diminishing health and welfare services, and increasing inequalities in our society today.

The seven good practice recommendations I opened this article with are a practical distillation of relevant outcomes from this study. I also strongly recommend Helen Kewell's¹⁸ excellent book, *Living Well and Dying Well*, with a wise foreword written by Emmy van Deurzen.¹⁸ This perceptive, respectful and deeply thoughtful collection of eight case studies was one of the early inspirations for my PhD research project.¹⁸ I'm grateful to my thoughtful and wise contributors, who all had inspirational stories to tell about self-help and varied encounters with counselling relationships. ●

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YOUR THOUGHTS, PLEASE

If you have a response to the issues raised in this article, please write a letter, or respond with an article of your own. Email:

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¹⁸ Kewell H. *Living well and dying well: tales of counselling older people*. Monmouth: PCCS Books; 2019.

