Life & Times

The other Self:

a note on counselling practice

Although there are many approaches to counselling, they do have some key characteristics in common. They are person-centred, involve empathic listening, non-judgemental, and confidential. They offer space to explore things and get things out into the open. They encourage patients to consider options for the future and provide time for the expression of uncomfortable feelings.

They often work in tandem with various forms of medical treatment (such as anxiety and depression). In many UK medical practices and health centres, doctors and nurses can and do refer patients regularly to counselling and chaplaincy listening services. Individual sessions may last 45 minutes or more, and a cycle of care can extend to up to six sessions and more. Often the work is carried out by suitably trained and mentored volunteers.

Sessions may or may not be 'spiritual' in any sense except that of exploring purpose and meaning, that is to say having a focus on the human 'spirit' and its ups and downs. To that extent, they may claim to enhance the critical 'curing' function with a 'healing' function too, although a 'religious' intervention occurs only if the patient explicitly wants it, and then no presumptions are made that prayer can heal what medicine cannot cure.

THE PATIENT'S STORY

It often takes courage for a patient to arrange a counselling appointment, even though talking to a caring professional might seem easier than speaking to members of your family. Patients who are referred by GPs have already decided to get help and advice, and, if counselling goes well, it can lead to more intensive cycles of care, opening up deeper levels of self-awareness and improved coping strategies. At any stage, referral back to medical care (for example, the GP and the psychiatry out-patient clinic) is possible. It often takes several sessions before a patient tells the whole story, or before they come to see what a complex story it really is, or decide it's not going to work.

The patient's 'story' is a fabric of hinted meanings, implied understandings, self-imaginings, and self-projections; the 'I' is after all, both the narrator and the protagonist. The patient is not only presenting (and admitting to) symptoms such as depression, stress, self-harm, or insomnia, but they are presenting a version of themselves, knowingly and meta-cognitively. As theologian James W Fowler writes in *Faith Development and Pastoral Care*, *'I see you seeing me / I see the me I think you see / You see you according to me / You see the you you think I see.'*[1]

This 'hall of mirrors' effect characterises many forms of counselling, needing more time than the average GP consultation allows. Counselling can also be complementary for conditions like anxiety, loneliness, and bereavement. The patient's narrative may offload blame on to others: mum, dad, sister, brother, or partner. It may take the form of helplessness and self-pity, implausibly melodramatic, full of catastrophes and self-exculpation, irresolvable in one (or even six) sessions (or ever). The 'narrative of the Self' is shaped in the telling, and may include imagined hopes, fears, explanations, and causalities — illogical or irrational.

MORE FULLY YOURSELF

We face, then, the challenge of separating out true feelings from false, hoping that what seems a naturalistic conversation to the patient becomes a journey towards authenticity and a new hard-won conception of self. Physical and psychological symptoms may have been knowingly ignored for too long. The 'aha!' moment is elusive, the patient evasive in acknowledging 'the other Self' that needs help, that help is not weakness; that 'I'm not normally like this' or 'I miss him and didn't think I would' papers over the cracks and the cracks are hurting. Goffman's *The Presentation of Self in Everyday Life*[2] is the theory; counselling the ground work.

Even in fiction we can confuse fact and fiction: detective novelist Andrea Camilleri says of his work that *'it is completely made up … if someone comes out thinking they recognise himself or herself in one of my characters … perhaps they are unsatisfied with their own reality.'*[3]

The ultimate aim of counselling is to encourage and enable coping and self-realisation. Helping patients to be more fully themselves and better able to understand their own reality can often be a journey too difficult without a counselling intervention — the anger refusing to lie down; the grief that ricochets years later; the dream that the big win will fix things; the empty feeling there's no one to tell; the year when things fall apart. Past regrets, future fears, the enigma of 'being me' and knowing that it's all we have and all we are. Counselling can offer a safe place, a safe space, within the framework of medical care, mental health, and wellbeing.

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REFERENCES

1. Fowler JW. *Faith Development and Pastoral Care*. Minneapolis, MN: Fortress Press; 1987.
2. Goffman E. *The Presentation of Self in Everyday Life*. London: Penguin, 1990.
3. Camilleri A. *Blade of Light*. Trans. Sartarelli S. Crodyon: Mantle, 2015.