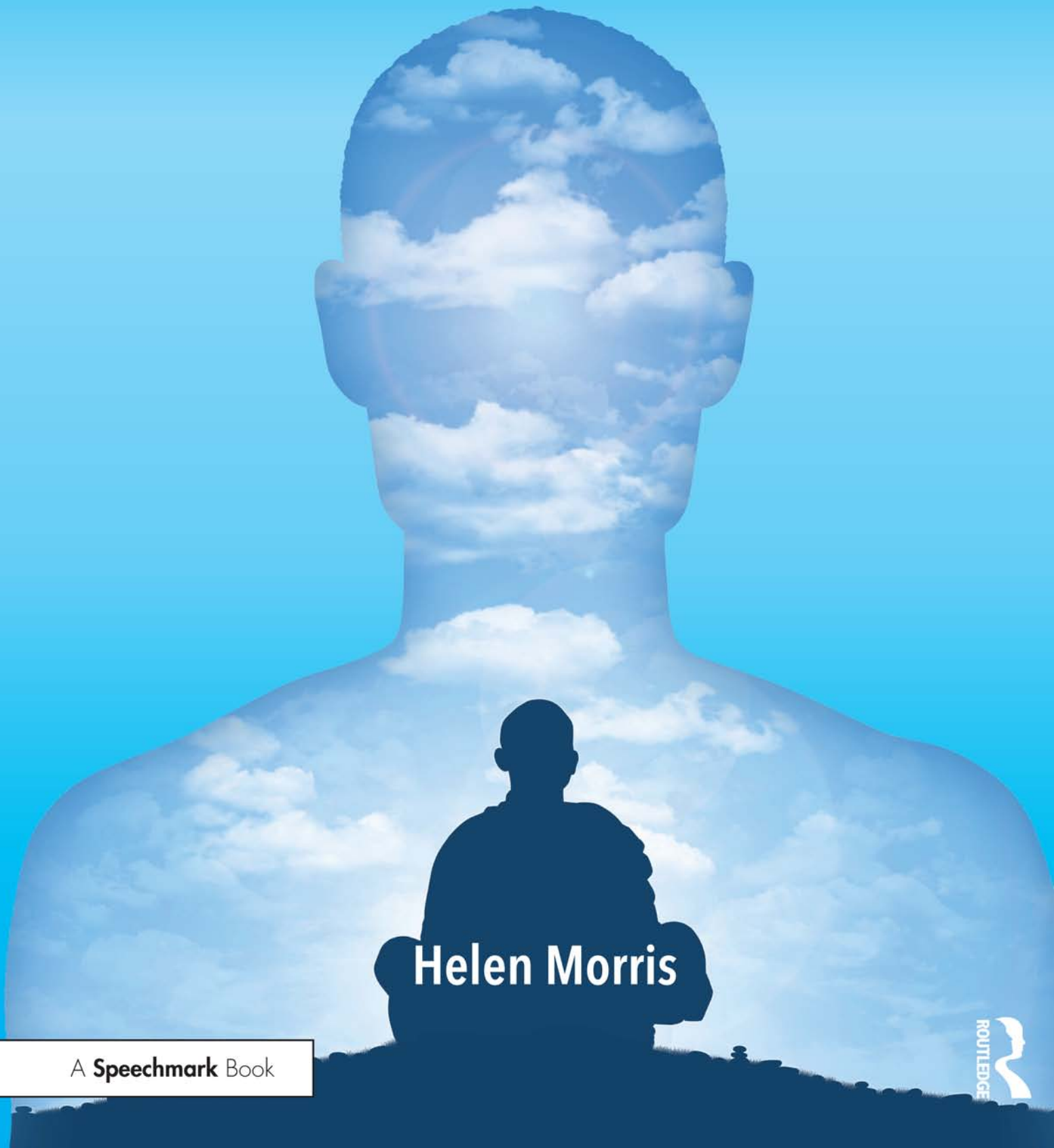
Working with Stress and Tension in Clinical Practice

A Practical Guide for Therapists



Helen Morris

A **Speechmark** Book

ROUTLEDGE

Working with Stress and Tension in Clinical Practice

Working with Stress and Tension in Clinical Practice is a practical toolkit that sets out a wide range of approaches for reducing stress and anxiety in clients so that they are mentally prepared for more effective therapy sessions. Combining research, real-life examples and practical advice, the book discusses the potential psychological barriers to therapy that can stand in the way of helping clients and offers concrete solutions to overcome these issues. This toolkit clearly outlines a range of approaches such as mindfulness and meditation techniques that can help clients focus on their therapy and overcome stress and anxiety.

Key features include:

- Guidance and activities supporting the use of meditation, breathing exercises and visualisation techniques in therapy
- Ideas that can be used as short introductory activities at the beginning of a therapy session to help patients get the most from the therapist's time
- Suggested whole sessions on stress reduction for those focusing on anxiety itself.

This book is a must-have resource for Speech and Language Therapists, Occupational Therapists, Psychologists, Counsellors, Psychotherapists and any professionals working with clients who wish to help the people they work with get the most from therapy.

Helen Morris has worked as a Speech and Language Therapist for many years in hospitals, clinics and community settings, in the UK and internationally. She has extensive experience of the need to help patients overcome anxiety and other emotional obstacles that stand in the way of effective therapy.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Working with Stress and Tension in Clinical Practice

A Practical Guide for Therapists

Helen Morris

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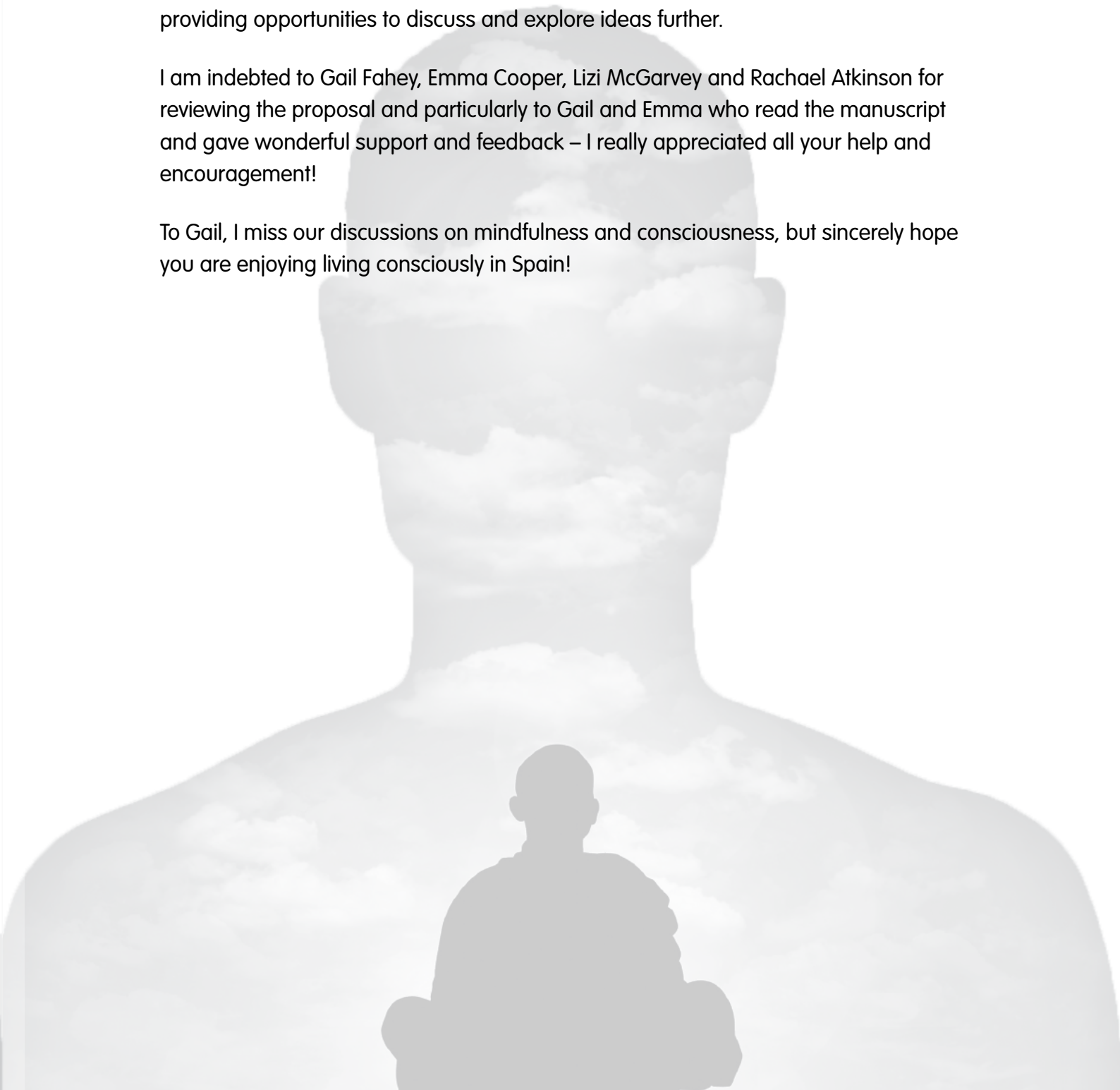
To Gail, I miss our discussions on mindfulness and consciousness, but sincerely hope you are enjoying living consciously in Spain!

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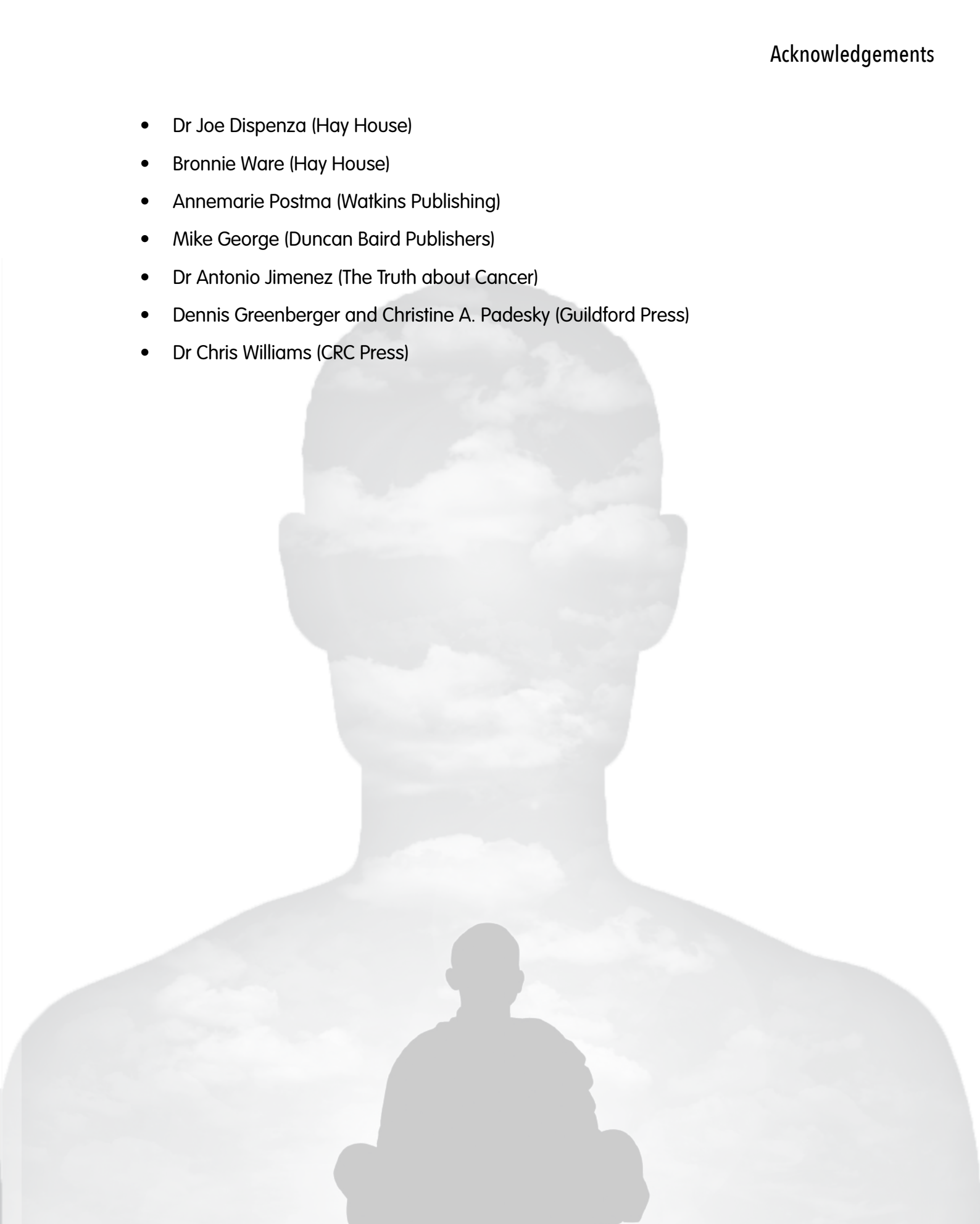


Introduction

During the course of my practice as a Speech Therapist, I have observed that with the majority of clients getting down to the business of therapy is not straightforward. It is usually impeded and obstructed by clients' divided attention; this is not, however, just because of cognitive impairment. Clients come to us because they need help; they are at a difficult time in their lives, and because of this they not only have their impairments to deal with, but also their emotional reactions to cope with too. In our society we have not been taught how to cope with our thinking mind – our runaway thoughts – or to confront our emotions and process them in a constructive way. Consequently when clients reach this challenging time, they are not always well equipped to deal with it.

> This can result in spiralling stress and tension. Consequently clients can become stuck in their minds – locked in a cycle of worrying thoughts, making attending to therapy very difficult to near impossible.

This book aims to address this key issue of working through a client's processing of their situation and bring their attention back to therapy in order to achieve optimal therapy outcomes. It is intended for therapists to help clients reduce stress and fear – which is felt as tension throughout the body and mind. The worries and tensions can take hold of clients and hijack their attention. This can significantly affect their ability to perform optimally in assessments and therapy and achieve the best possible outcomes. Therefore therapists are not able to get an accurate assessment of the client – clients are unknowingly disabling themselves. It also severely impacts on their quality of life.

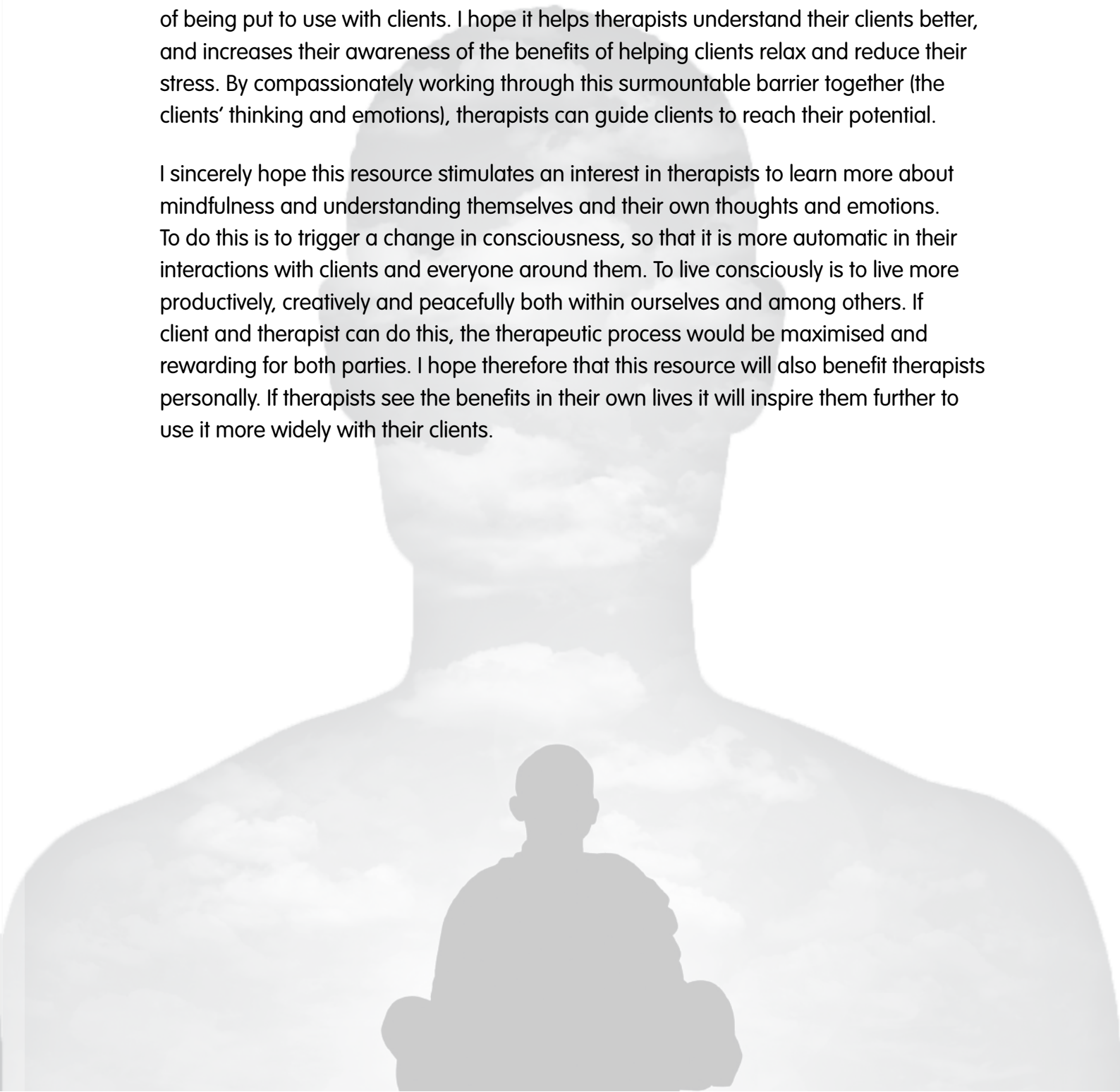
I hope to highlight the importance of working on tension and stress, and encourage therapists to allow the time to do this within therapy sessions. This resource will aim to give therapists the confidence to reach out and connect with clients on a deeper level. To metaphorically take clients by the hand and explore their feelings and to enable them to find the space, the stillness and the peace that IS within them, and is ALWAYS there. However, this stillness is usually concealed, not only in our clients but in everyone, by the layers that we add – the tensions, the stresses, the distractions – the thinking mind. By rediscovering this peace, this sanctuary, clients create a space inside themselves in order to process information much more effectively. It is my intention that they will also rediscover joy. This I hope will give them new energy to move forward in a positive way and accept and embrace life.

This book covers a variety of related topics which can all increase a patient's self-awareness and confidence to take control of their emotions and their psychological

well-being. It will allow clients to gain a new perspective into themselves and take away the fear of the unknown/the darkness within themselves. Clients can be empowered by being taught ways to reduce their tension. The methods are simple and effective, and most clients become increasingly interested even when initially very reticent.

These are not new ideas but merely presented in a new way specifically with the aim of being put to use with clients. I hope it helps therapists understand their clients better, and increases their awareness of the benefits of helping clients relax and reduce their stress. By compassionately working through this surmountable barrier together (the clients' thinking and emotions), therapists can guide clients to reach their potential.

I sincerely hope this resource stimulates an interest in therapists to learn more about mindfulness and understanding themselves and their own thoughts and emotions. To do this is to trigger a change in consciousness, so that it is more automatic in their interactions with clients and everyone around them. To live consciously is to live more productively, creatively and peacefully both within ourselves and among others. If client and therapist can do this, the therapeutic process would be maximised and rewarding for both parties. I hope therefore that this resource will also benefit therapists personally. If therapists see the benefits in their own lives it will inspire them further to use it more widely with their clients.

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1. Identifying barriers to therapy

Understanding each client and their internal obstructions (fears and uncertainties) to therapy allows therapists to work more effectively with them.

Aims

- To understand potential psychological barriers to therapy.
- To understand how to identify barriers.

A client's readiness to engage

"Getting going" with therapy can be challenging in many cases. Clients can be difficult to engage with in the therapy process. This may happen initially, throughout the course of intervention or occur sporadically. Clients may be completely resistant to any intervention from the outset, they may not put their full effort into therapy, they may respond with "No. I can't." when new suggestions or activities are introduced, there may be poor compliance with completing the tasks you provide between sessions and there may be hesitancy in attempting carry-over of new skills to real-life situations outside the therapy session (even if you are confident they can manage this).

We meet clients because they need support, so why are they holding back from the support you are trying to give?

Reactions

When we see clients they are at a vulnerable point in their lives. We are seeing them for a particular, possibly new issue. However, the "problem" is more than just the impairment or disease. The "problem" is immediately and inextricably connected to the client's reaction to it. The reaction is usually a problem in itself and often eclipses the original issue; clients thereby more than double their problem.

A client's reactions (thoughts, feelings and beliefs) about their situation are the first aspect to be focused on, as this is where the resistance to therapy lies. Reactions are instant and can be difficult to move on from, clients can get "stuck" in their panic and despair and this is what shapes their responses or lack thereof. If a client's thoughts are dominated by the stresses and tensions that consume them, they become psychological barriers. A true understanding of a client's abilities and potential cannot be gained. We need to differentiate between the initial "problem" and the reactions which cause additional limitations. How much more could a client achieve and how much further could they progress without those limitations? How much are they limiting themselves? Any impairment or "problem" which they come to you with then is not the initial problem to work on but the psychological barrier.

Reactions come from our past

Reactions are heavily influenced by our past experiences, our background, our childhood, and our culture and religion which guide our thinking and form our beliefs (see also chapter: "An Introduction to Mindfulness for Reducing Stress"). These factors are what we are all composed of and what have fundamentally shaped us unless we become conscious of them, consider them carefully and challenge them. These beliefs will also determine a client's openness to strangers and expectation about appointments, the process of therapy and outcomes. Additionally, clients will have unique character traits, abilities to learn and styles of learning, and they will also have their usual day-to-day concerns such as finances which add to their psychological load. Consequently, to maximise the opportunity you have for supporting a client with their difficulty, the client must be considered holistically to be understood better so that as a clinician you can support them more effectively. To do this they need to be observed with care, empathy and detachment. If they are not, all these other facets can potentially also become barriers to therapy.

Lack of awareness

Clients themselves may not understand they are creating barriers and inadvertently adding to their issues. Being immersed in and at the heart of the situation they are unlikely to have this perspective and insight; they would also be unaware they are able to change and control their reactions by developing their ability to respond. Reactions are unconscious responses.

We can all become more conscious of ourselves and our circumstances and take control of how we mentally respond, and we can teach clients to do this. The first step is to be aware of the resistance coming from within the client and encourage them to

develop this awareness of themselves in order to then let go and move on in therapy. It may be the case, however, that on understanding these barriers you realise that your intervention is not appropriate at this time.

Examples of psychological barriers to therapy

- Low motivation.
- Impairment/issue not severe enough for patient to warrant the effort required in therapy.
- Emotions – low mood/depression/self-pity, fear, anxiety, anger, guilt, shame, embarrassment, frustration.
- Reduced confidence.
- Harsh self-criticism.
- Non-acceptance of situation.
- Resignation/giving up.
- Unused to/unwilling to take responsibility for themselves – expectations of health care professionals providing a "quick fix".
- Lack of trust in therapist.
- Character trait – prefers to talk/do it their way rather than listen to information and follow advice.
- Other issues pre-dominate consciousness.
- Not feeling understood by therapist – misunderstandings of therapist.
- Age/cultural differences of client/therapist.
- Lack of family support.

Case examples of reactions and barriers to therapy

OS

OS was an elderly widow living alone. She was registered blind. However, she continued to run a small guest house in her home, mainly taking in foreign students. She had two daughters who did not live nearby.

OS had just been discharged home from hospital following a stroke. OS also immediately resumed the running of her guest house which involved not only making breakfasts but also dinners. When guests were out for the day she would always find things to do, tiring herself out. Her fatigue was impacting therapy sessions.

When this was discussed, OS reported feeling that she couldn't allow herself to sit down and rest, "doing nothing" made her feel guilty and agitated. OS only felt ok about herself if engaged in activity. There was no flexibility in her thinking. Her beliefs lead to high expectations and demands of herself without taking into account her recent stroke. She had not questioned if that was reasonable.

CS

CS was a retired woman who had had a stroke. She welcomed support and was usually very motivated. Low mood was an issue for CS at times but she could be jovial and was generally open to therapy. From time to time, however, there was complete resistance to therapy, like a brick wall had suddenly gone up. This was in response to feeling like she was being pushed into doing therapy tasks she did not like to do as she did not enjoy them, did not feel she could do them and did not want to expose these weaknesses, and she also did not believe they would help her.

The barriers were her mood, fears and misunderstandings. This resulted in her retreating into herself away from the therapist – her attention was away from the therapy and focused on her negative feelings, and it was very hard to pull her attention away from them.

JC

JC was a palliative client. He had significant swallowing difficulties (dysphagia). JC needed a modified diet to reduce the risk of aspiration pneumonia; he was also recommended exercises to strengthen the muscles involved in swallowing. JC lived with his wife who had advanced dementia. He welcomed therapists into his home; his pleasures came from talking to visitors, watching programmes about World War II and eating the food he liked.

JC was not compliant with either the dietary advice or the exercises. This lack of compliance was due to complete acceptance. JC understood his situation; he was aware of what he was doing and he was making choices. His priority was short-term pleasures.

BM

BM was retired. He was visited at home for six weeks following his stroke. BM was resistant to therapy throughout most of the course of intervention. He was able to engage to a degree, but often became irritable: he wasn't able to concentrate on tasks and explore his full potential as a result.

BM behaved like this in therapy because he was guarded. BM was embarrassed about his weaknesses and also fearful of exploring the depth and range of them with a stranger.

LS

LS was a young woman who had mild impairments following a stroke. She was unable to fully engage in therapy as she had more significant housing and relationship issues to think of. These matters subsequently dominated sessions. The impairment was not significant enough to concern her compared to these other worries.

KS

KS was highly anxious following his stroke. He was retired and lived with his wife who was also just as anxious about their changed circumstances.

KS was grief stricken. His impairments were significant, and the stroke was very recent. He was overwhelmed by his emotions but he also had to deal with his wife's, which dominated the therapy sessions due to her ability to articulate them more easily. KS was unable to accept what had happened to him and he was locked in his all-encompassing despair. It took six weeks to work on this in order to prepare him for beginning to work on the impairments.

DB

DB was elderly and lived alone. She had relatively mild impairments following her recent stroke. She was evidently highly anxious when attempting therapy exercises. DB was terrified about getting things wrong, and her anxiety hijacked her ability to focus on tasks. It was this anxiety that was the primary barrier.

Contrast with these case examples

BH

BH was young and in employment prior to his stroke. He lived alone but had supportive family nearby. BH had mild-moderate communication impairments.

From the outset BH engaged fully in therapy. He had insight into his difficulties and was very motivated to improve in order to return to work.

DI

DI was recently retired, but led an active life with her various hobbies and helping with the care of her grandchildren.

Following her stroke which left her with moderate communication impairments she was keen to improve and return to her everyday activities and resume her role within the family.

DB

DB had mild impairments following his recent stroke. He was a retired widower but had a large supportive family who all lived locally. He was also actively involved in his church and enjoyed going out on the train for days out independently. He was keen to return to resuming this life.

DB was open to seeing therapists, and fully focused on participating in all therapy tasks.

Common factors which contributed to openness to the therapy process

- An ability to accept situation enough to move focus on to dealing with their difficulties.
- An ability to manage anxieties sufficiently to explore impairments – degree and range of.
- Insight into problems and need to engage to maximise outcomes.
- Having reasons to be highly motivated to do as well as possible, e.g. return to work, leisure activities and resume role within family.
- Trust in the therapist.
- Well supported by family.
- Mood sufficiently positive to not be consumed by negative emotions.

How to identify potential psychological barriers to therapy

- Do you sense tension, stress, worries (facial expressions, body language, do they appear nervous, have you observed obsessive negative thinking)?
- Is the client distracted by them?
- Is the client avoiding doing therapy tasks?
- Is work set between sessions unfinished/not attempted?
- Is performance in therapy tasks variable?
- Does the patient behave in a hostile manner?
- Does the patient lack or appear to lack a sense of seriousness/gravity regarding their difficulty (patient not taking time to think when asked questions or doing activities, preferring to joke their way through, perhaps to mask their difficulties)?

Once you have identified the potential barriers you can start to support your client to deal with them; you will then be able to move forward effectively with the therapy process.

Summary

- Clients may not be ready to fully engage in therapy due to psychological barriers.
- We react to situations based on our programming – our conditioning in childhood.
- Understanding that clients may be holding back for a variety of reasons, which they may not be aware of and/or unwilling to discuss, can help you to approach the situation with care, patience and compassion.