# The Effect of Integrative Counselling on Psychological Well-Being in Adult Patients with Cancer: A Mixed Methods Study


## Abstract

***Objectives:*** This study aimed to (1) investigate the effectiveness of short-term integrative counselling on the psychological well-being of adult patients with cancer and (2) explore their reported experience of receiving integrative counselling.

***Design:*** A mixed methods embedded design was used to compare psychological well-being in two groups of patients with cancer; one group ($n$ = 15) received 6-9 weekly, hour-long sessions of integrative counselling, and the other group ($n$ = 16) were on the wait list.

***Methods:*** Pre and post intervention symptoms of anxiety, symptoms of depression and levels of self-esteem were measured using the Hospital Anxiety and Depression Scale and the Rosenberg Self-Esteem Scale. The counselling group also answered an open-ended qualitative question with the posttest measures about changes they experienced through having had counselling.

***Results:*** In the counselling group there were substantial and statistically significant improvements in symptoms of anxiety, symptoms of depression, and levels of self-esteem. No significant changes were observed in the wait list group. Three themes of change experienced through counselling were identified in the qualitative data: *Acceptance*, *Self-Awareness*, and *Moving Forward*.

***Conclusion:*** Short-term integrative counselling is an effective therapeutic intervention for improving psychological well-being in adult patients with cancer.

## Introduction

***Psychological well-being in patients with cancer***

The psychological impact of cancer diagnosis and treatment can be considerable (Selmar, 2015). Although estimates of psychological distress vary (Hulbert-Williams, Neal, Morrison, Hood & Wilkinson, 2012), Linden, Vodermaier, MacKenzie and Greig (2012)'s study of 10,153 patients with cancer, over five years, suggested that more than a third of patients will need psychological support for anxiety, and just under one third will need support for depression, at some point during or after diagnosis and treatment.

The shock of diagnosis can cause high levels of fear and distress in patients (Bonito, Horowitz, McCorkle & Chagpar, 2013). Poor prognosis has been associated with higher incidences of anxiety and depression, possibly due to anticipation of great difficulty ahead and a sense of impending doom (Zabora, Brintzenhofeszoc, Curbow, Hooker & Piantadosi, 2001). Treatment can take a considerable emotional toll, with chemotherapy producing fatigue and sleep disturbance and having a negative impact on memory and concentration (Mitchell, 2007). Physical changes and pain, experienced as a result of illness and treatment, are also risk factors for psychological distress (Cardoso, Graca, Klut, Trancas & Papoila, 2016; Lima, Longatto-Filho & Osório, 2016).

Diagnosis and treatment can also impact on self-esteem, defined as an individual's perception of their skills, abilities and qualities (Juth, Smyth, & Santuzzi, 2008) through both the resultant depression (Yilmaz, *et al*., 2015), and the impact of the physical effects of treatment on body confidence (Kurowecki & Fergus, 2014). Carpenter, Brockopp and Andykowski (1999) found that patients who described 'feeling stuck' post-treatment had significantly lower self-esteem than other

survivors, indicating the significant emotional impact that cancer treatment can have on one's sense of self. There is extensive evidence linking chronic diseases, such as cancer, with low self-esteem and, in particular, that low self-esteem poses a greater risk for depression in patient populations than in a healthy population (Juth, Smyth & Santuzzi, 2008). Self-esteem is an important coping resource, so it is concerning that this patient population is particularly vulnerable in this respect (Schroevers, Ranchor & Sanderman, 2003).

Psychological distress can impact treatment compliance and treatment outcomes (Linden, *et al*., 2012). Anxiety, depression and low self-esteem can affect patients' ability to cope with treatment, which can lead to non-compliance (Cardoso, *et al*., 2016). Distress can also exacerbate symptoms, such as pain, which in turn affects patients' ability to cope with treatment (Selmar, 2015). There is evidence that psychological distress can detrimentally impact various cancer-relevant biological processes such as immune function, DNA repair and BMI (McGregor & Antoni, 2009). The implication is that reduction in psychological distress could positively impact treatment outcomes and survival rates. Although the evidence for this is still emerging, there is a growing body of research to indicate that psychological intervention can have a positive effect on treatment outcomes (McGregor & Antoni, 2009).

Psychological support is therefore an essential part of cancer treatment, but the degree to which it is available varies (Linden, *et al*., 2012). Additionally, the overlap between emotional and physical symptoms, such as fatigue, can lead to difficulty in the assessment and treatment of psychological distress (Selmar, 2015). Healthcare professionals are often not equipped with the specialist training necessary to identify emotional symptoms and offer psychological support (Lima, *et al*., 2016). There is

evidence to suggest that psychosocial difficulties are often not addressed in medical consultations despite both patient and clinician preference to discuss the emotional impact of diagnosis and treatment (Taylor *et al*., 2011) which might reflect the emphasis in medical Oncology and Haematology for survival-focused treatment. There is a clear need for psychological support and research into effective psychological care within cancer services.

***Counselling in cancer care***

The National Institute for Health and Care Excellence (NICE) guidance on cancer services recommends a four level model for psychological assessment and support for adult patients with cancer. All health and social care professionals can offer general psychological support at level 1. At level 2, professionals such as specialist nurses, GPs, and social workers, should screen all patients for psychological distress and refer on to professionals working at levels 3 and 4 where appropriate. Patients suffering from mild to moderate distress should be referred for counselling with a trained and accredited counsellor at level 3. Patients suffering from severe distress and psychopathology should be referred to mental health professionals such as specialist Clinical Psychologists and Psychiatrists for specialist intervention including Cognitive Behavioural Therapy (CBT) at level 4. The expectation in the NHS (in the UK) is that the NICE model will be followed in all cancer care services (NICE, 2004). However, although counselling is identified as the level of support (level 3) appropriate for the majority of psychological distress, most of the research on psychological interventions for adult patients with cancer has only looked specifically at CBT (level 4).

For example, in Osborn *et al*.'s meta-analysis of psychosocial interventions for cancer survivors, the only intervention included is CBT (Osborn, Demoncada, &

Feuerstein, 2006). Similarly, in Sheard and Maguire's (1999) meta-analysis which looked at studies from the late 70's through to the early 90's, of the 39 studies included, only 9 involved individual therapy, and of those only 4 involved non-CBT interventions that would meet the current NICE guidelines for level 3 psychological support. This reflects the dominance of CBT as the therapy most commonly offered in healthcare systems, particularly the NHS (Pilgrim, 2009), and the dearth of research into other psychological therapies.

Since CBT has been shown to be both cost-effective and has an extensive evidence-based, there is good reason for this. Cost and efficacy are essential considerations for any health care service. However, although there is evidence to suggest that a range of therapeutic options is warranted (Pilgrim, 2009), that one size does not necessarily fit all, and as such that there is good reason to explore the efficacy and cost-effectiveness of other psychological interventions, as yet there have been only a handful of studies that have looked at counselling therapies that would fit the NICE guidelines for level 3 support in cancer care.

For example, Hutchison, *et al*. (2011) examined the effect of short-term telephone counselling. A combination of therapeutic interventions was offered in addition to CBT including Acceptance and Commitment Therapy (ACT), Mindfulness and Psycho-education. This study showed significantly reduced distress post-intervention. However, a limitation of this study is the lack of a comparison group.

Naumann, *et al*., (2011) looked at the effect of individual versus group-based short-term exercise and counselling interventions for patients with breast cancer on Quality of Life, using a client-centred counselling approach. The individual-based intervention showed significant improvement over the control group, whereas the

group-based intervention did not. Since the intervention was a combination of therapy and exercise, it is not clear if the counselling, exercise, or interaction between the two produced the effect.

Ramsay, Ramsay and Main (2007) examined the effect of short-term individual and group counselling on anxiety, depression, self-esteem and life satisfaction in palliative cancer patients. The individual counselling involved relaxation and visualization exercises, and the group counselling was art therapy. Both interventions showed significant improvement, however, there was no control group for comparison.

Morgan and Cooper (2015) presented qualitative data that suggested that integrative counselling helped patients with breast cancer process difficult feelings and resolve specific problems. However, the qualitative nature of this study limits the generalizability of the findings. Integrative counselling is a particularly under researched area in cancer care, and this is one of the few studies to date.

There is a body of evidence emerging for the effectiveness of short-term integrative counselling in reducing psychological distress in primary care settings (Davis, Corrin-Pendry, & Savill, 2008; van Rijn, Wild, & Moran, 2011). Additionally, a Cochrane review into the use of counselling in primary care settings in the UK found that there were no significant differences in cost between CBT and counselling therapies, which indicates that cost considerations between CBT and counselling are on a par (Bower & Rowland, 2006), although the review highlighted that the evidence is limited since it is based on the small number of studies that have been conducted to date.

***Integrative counselling***

Despite the emerging evidence from primary care, there is very little research into the efficacy of integrative counselling specifically in cancer care. Integrative therapeutic practice has become an increasingly preferred approach for counselling and psychotherapy practitioners because it allows for therapeutic flexibility and can be adapted to individual client requirement and need (Gilbert & Orlans, 2011). The process of integration for counsellors, has traditionally involved beginning by learning one or two models well and, through continued training and practice, incorporating further models and interventions throughout one's career, although many training courses are now beginning to offer training specifically in integrative counselling therapy (Lowndes & Hanley, 2010).

Integrative counselling therapy uses techniques, interventions and tools from different modalities to tailor an individual approach to the client, by considering the physical, emotional and psychological needs of the person. It is a relational approach that takes into account the whole person. (British Association of Counselling and Psychotherapy, 2020).

As an evolving approach there are differences from one practitioner to the next, but there is a general consensus that there are three overarching therapeutic approaches under which all models sit. These are; psychodynamic, humanistic-existential, and cognitive-behavioural. An integrative practitioner will incorporate interventions and techniques from all three approaches and the basic tools that characterize each approach, although they may have training in specific models within an approach (Brien & Houston, 2007). For example, the Rogerian core-conditions are a basic tenet of the humanistic-existential approach, but a therapist may

have model-specific training in Person-centered, Gestalt, Existential, or many other models that come under this overarching approach.

Therapy can be viewed as a developmental process, a progression that starts with meeting the client's need to feel supported and accepted at the beginning stage; facilitates learning and understanding through the middle stage and; leads on to action or behavioural change in the end stage (Brien & Houston, 2007). These stages are mirrored in integrative therapy by the use of a humanistic-existential approach in the beginning relationship-building stage, the psychodynamic approach in the middle, exploration stage, and the cognitive-behavioural approach in the end empowering and change-creating stage. The main aim in the first stage is to help the client feel accepted, through unconditional positive regard, and create a safe space for expression of thoughts and feelings. The middle stage often involves looking at how the client's past experiences connect to present circumstances, which aids the process of self-discovery. The final stage aims to enable clients to create positive change in their lives, and take steps to achieve this.

In reality, therapy is never as neat and straightforward as this, and the integrative practitioner might use the interventions, techniques and tools of all three overarching approaches at every stage, tailoring their use to the needs of the individual client (Brien & Houston, 2007; Gilbert & Orlans, 2011). However, it is a useful framework that describes in general terms the integrative approach.

***Aims of the study***

The primary aim of this study was to compare whether short-term integrative counselling had a positive effect on psychological well-being in patients with cancer relative to a wait list control group. Well-being was assessed based on changes in symptoms of anxiety, symptoms of depression and levels of self-esteem, which have

been identified as salient factors in psychological distress for patients with cancer (Linden, *et al*., 2012; Carpenter, *et al*., 1999). A secondary aim was to explore the subjective changes patients with cancer experienced through receiving short-term integrative counselling, using a qualitative approach.

## Methods

### *Design*

An Embedded Design-experimental model based on a quasi-experimental pretest-posttest design was used to compare changes in symptoms of anxiety, symptoms of depression and levels of self-esteem in two groups of patients with cancer; one group ($n$ = 15) received weekly individual counselling sessions, and the other group ($n$ = 16) were on the wait list for counselling. The counselling group were asked an open-ended qualitative question when the posttest measures were taken. In this type of mixed methods design, the qualitative data component is embedded within the quantitative experimental design (Creswell & Plano Clark, 2011). The purpose of this is to enable expansion of the research area (Lopez-Fernandez & Molina-Azorin, 2011).

This model was appropriate for this study since there is limited research in this area, so the open-ended question “Has anything changed for you as a result of having counselling? Please briefly explain” was given in addition to the quantitative posttest measure in the counselling group only. This allowed exploration of any changes participants experienced through counselling that may not have been tapped by the quantitative measures. The quantitative measures looked at what change occurred, and the qualitative question explored the nature of that change by giving the participants a voice, thus complimenting the quantitative data. The open-ended

question was developed in discussion between the first author (JKM) and the third author (AS), who clinically supervised JKM, with the aim of not leading the participants, but allowing the participants voices to be heard to explore the process of change. The qualitative data were collected at the same time as the quantitative postmeasure data in the counselling group, the two data sets were analyzed separately, and were brought together in the interpretation of the results (Creswell & Plano Clark, 2011).

***Counselling and wait list control groups***

Participants in the counselling group were offered short-term counselling of six once weekly hour-long sessions, with the option of extending up to a total of nine sessions ($M$ = 7 sessions). One participant only had five sessions due to an altered surgical date. There were three counsellors, all of whom offered client-led counselling following an integrative model of client-centred therapy that incorporated psychodynamic, humanistic and cognitive approaches. Participants in both groups were recruited from the wait list for counselling, with a mean time spent on the wait list of 8 weeks in the counselling group and 5.81 weeks in the wait list group.

***Participants***

Thirty-one patients with cancer participated in this study. Twenty-five were female and six were male. Ages ranged from 29 to 71 years ($M$ = 53.29, $SD$ = 9.88 years). Participants were referrals for counselling at regional cancer support centre in the UK. Participants had a range of 10 cancer types, both curative and non-curative, but there were no participants receiving palliative care (Table 1). No payment or other incentives were offered for taking part.

***Measures***

Symptoms of anxiety and depression were measured using the Hospital Anxiety and Depression Scale (HADS). The HADS was developed to measure anxiety and depression in (non-psychiatric) medical patients (Zigmond & Snaith, 1983) and has been demonstrated to have good validity and reliability (Bjelland, Dahl, Haug, & Neckelmann, 2002). It is a 14-item scale, alternating between symptoms of anxiety (HADS-A) and depression (HADS-D), with each item assessed on a 4-point Likert scale. Out of a score of 21 on each subscale, 0-7 indicates normal range, 8-10 indicates borderline levels, 11-21 indicates clinically significant levels.

Self-esteem was measured using the Rosenberg Self-Esteem Scale (RSE) (Rosenberg, 1965) which has been demonstrated to be a valid measure of self-esteem in many different populations (Beeber, Seeherunwong, Schwartz, Funk, Vongsirimas, 2007), (Vermillion & Dodder, 2007) and to have good reliability (Gray-Little, Williams & Hancock, 1997). The RSE is a 10-item measure, with each item on a 4-point Likert scale, giving a self-esteem score from 0-30 where the higher the score, the higher the self-esteem.

The qualitative data from the counselling group was collected when the posttest measures were taken, through the open-ended question "Has anything changed for you as a result of having counselling? Please briefly explain."

***Procedure***

The service target was for waiting times not to exceed 8 weeks, so it was not possible to randomly allocate participants to the two groups since this would have resulted in the possibility of patients waiting longer for counselling if they were allocated to the wait list group and had already been on the waiting list for a number of weeks. There was only a short timeframe available for collection of data for this study, so patients who had been on the waiting list for longer and were about to

receive their counselling were approached for recruitment to the counselling group. Patients who had more recently been added to the waiting list, and would be waiting to commence their counselling for some weeks were approached for recruitment to the wait list group.

Participants for both groups were recruited by phone. Participants in the counselling group were then met by a Cancer Support Specialist (CSS) immediately before their first counselling session, gave informed consent and completed the pretest HADS and RSE measures. Immediately after their last counselling session, they completed the posttest HADS and RSE measures, the qualitative open-ended question, and were debriefed by a CSS. The qualitative question was printed at the top of an A4 piece of plain paper. Participants were instructed to first complete the HADS and RSE, and then write their answer to the open-ended question on the piece of paper that had the question printed at the top.

Participants recruited to the wait list group either met a CSS at the Centre, where they gave informed consent and completed their pretest HADS and RSE measures, or spoke to a CSS on the phone where they gave informed consent and sent their pretest HADS and RSE measures in by post. When they were taken off the waiting list to be booked for their first counselling session, they completed the posttest HADS and RSE measures and were debriefed.

***Analysis Plan***

Independent *t*-tests were performed on pretest measures to assess equivalence between the two groups at baseline. An ANOVA was used to examine whether there was a difference in outcomes (symptoms of anxiety, symptoms of depression and levels of self-esteem) across two independent variables. The first Independent variable was Group (counselling vs. waitlist) and the second independent variable was

Time (before vs. after treatment). Since a mixed-design of Group (where a participant could be allocated to *either* counselling *or* waitlist) and time (where a participant was assessed both before *and* after treatment) was used, a mixed-design ANOVA was employed. If the interaction term is significant this indicates that the change in outcome across time is different for the counselling vs. the waitlist group. If this is the case, it will be explored further with simple effects analysis, which is a paired-samples *t*-tests comparing before vs. after outcomes for (a) the counselling group only and (b) for the waitlist group only. As this required two separate tests, we set a Bonferroni correction of .025 to account for the two tests (.05/2 = .025).

The qualitative data were collected to gain a richer understanding of the changes participants' experienced through counselling and was analyzed using thematic analysis. Thematic analysis was selected as the method for analyzing the qualitative data due to its flexibility and accessibility as a qualitative analytic tool (Braun & Clarke, 2006). A rich thematic description of the data set was undertaken because this is an under-researched area, so this allowed a sense of the important themes present throughout the data. Themes were identified using data-driven inductive analysis because as an under-researched area there was no pre-existing theoretical framework, and this approach allowed the participants' experiences to be heard without trying to fit the data to a pre-existing coding frame (Braun & Clarke, 2006).

Themes were identified at the semantic level because the aim was to identify themes at the surface level of the data in order to allow the participants voices to speak without assuming what the process of counselling may have been like for them. An essentialist/realist analysis approach was taken because experience and meaning were inferred directly from participants' answers to the open-ended question, with the

assumption that there is a direct relationship between language at a surface level and participants articulation of their experiences and meaning (Braun & Clarke, 2006).

The researcher (JKM) discussed possible biases and her epistemological position with the third author (AS). JKM was one of the three counsellors in the study so provided therapy to some of the participants. JKM discussed her own subjective experiences with AS in terms of this and in terms of her own investment in the research. This process was undertaken to help bracket any preconceptions and biases whilst also acknowledging that a purely objective analysis would not be possible as a level of interpretation needs to occur.

The thematic analysis was conducted using the six steps as outlined by Braun and Clarke (2006). JKM read and reread the data several times in order to be immersed in the data, which led to familiarization. Next initial codes were generated through consideration of interesting features of the entire data set, which were then collated into potential themes. The themes were reviewed and then refined, to create clear names and definitions of each of the main themes, and the sub-themes within each theme (Braun & Clarke, 2006). The analysis was conducted by JKM and was discussed with and checked by AS.

***Ethics***

This study was reviewed and received ethical and risk assessment approval. All participants provided written informed consent. Participant codes were used so that all data were anonymised.

## Results

### *Quantitative Findings*

#### Baseline Equivalence

Independent *t*-tests were conducted comparing pretest measures to assess equivalence between the two groups at baseline. This confirmed that there were no significant differences between the groups on levels of anxiety symptoms, depression symptoms or self-esteem (see results in table 2, means and S.D.'s in table 4).

#### Effect of counselling vs. waitlist allocation on psychological well-being

A 2X2 mixed-design ANOVA found a significant main effect of Time and a significant Time x Group interaction, for symptoms of anxiety, symptoms of depression and levels of self-esteem (all $p$ values $\leq .002$), consistent with a beneficial effect of counselling. There was not a significant main effect of Group. See Table 3 for full results.

The means plots of the interactions suggest that counselling resulted in large reductions in symptoms of anxiety and depression (figure 1), and a large increase in self-esteem levels (figure 2), over time with little change in the wait list group. (See table 4 for all means and S.D.'s)

Simple effects analysis was carried out with paired-samples *t*-tests comparing before vs. after for both the counselling and wait list groups, against a Bonferroni adjusted significance level of .025 (see Analysis Plan section). Counselling resulted in a significant decrease in both symptoms of anxiety and depression ($p$ values $\leq .001$), and a significant increase in levels of self-esteem ($p < .001$), whereas waiting time resulted in no significant change (Table 4). The magnitude of the change in the counselling group was large, with the biggest change in levels of anxiety symptoms (Table 5).

***Qualitative Findings***

Thematic analysis was carried out by JKM on the qualitative data collected from the counselling group. Three major themes were identified in the data: *Acceptance* was a theme in seven of the fifteen answers; *Self-Awareness* in ten; *Moving Forward* in twelve. This is detailed in Table 6 where Acceptance is Theme 1, Self-Awareness is Theme 2 and Moving Forward is Theme 3 (all names are pseudonyms). Each of the three themes had several sub-themes, detailed in Figure 3.

*Acceptance* involved both self-acceptance and acceptance of circumstances. Participants described how counselling helped them to accept their feelings and needs, which were often related to acceptance of the effects of their cancer. One participant described how acceptance helped her to no longer feel she was a failure when she struggled with the side-effects of her treatment:

> "I feel far more comfortable about my situation and feelings than I did before I started. I am less likely to blame myself or feel a failure when I struggle to cope with the demands of life and the tiredness etc. that comes as a result of my cancer treatment." (Susan)

This illustrates how self-acceptance seemed to be related to acceptance of circumstances. The process of talking through feelings seemed to lead to acceptance; "I have been able to talk openly about my feelings/worries and accept and deal with past issues" (Alice). Acceptance seemed to be the starting point for developing awareness and finding a way to move forward in their lives, showing how the three themes were linked: "I feel it's ok for me to move on and find happiness where I can. It's ok to feel sad/low and it's ok to look after myself and take time for me" (Nicola). This illustrates how an acceptance and understanding of feelings and needs seemed to help participants begin to find a way forward.

*Self-Awareness* involved gaining a greater understanding of feelings, issues and problems, and so developing a better understanding of themselves: "I have come to recognise when I am going to have an episode of worthlessness and I try to do something about it" (James). Participants described how the sometimes difficult process of self-discovery through therapy had helped them: "I feel as though counselling has revealed truths about myself that I have to face" (Anna), but that this process had given them a sense of control: "I feel more aware of why I feel the way I do and therefore have more control" (Rachel). Participants seemed to find that through developing a greater understanding of themselves and what they'd been through, they were able to start to find a way forward, showing how theme 2 Self-Awareness may lead to theme 3 Moving Forward: "I have a clearer picture in my mind of why treatment has affected me profoundly and can see a path through the next few months" (Lauren).

The theme of *Moving Forward* was found in the majority of answers, and seemed to reflect a powerful change for participants, from feeling stuck to being able to see a way forward in their lives. Participants described a positive change, moving through difficult feelings to a lighter, more hopeful state: "I feel a lot better than when I started, I was crying all the time and I felt traumatized. Today I am happy and cheerful and feel like I have accomplished something and I feel more positive" (Emily). This positive emotional change seemed to create movement from a state of feeling stuck to taking steps to move on: "I feel that I know certain steps or actions that I need to take to help me and my family move forward" (Liz). Feeling able to take specific steps to move forward seemed to be connected to gaining a sense of being able to cope with life again: "I am able to rely on myself, be on my own, make decisions, due to the changes I have made with the help of my counsellor" (Isobel).

Moving through negative feelings, taking specific steps for change, and feeling able to cope again gave participants a sense of hope for the future: "I have hope to tackle the year ahead with confidence" (Diana). Finding a way forward, feeling able to cope with life and move on, is often characteristic of the end stages of therapy, and is in some ways a main aim of counselling for patients with cancer.

**Discussion**

Overall, the findings showed a significant decrease in symptoms of anxiety and depression, and a significant increase in levels of self-esteem, in the counselling group, whereas there were no significant changes observed between pretest and posttest measures in the wait list group. The magnitude of change in the counselling group was large. The pretest mean scores were at the clinical level for symptoms of anxiety and the sub-clinical level for symptoms of depression. However, the posttest measures for symptoms of both anxiety and depression in the counselling group were in the normal range (Zigmond & Snaith, 1983; Crawford, Henry, Crombie & Taylor, 2001). This suggests that short-term integrative counselling can significantly improve the psychological well-being of patients with cancer.

The themes of *Acceptance*, *Self-Awareness* and *Moving Forward*, identified in the qualitative data, potentially offer an insight into the processes involved in the counselling that resulted in the changes observed in the analysis of the quantitative data. Perhaps the process of accepting their cancer experience, understanding themselves and their response to the experience, and being able to find a way forward in their lives (even in cases where the cancer was non-curative), helped them to feel less anxious, less helpless, less hopeless about their future and more in control.

Patients with cancer experience loss at many levels; loss of health, time, work, relationships, role, ability, and life (Lima, *et al*., 2016). They suffer both emotionally

and physically. The patients in this study came to counselling in a state of psychological distress, as evidenced by their pretest measures. The combination of quantitative and qualitative findings in this study suggest that short-term integrative counselling allows patients to come to terms with their cancer experience, relieves the psychological distress associated with diagnosis and treatment, and is an effective psychological intervention in cancer care.

The qualitative findings relate to Morgan and Cooper's (2015) exploration of what patients with breast cancer found helpful in counselling, and extends the exploration to look at what changes participants' experienced through therapy. Additionally, the use of quantitative measures demonstrates that the rich descriptions of changes experienced by participants correspond to clinically significant measurable change in levels of psychological distress.

This study confirmed Ramsay *et al.*'s (2007) findings that counselling improves psychological well-being in patients with cancer and extended the findings beyond palliative care to a sample of non-palliative patients both on and off treatment. Additionally, this study looked specifically at integrative counselling, used a larger sample, and addressed the limitation in Ramsay *et al.* (2007) of no control group.

### *Study Limitations*

There was no longitudinal follow-up, which means that it is not possible to say if the changes observed were sustained in the long-term. This could be addressed by extending the study to include follow-up measures at 3-monthly periods for a year.

Random allocation was not possible within the timeframe of this study and a longer timeframe for data collection could address this limitation. As such, it cannot be discounted that differences in unmeasured variables (such as the more recent diagnoses for those in the waitlist group who were selected from the bottom of the

waitlist) may have affected the course of outcome change across time differently across the two groups. Baseline equivalence between the two groups on pretest measures was demonstrated, age and gender balance were equivalent in the two groups (Table 7), and participants in both groups were referred for counselling within a few weeks of each other, so the groups are meaningfully comparable. Nevertheless, the fact that true randomisation was not possible does mean that results should be considered preliminary pending replication of our results in a fully randomised sample.

The sample size (31 participants) limits the generalizability of the findings. Although a smaller sample size can still demonstrate the efficacy of therapy (Ramsay *et al*., 2007), a larger sample would allow for more variability among participants. Extending the time frame of the study and running it at multiple centres could address this. Additionally, the majority of participants were white British due to the socio-demographic location of the centre where the study was conducted (see Table 7), which also affects the generalizability of the findings. This could also be addressed by running the study at multiple centres in different locations.

The majority of the participants (58%) were female patients with curative breast cancer, which may reflect the fact that the most common type of cancer in the UK is breast cancer in women (Ferlay, Héry, Autier, & Sankaranarayanan, 2010). This limits the applicability of claims of effectiveness for this intervention with other cancer types. However, the design of this study included the exploratory qualitative data since this is a new area of research, so these results can be considered preliminary and grounds for further research with a larger sample of cancer types.

### *Clinical Implications*

Psychological distress is a considerable concern for the well-being of patients with cancer (Linden, *et al*., 2012). Anxiety, depression and low self-esteem can impact treatment compliance and outcomes, as well as emotional quality of life (Cardoso, *et al*., 2016). Although the link has not been fully established, there is beginning to be evidence that psychological intervention can have a positive effect on treatment outcomes (McGregor & Antoni, 2009). Further corroborating studies are needed.

Effective psychological support and intervention is an essential part of cancer care, but availability is variable due to the cost to health care services (Selmar, 2015; Lima, *et al*., 2016). Mental health services are notoriously under-funded, with one report into NHS commissioning highlighting the disparity between NICE recommendations and funding for psychological treatment in the UK (Layard, *et al*., 2012). This study demonstrates the effectiveness of short-term integrative counselling in reducing distress in a patient population with a range of cancer types, ages and both genders. This suggests that integrative counselling is a form of therapeutic support that is applicable to people with a range of cancer experiences, and therefore an appropriate intervention in cancer care.

Integrative counselling is an adaptable form of psychological therapy that is well suited to a healthcare setting due to its flexible applicability to differences in patient circumstances and responses to health crises, which has led to its successful implementation in primary care settings (Davis, *et al*., 2008; van Rijn, *et al*., 2011). In contrast, a criticism that is often raised against the use of CBT in the NHS as a panacea for all mental health needs is that one size simply does not fit all, and a diverse society requires diversity of therapeutic possibilities (Pilgrim, 2009).

However, CBT fits well in a healthcare setting where length of intervention must be balanced against service provision and funding (Lima, *et al*., 2016). There is evidence to suggest that counselling is comparable to CBT in terms of cost-effectiveness in primary care settings in the UK (Bower & Rowland, 2006). What the present study demonstrates is that short-term integrative counselling can have a significant effect on psychological health, which suggests it has the potential to be a cost-effective cancer support resource.

***Conclusion***

This study contributes to a small but growing body of research that demonstrates the effectiveness of integrative counselling for improving psychological well-being in patients with cancer in the short-term. Reducing distress may have ramifications for treatment compliance. More research is needed to develop an evidence-base for the effectiveness of this intervention within cancer services and to assess long-term outcomes.

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**Tables.**

**Table 1.** Participant demographic information – age, gender, cancer type, treatment stage, prognosis and ethnicity.

Cx indicates counselling group participant

Wx indicates waiting list participant

| Participant | Age | Gender | Cancer | Treatment Stage | Prognosis | Ethnicity |
|---|---|---|---|---|---|---|
| C1 | 42 | F | Metastatic Breast | On Treatment | Non-curative | White European (Ukrainian) |
| C2 | 55 | F | Breast | Post Treatment | Curative | White British |
| C3 | 47 | F | Breast | Post Treatment | Curative | White Irish |
| C4 | 48 | F | Breast | Post Treatment | Curative | White British |
| C5 | 57 | F | Metastatic Bowel | On treatment | Non-curative | White British |
| C6 | 44 | F | Breast | Post Treatment | Curative | White British |
| C7 | 64 | M | Prostate | Post Treatment | Curative | White British |
| C8 | 29 | F | Larynx | Post Treatment | Curative | White British |
| C9 | 54 | F | Breast | Post Treatment | Curative | White British |
| C10 | 63 | F | Breast | Post Treatment | Curative | White European (German) |
| C11 | 57 | F | Metastatic Breast | On Treatment | Non-curative | White British |
| C12 | 58 | M | Metastatic Prostate | On Treatment | Non-curative | White British |
| C13 | 68 | M | Bladder | On Treatment | Curative | White British |
| C14 | 54 | F | Breast | Post Treatment | Curative | White British |
| C15 | 45 | F | Breast | Post Treatment | Curative | White British |
| W1 | 57 | F | Breast | On treatment | Curative | White Irish |
| W2 | 62 | F | Breast | Post Treatment | Curative | White British |
| W3 | 63 | M | Prostate | Post Treatment | Curative | White British |
| W4 | 44 | F | Breast | On treatment | Curative | White British |
| W5 | 53 | F | Breast | Post Treatment | Curative | White British |
| W6 | 39 | F | Ovarian | On treatment | Curative | White British |
| W7 | 57 | F | Melanoma | On Treatment | Non-curative | White British |
| W8 | 40 | F | Breast | Post Treatment | Curative | Japanese |
| W9 | 53 | F | Breast | Post Treatment | Curative | White British |
| W10 | 63 | F | Breast | Post Treatment | Curative | White British |
| W11 | 60 | F | Breast | Post Treatment | Curative | White British |
| W12 | 41 | M | Metastatic Bowel | On Treatment | Non-curative | White British |
| W13 | 50 | F | Breast | Post Treatment | Curative | White British |
| W14 | 47 | F | Breast | On Treatment | Curative | White British |
| W15 | 67 | F | Non-Hodgkin Lymphoma | Post Treatment | Curative | White British |
| W16 | 71 | M | Melanoma | On Treatment | Non-curative | White British |

**Table 2.** Results of independent t-tests comparing pre-test levels of anxiety, depression and self-esteem between groups.

| | |
|---|---|
| Anxiety | ($t(29) = 0.24$, $p = .812$) |
| Depression | ($t(29) = 0.679$, $p = .502$) |
| Self-esteem | ($t(29) = -0.536$, $p = .596$) |

**Table 3.** Results of 2X2 mixed-design ANOVA on Anxiety, Depression and Self-Esteem.

| | Time | Time x Group | Group |
|---|---|---|---|
| Anxiety | $F(1,29) = 30.97$, $p < .001$ | $F(1,29) = 13.09$, $p = .001$ | $F(1,29) = 1.75$, $p = .196$ |
| Depression | $F(1,29) = 19.03$, $p < .001$ | $F(1,29) = 12.39$, $p = .001$ | $F(1,29) = 0.91$, $p = .348$ |
| Self-esteem | $F(1,29) = 23.15$, $p < .001$ | $F(1,29) = 11.10$, $p = .002$ | $F(1,29) = 1.01$, $p = .323$ |

**Table 4.** Means and standard deviations before and after intervention in both the counselling and wait list groups.

| | Before | | After | |
|---|---|---|---|---|
| | Counselling | Waiting List | Counselling | Waiting List |
| Anxiety | M=11.2, S.D=4.39 | M=10.81, S.D.=4.58 | M=5.6, S.D=2.80 | M=9.63, S.D=4.63 |
| Depression | M=8.93, S.D=4.20 | M=7.81, S.D.=4.93 | M=3.67, S.D=2.66 | M=7.25, S.D.=3.99 |
| Self-esteem | M=14.80, S.D.=5.49 | M=15.81, S.D.=5.02 | M=21.33, S.D.=5.37 | M=17.0, S.D.=4.55 |

**Table 5.** Results of paired-samples t-tests comparing levels before and after intervention for anxiety, depression and self-esteem.

| | Counselling | Wait List |
|---|---|---|
| Anxiety | $t(14) = 5.63$, $p < .001$, $d = 1.454$ | $t(15) = 1.64$, $p = .123$, $d = 0.409$ |
| Depression | $t(14) = 4.49$, $p = .001$, $d = 1.159$ | $t(15) = 0.82$, $p = .423$, $d = 0.206$ |
| Self-esteem | $t(14) = -4.48$, $p <.001$, $d = 1.261$ | $t(15) = -1.29$, $p = .216$, $d = 0.323$ |

**Table 6.** Themes identified in the answer to the open-ended question and number of counselling sessions for each participant in the counselling group (all names are pseudonyms).

| Participant | Theme | Number of Sessions |
| --- | --- | --- |
| Sarah | 1, 3 | 9 |
| Anna | 1, 2, 3 | 9 |
| Emily | 3 | 6 |
| Liz | 3 | 6 |
| Lisa | 3 | 8 |
| Alice | 1, 2 | 9 |
| Ian | 2 | 6 |
| Rachel | 2 | 6 |
| Susan | 1, 2, 3 | 6 |
| Diana | 2, 3 | 9 |
| Isobel | 2, 3 | 9 |
| James | 1, 2, 3 | 6 |
| David | 3 | 5 |
| Lauren | 1, 2, 3 | 7 |
| Nicola | 1, 2, 3 | 6 |

**Table 7.** Comparison of characteristics of the two groups

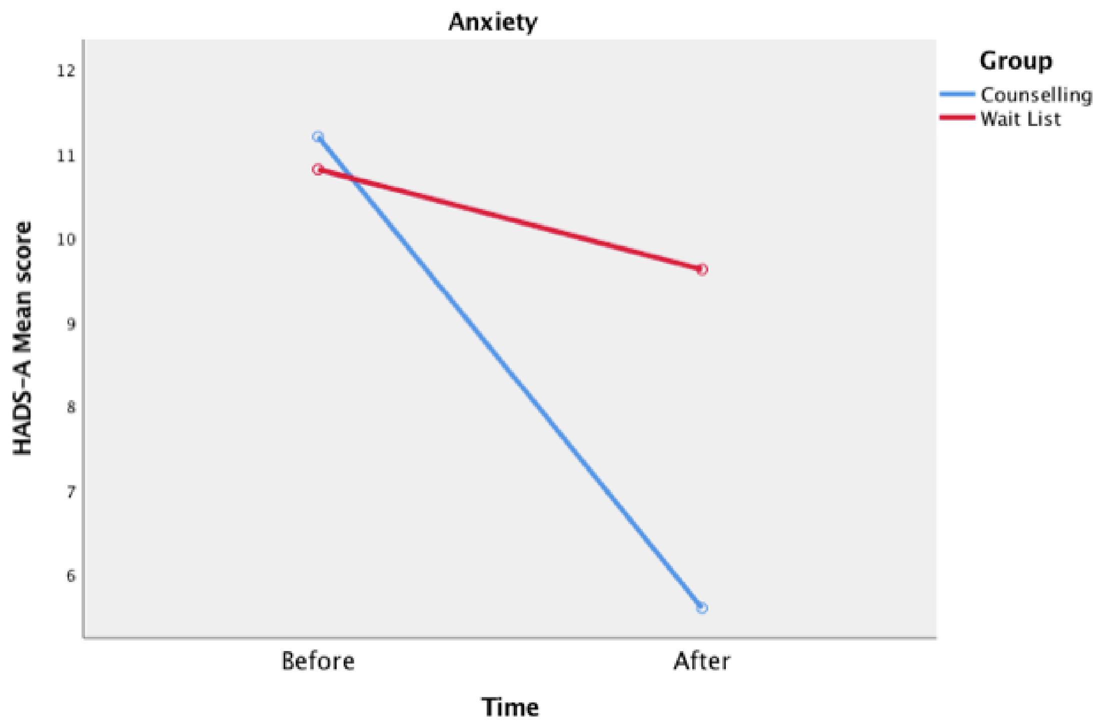
| | Counselling | Wait List |
| --- | --- | --- |
| Number of participants | 15 | 16 |
| Female | 12 | 13 |
| Male | 3 | 3 |
| Age range | 29 - 68 | 39 - 71 |
| Mean age | 52.3 | 54.2 |
| On treatment | 5 | 7 |
| Post treatment | 10 | 9 |
| Curative | 11 | 13 |
| Non-Curative | 4 | 3 |

**Figure captions.**

**Figure 1**. HADS anxiety (HADS-A) and depression (HADS-D) means before and after counselling and waiting time.

**Figure 2**. Self-esteem (RSE) means before and after counselling and waiting time.

**Figure 3.** Three identified themes and associated sub-themes in the qualitative data.



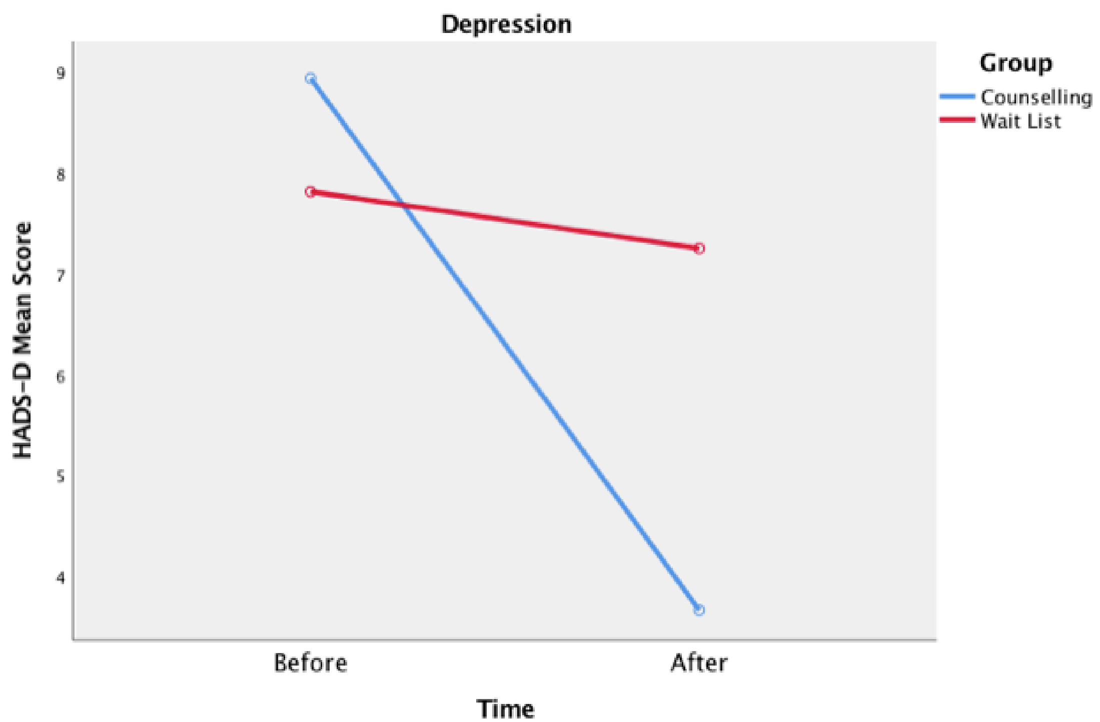




**Figure 1**. HADS anxiety (HADS-A) and depression (HADS-D) means before and after counselling and waiting time.

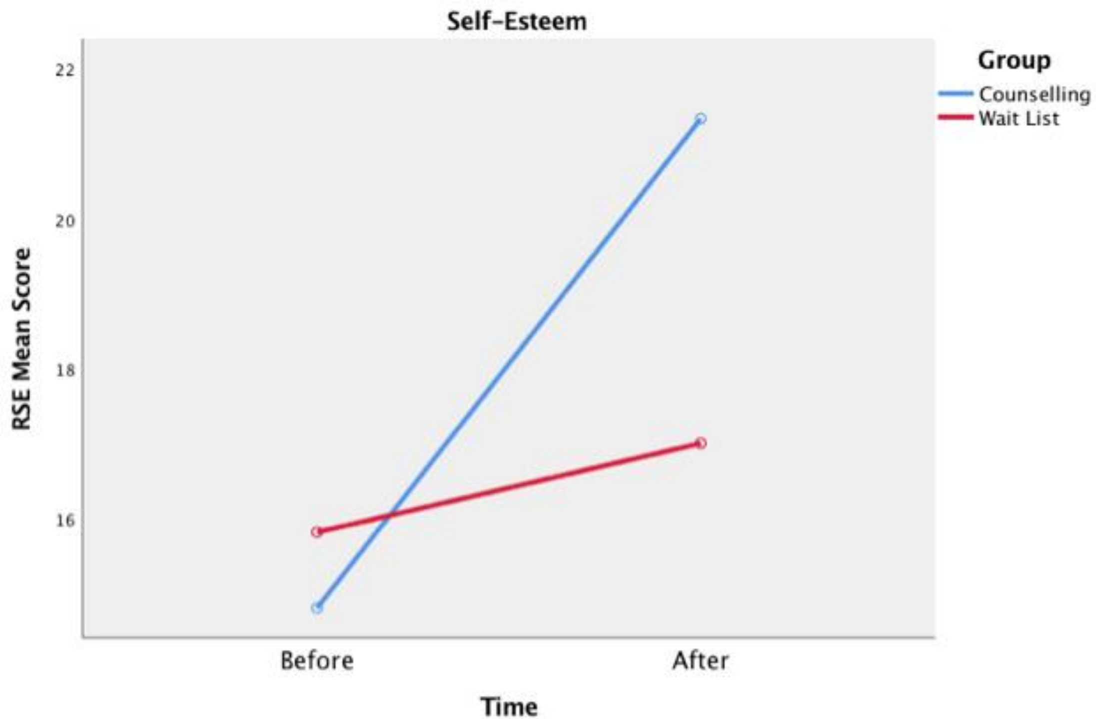



**Figure 2**. Self-esteem (RSE) means before and after counselling and waiting time.

1. Acceptance
   - (i) Self-acceptance
     - a. Accepting needs
     - b. Accepting feelings
   - (ii) Acceptance of circumstances
     - a. Accepting illness and cancer experience
     - b. Accepting the past

2. Self-Awareness
   - (i) Understanding feelings
   - (ii) Understanding issues/problems
   - (iii) Sense of control

3. Moving Forward
   - (i) Positive emotional change
   - (ii) Looking to the future
     - a. Hope
     - b. Taking steps for change

**Figure 3. Three identified themes and associated sub-themes in the qualitative data.**