Introduction to the Special Theme Issue — Living with Serious Illness: Innovations in Counselling

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At the turn of the 20th century, death was most often ushered in by infectious disease. By the turn of the 21st century, chronic health conditions have become the most common cause for death. Although we continue to look to science for magical treatments that may instantly restore health, the majority of illness sufferers must co-habit with their conditions, sometimes for decades. Unfortunately for many, the chronicity and progression of illness can insidiously bid exhaustion and despair. Loss and adjustment become hallmarks of the experience for sufferers and their families.

Increasingly, as counsellors, we meet the seriously ill, their families, and their companions. The faces of chronic illness in counselling practice are innumerable and familiar to many of us regardless of practice specialty. Perhaps you know the husband who is torn between his career and his ailing wife; the once dynamic professional woman whose life has been stolen by pain; the young girl acting-out while her sister succumbs to the lifetime drama of cystic fibrosis; the colleague who seeks support during the long walk back from fibromyalgia; or any number of others affected by serious illness. Moved by the struggles of our clients, we may also be aware that we are pushing ourselves in our professional roles — thinly believing that illness is something that happens to someone else.

Counselling is contributing in major ways to enhance health and living with serious illness. Of this there is no question. Medical utilization studies repeatedly document our capacity to positively influence health in measurable ways. As editors and practitioners in the medical care field, we are also aware that while research in health counselling is growing, it addresses only a small portion of the health counselling field.

In settings across Canada, and with a variety of illnesses, well-trained, well-experienced, and well-read counselling practitioners are thrust into becoming innovators. We may think of these individuals as *local clinical scientists* (Trierweiler & Stricker, 1992). Faced with clients whose conditions and situations remain unaddressed by current literature, we are challenged to develop treatment approaches based on informed experience, assessing effectiveness as we proceed. In doing so, our work becomes a series of small scale research endeavours — one client at a time. Interestingly, this pattern follows the long standing tradition of psychological practice reflexively informing research (Howard, 1986). Unfortunately, our practical innovations and our accompanying knowledge are rarely

shared with other clinicians. In this special issue, we have intentionally invited practitioner knowledge and experience cognizant that this is where most counselling knowledge and research begins.

We hope that in our selection of articles for publication you are invited to think about innovations in health counselling and in counselling in general. We also invite you to think about innovative disciplined inquiry. Innovation implies newness. The treatment innovations you will read about herein are too new to be considered "empirically validated" — a movement now questioned from a variety of perspectives (e.g., Peavy, 1998; Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997) and initially launched more to hold the professionally dominating forces of biological psychiatry at bay than to enhance our own practice (Heppner, Casas, Carter & Stone, 2000). Rather the innovations contained herein are the springboard for new ways of approaching client-care, new ways of understanding living with serious illness, and ultimately we hope, temptations for further research and investigation. The knowledge these methods are based upon does not harken to logico-scientific methods for validation. It finds its foundation in the tacit practical knowledge of veteran clinicians' experience based on years of refining and experimenting with clinical realities (Polkinghorne & Hoshmand, 1992; Schön, 1987).

The articles in this special issue each offer thought-provoking alternatives. Wendy Edey and Ronna Jevne highlight the importance of hope in addressing issues with serious illness. Through the use of two examples, specific suggestions are made about how to use language which conveys hope and makes hope visible in the counselling encounter. June Slakov and Mary Leslie share their innovative group work with breast cancer patients using a primarily non-verbal approach. Gina Wong-Wylie outlines a four-level guide to ethical decision making with HIV seropositive clients. She maintains that considerations of hope are an ethical and health-promoting responsibility of the clinician. Susan Baerg discusses the work of two adolescent clients with cancer. Client artwork and poetry are specific methods used to address the difficulty of putting the experience of serious illness into words. In her brief report, Jennifer Boisvert candidly shares a part of her recovery from anorexia nervosa through a hope-focused use of photography and personal journaling. A psychology researcher herself, she reflexively discusses the self-healing effects of these innovative techniques. Rebecca Jacoby's article features innovative research specifically highlighting themes found in the poetry of breast cancer patients. finally, Shann Ferch and Marlene Ramsey share their practice and theory-building around "sacred conversation" — a method which they have developed in working with those who must endure unavoidable suffering.

A French article by Marie-Line Morin presents the case study of a woman who experienced a complete remission of the syptoms of fibromyalgia through a journey of psychological and spiritual growth.

All articles appear in this special theme issue with the exception of the article by Marie-Line Morin which will be published in the April issue of the *Journal.*

We are pleased to have had the opportunity to act as co-editors of this special issue and we welcome your feedback. In closing, as you read the following articles, we invite you to consider these questions.

1. What do you understand about the condition addressed?
2. How condition specific must counselling be with the seriously ill?
3. How can we become innovative if we rarely experiment — if we are driven solely by empirically-based treatments?

References

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