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Article 47

Counseling and Human Suffering: An Approach to Healing

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The alcoholic client, the depressed client, the divorcing, and the widowed client present in the counselor's office with a problem. The cancer patient, the back patient, and the stroke patient present in the physician's office with a problem. For both the physician and the mental health counselor, the fundamental question of response is the degree to which the presenting problem can be divorced from the person experiencing it. This fundamental question frames the thoughts, actions, and words of those providing care. In the realm of medicine, the words "illness," "disease," "pain," and "suffering" take on specific meanings with specific implications (Cassell, 2004; Kleinman, 1988) for the helper and the patient. Similarly, in mental health the words "presenting problem," "disorder," and "suffering" hold distinct meanings.

For example, in the physician's office, a patient presents with a series of complaints or symptoms such as fatigue and weakness, weight loss, and loss of appetite. These perceptions of the patient represent the patient's felt experience of illness. The physician seeks some more specific information about the patient's pain: that is the experience of the messages of nociceptors, neurons dedicated to respond to painful messages. The patient reports abdominal pain. The physician attempts to diagnose a disease: that is to develop an organized understanding and naming of the patient's experience by gathering the subjective information of the patient and objective information such as temperature, bruising, blood chemistry, heart rate, and blood pressure. As a result of this process, the patient is diagnosed with leukemia. It is here that the clinician's fundamental question of response emerges. Is the physician treating the patient who has been diagnosed with leukemia or is the physician treating leukemia that has found its way to the patient?

Similarly, in the counselor's office, the client presents with a series of complaints or symptoms which are the client's felt experience of physical, social, emotional, and spiritual illness. For example, a male client seeks counseling for sadness resulting from the death of his wife of 30 years. He talks of his loneliness, isolation, anhedonia, and hopelessness that have worsened over the nine months since her death. The counselor attempts to gather objective information about the condition of the client such as sleeping

and eating habits, changes in external behaviors such as school or work performance, life changes, etc. The client reports that he is on probation at work due to excessive absence since the death of his wife, resulting from his inability to get up in the morning. He also reports insomnia, weight loss of 15 pounds, and relationship difficulties with his two adult children. The counselor attempts to develop an organized understanding and naming of the client's experience which is then recorded as the diagnosis. In this client's case, major depressive disorder, single episode. Again, the fundamental question of clinical response emerges. Is the counselor treating the client whose experience of loss and life changes have brought about a condition of dis-ease that has been labeled depression or is the clinician treating depression that has found its way to the client?

Perhaps no less in mental health than in medicine, the lure of the microscope and the spect scan and the indisputable efficacy of chemistry and pharmacology draw our attention to the physical nature of the person and the cellular level of intervention. It is true that much of the illness and dis-ease described by both the leukemia patient and the depressed client will be ameliorated and perhaps cured by medicine and other physiological interventions. No less in mental health than in medicine, the ethical treatment of disorders that respond to medication and physiological interventions requires their consideration and use. Miller (2004) however, argues that both the counselor and the physician have reduced human suffering to a "mere epiphenomenon" (p. 39) and its reality has been replaced by the presumably more precise, more measurable, and more treatable diagnosis. Recently, scholars in medicine (Cassell, 2004), nursing (Ferrell & Coyle, 2008; Kahn & Steeves, 1986), and psychology (Miller 2004, 2005; Norcross, 2002) are making the case that in their disciplines, such treatments are necessary but not sufficient for the healing of the person. They have suggested that in order to help others heal, it is necessary that the helper identify and respond to the human suffering of the patient. This recent conversation of the helping professions regarding suffering seems to have coalesced around several topics including its nature and meaning, its transformative potential, and the role of the helper in addressing suffering. This paper presents a review of these basic themes of the literature of suffering and a model for including conceptualization of client suffering into the counseling session.

Human Suffering

From Socrates to Sartre, from Job to Jesus, and from Allah to Buddha, the condition and the meaning of suffering has been essential to the understanding of the human experience, search for meaning, and the relationship with the cosmos. Goldberg and Crespo (2003) suggested that suffering is "humankind's most puzzling and persistent concern" (p. 85). According to McGill (1982), contemporary attitudes in medicine, mental health, and society at large seem to deal with the pesky problem of suffering with the conviction that it is incompatible with genuinely human experience. Cassell (2004) suggests that this modern attitude establishes a dualism in which the person is separated from the suffering which leads to what Miller calls, "medicalization" (2005, p. 305). From his perspective as a psychologist, Miller explains:

> As emotional pain and suffering, and the agonizing moral choices, personal betrayals and injuries that occasion them are redefined as disorders of the individual produced by the brain, psyche, or environment,

> the meaning of human suffering is fundamentally altered and the act of altering it is almost magically concealed. (2005, p. 305)

Recognizing that patients go to physicians for help with physical ailments that are causally related to their suffering, Miller (2004) suggests that it is understandable for the physician to view the patient's suffering as secondary to (albeit connected to) the physiological problems. He then states, "…in…mental health professions it is usually the case that all the patient brings to the practitioner for treatment is emotional pain, suffering, and misery" (p. 43). He suggests that offering treatments that exclude client suffering as a critical variable in treatment is "the height of absurdity, perhaps even dishonesty" (p. 43).

Cassell (1982, 2004) who brought the conversation of suffering to the fore in the medical community over 20 years ago, framed his conversation of the nature of human suffering around three major points. The first was that "suffering is experienced by persons" (2004, p. 32). With this point he emphasized the holistic nature of suffering, as an experience of the totality of the physical, emotional, social, and spiritual being. Of significance to the discussion of suffering, he distinguishes "person" from "self" indicating "Self is that aspect of person concerned primarily with relations with oneself. Other parts of a person involve relations with others and with the surrounding world" (2004, p. 33). Thus, according to Cassell, suffering as experienced by the person impacts on the person's relationship with himself or herself as well as others and the environment in which the person lives.

A second focus point for Cassell's discussion of suffering is that suffering occurs "when an impending destruction of the person is perceived; it continues until the threat of disintegration has passed or until the integrity of the person can be restored in some other manner (2004, p. 32). From his world of medicine, Cassell (2004) discussed this point in relation to physical pain and suffering, indicating that both severe pain and prolonged pain may be interpreted by patient's as destructive of the person. Kahn and Steeves (1986, 1994) echoed the point indicating that suffering is the result of threats to important aspects of the person's identity and lost personal meaning. Extending the work of Cassell (2004) and Kahn and Steeves (1986, 1994), Ferrell and Coyle (2008) continue the discussion of the relationship of suffering to the fear of loss of personhood. They state, "The loss may be evident only in the mind of the sufferer, but it nonetheless leaves a person feeling diminished and with a sense of brokenness" (p. 108).

Cassell's third focus point in his discussion of human suffering is that suffering is multifaceted. He states, "…suffering can occur in relation to any aspect of the person" (Cassell, 2004, p.32). Miller (2004) clarifies this concept when he suggests, "Suffering is a totalizing, consuming experience blending physical conditions, psychological experiences, and the rupture of social connections" (p. 61). Dorothy Soelle (1975) suggests that suffering threatens every dimension of life, stating "the word suffering expresses first the duration and intensity of a pain then the multidimensionality that roots the suffering in the physical and social sphere" (p 16). Both Cassell (2004) and Miller (2004) recognize that the suffering person may be responding to an internal or external condition that affects any facet of the person. They recognize also that regardless of the facet initially affected, the resulting fear of loss generalizes beyond that facet to others. Kahn and Steeves (1986) point out that:

> Unlike pain, suffering is not a phenomenon that can be reduced beyond the whole person. This distinction is acknowledged in everyday language. For example, I may complain that my head or my arm hurts, but only I can suffer. (p. 625)

Building on the work of Cassell, Ferrell and Coyle (2008) described the multidimensionality of suffering in their 10 tenets of suffering (p. 108). Suffering is a "loss of control which creates insecurity" (p. 108). According to Ferrell and Coyle (2008), it is associated with loss and fear of impending loss of some aspect of the person. They suggest that it is "often accompanied by spiritual distress" (p. 108) and reevaluation of one's relationship with a higher being. They note that suffering is a personal experience that is accompanied by intense emotions and often associated with loneliness and separation from the world.

Miller (2005) discussed the isolation associated with suffering stating, "There is a kind of physical, social, and ultimately moral isolation in human suffering that is to be distinguished from how we live when we are not suffering" (p. 324). According to Miller, those who suffer not only feel the physical or emotional pain associated with the diagnosis and presenting problem, but also the pain of isolation.

The literature of suffering suggests that the people presented above with leukemia and depression may be described as suffering to the extent that their disease has impacted and threatened multiple facets of life, the perception of self, and social relationships.

Counseling and Human Suffering

Suffering is a social phenomenon. Goldberg and Crespo (2003) suggested that "…suffering is a learned process transmitted to us interpersonally" (p. 87). According to Miller (2004), counselors must "attempt to understand the emotional anguish in terms of the physical pain, cognitive confusion, social isolation, and moral disengagement from the individual's own community" (p. 248). In discussing nursing, Donley (1991) suggested that the response to the suffering person can be characterized in three dimensions: "accompaniment, meaning giving, and action" (p. 179). While the professional service is different, the dimensions of response are the same for counselors and nurses.

In large measure, the counselor accompanies clients on their journey of suffering. Clients often report the value of having someone hear them and stand with them, even when they find it difficult to stand themselves. Counselors provide clients with the opportunity to give meaning to their suffering. Ferrell and Coyle (2008) stated that "simply being present in the face of suffering is a basic, yet profoundly complex act" (p. 9). Kahn and Steeves (1986, 1994) described the importance of the "witness" to suffering who validates the experience of the sufferer and provides a caring environment which influences a person's suffering. Goldberg and Crespo (2003) summarized accompaniment, calling it authentic caring. They state:

> Authentic caring is a demonstration of respect for the other's complexity and mystery. It is the willingness to be there for the other rather than simply do for the other; it is exemplified in a capacity to listen responsibly. (Goldberg & Crespo, 2003, p. 88)

The counselor assists the client in giving meaning to suffering. From Viktor Frankl (2006) to Irvin Yalom (1980) the concept of the person as meaning maker has dominated existential thought in psychology. Goldberg and Crespo (2003) suggest "that the capacity to find meaning in one's suffering is not a singular endeavor- entirely the product of a personal assessment of one's state of being" (p. 85). Rather the finding of meaning in suffering is a "socio-emotional process that involves the sufferer's willingness to define himself to self and others in ways that respects his personal agency" (p. 85). Counseling provides a vehicle for this process to occur.

The third dimension of counseling's response to suffering is action. Helping clients to identify courses of action and take steps to implement them requires an identification of resources (DiClemente & Valasquez, 2002). Regardless of the presenting problem, the sufferer is asked throughout the process of counseling, "What resources can be drawn on to help create positive change?" Those resources will range from the cellular level (e.g., medicine) to the societal level (e.g., changing laws that allow for such suffering). The identification of internal strengths and external supports has been associated with resilience and recovery.

Since suffering is a condition that both clients and counselors may attempt to avoid and may find difficult to articulate and quantify (Miller, 2004), an instrument that focuses attention on the suffering and strengths of the client is useful. Wouters, Reimus, vanNunen, Blokhorst, and Vingerhoets (2008) recognized the need for a tool to assist medical patients in quantifying their suffering. They developed an instrument to assist clients in the quantification of their illness by revising the Pictorial Representation of Illness and Self Measure (PRISM). That instrument, having as its goal a global assessment of the impact of illness on the life of the patient, asks patients to choose a disk varying in relative size from small to medium to large to represent the impact of the disease. Patients are asked to locate that disc somewhere on a board relative to a larger disc area representing their "life environment." The PRISM and its revisions are focused on the impact of physical disease and are useful in the global assessment of patient suffering. However, it does not provide any information about strengths and resources or the comparative impact of the patient's suffering on the various facets of the person. The Chart of Impact and Strengths (Figure 1) was developed to provide a pictorial representation of suffering and strengths appropriate for counseling.

Chart of Impact and Strengths

The Chart of Impact and Strengths (CIS) applies Cassell's framework for the understanding of human suffering to a pictorial representation that can be used with the client to discuss the nature and elusive quantification of client suffering as well as the resources and strengths that may be available to the client. The CIS provides a tool to scale the impact of a problem for an individual by depicting a problem in relation to various components of the person's life (See Figure 1). Such visualization allows both the individual and the counselor to articulate the challenges and the strengths that are related to the problem.

In the CIS, the person is represented by a circle composed of seven segments. Recognizing that segmentation is merely a rhetorical device, the segments each refer to interrelated and overlapping aspects of personhood which correspond to Cassell's (2004)

description of the person. A person exists in a constantly changing relationship with each of these segments. The segments include the following.

Body

The segment includes the person's health, wellness, physicality, sexual health and body image. A holistic approach suggests that a person is in relation with his/her body such that there is an interaction of one's physical self with one's spiritual, emotional, and social self.

Activities

Cassell (2004) discussed the nature of this segment by stating, "Persons do things. They act, create, make, take apart, put together, cause to be, and cause to vanish (p. 40)." Persons have regular behaviors associated with daily living, from simple behaviors such as getting dressed to more complex behaviors such as bowling, painting, or climbing telephone poles. The activities of persons are associated with their functioning as a person and within the vocational and avocational roles they play.

Interpersonal Relationships

The segment focuses on those relations that a person has with others- from intimate partnerships to family, friends, coworkers, neighbors, and acquaintances. Who one is as person is shaped by and shapes the interactions one has with others.

Roles

This segment refers to the ongoing definition of the person in relation to others and self concept as influenced by formal or informal rules of behavior and expectations associated with particular statuses, careers, and cohorts. The person may be a student, a member of a profession, social group, or age cohort, and as such, the person has a role to play by particular behaviors.

Self

This segment focuses on one's relationship with one's self, including one's identity, self-concept, self-esteem, and character. The person over the course of a lifetime develops an on-going relationship with the self. A person may say, "I am not feeling like myself today." This idiom makes no sense in its denotation, but its connotation is clearly understood to mean, "How I feel today is not consistent with what I think about who I am and how it feels to be me."

History, Culture, Environment

This segment acknowledges that the person exists in a context that includes one's own life history, the history of one's family of origin, and the influence of one's culture, ethnicity, and ecosystem.

Meaning

This segment addresses that part of the person that is referred to as spirituality and includes one's understanding of and relationship with nature of being, meaning, purpose,

and transcendence. For many, the relationship with meaning is expressed (in part or in whole) within the context of a religious tradition.

In the Chart of Impact and Strengths, clients are asked to consider the problem presented in counseling. In introducing the CIS, the clinician suggests that the instrument will provide the client with an opportunity to visually represent both the impact of the problem and the potential source of resources for addressing it. The client is presented with a copy of the chart and a red and green marker. Beginning with the "Body" segment, and proceeding sequentially in a clockwise direction, the client and counselor address each segment. For each segment, the counselor provides a brief description and asks the client to consider the parts of life in the segment that have been negatively affected by the problem. The client is then instructed to estimate its impact as "totally," "a lot," "a little," or "none." The client is then asked to color (starting on the outside of the circle) that portion of the segment in red to represent the degree of negative impact. Before leaving the segment, the counselor asks the client, "Is there anything in that segment that may serve as a resource or strength, from within yourself or outside of you that may help you with this problem?" If the client identifies a strength or resource, again the client is asked to scale the amount of help ("totally," "a lot," "a little," or "none") and starting from the inside out to color the segment green in relation to that estimate. When all segments of the circle have been completed, the greater the ratio of red, the greater is the level of suffering. Likewise, the greater the ratio of green, the greater is the level of resources to address the problems.

The use of the CIS allows the counselor to explore with the client the impact of the problem, the meaning of the suffering, and the resources available to the client. Clients have reported that the use of the CIS promotes not only greater self-awareness but indeed greater optimism and self-agency. The pictorial representation sometimes surprises clients, as they notice that both suffering and strength exist simultaneously within the person. The CIS promotes the accompaniment dimension of counseling by providing a vehicle by which the counselor can glimpse the world of the sufferer. It promotes the role of the counselor in helping the client to find meaning not only in the direct conversation in the meaning segment of the chart but also in the development of a holistic representation of the person. Finally, the CIS promotes the action dimension of counseling by providing information about untapped resources, both internal and external that can be developed to promote the client's positive outcome. The CIS may be utilized in subsequent counseling sessions as both a guide to relevant counseling issues and as a measure of the client's subjective experience of change.

Conclusion

The Chart of Impact and Strengths is a newly developed tool to assist counselors working with clients who are suffering. It provides a pictorial representation of the impact of physical, emotional, or social anguish on the person as well as the internal and external resources the person perceives to be available for the resolution of the suffering. In its earliest stages of development, the anecdotal data derived from over 100 administrations suggest that the instrument is helpful in promoting a holistic view of client suffering and client strength and is effective in focusing the clinician's attention on both.

Further research is needed to explore the nature and implications of suffering in the clients that mental health counselors work with. Additionally, further research using the CIS will provide information related to personality characteristics and other variables associated with suffering.

As Miller (2004, 2005) has suggested, it is imperative that mental health professionals recognize and address the suffering of the clients with whom they work. As he put it, "The work of therapy is largely about making suffering that feels meaningless become meaningful" (Miller, 2004, p. 249). The CIS provides a tool for the counselor to use in that endeavor.

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Figure 1
Chart of Impact and Strengths