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## Introduction

### Introduction

Locating client and therapist within the world of social and cultural contexts, psychotherapy takes as its focus the intra- and inter-subjective world of client and therapist and the meanings they attribute to experience as fundamental to the process of therapeutic change. By contrast, psychopathology examines the nature of the problem or diagnosis attributed to clients' experiences. It analyses how this problem evidences itself across people, in patterns often described as conditions, as for example depression, anorexia nervosa or borderline personality disorder. Current psychological services are largely framed by the latter psychopathological, or condition-focused, culture. Consequently, clients tend to be signposted towards, or excluded from, services based on whether they meet the criteria for a particular diagnosis or condition. The apparent tension between these two world views is regularly experienced by applied psychologists, psychotherapists and counsellors. Such experience reveals the profound importance of analysing how this tension manifests itself in work with clients, yet to date there has been little exploration of these tensions or how they translate into practice and might be addressed in the best interests of clients. The contemporary relevance of this book is therefore significant for practitioners in the development of their work with clients.

By examining the relationship between psychotherapeutic practice and the presenting issues experienced by clients this book aims to meet a fundamental need of trainees and qualified practitioners. Its central argument is that tensions between competing world views of humanistic and medical models characterise the learning, development and practice of many applied psychology trainees, psychotherapists and counsellors. Indeed, this may also be the experience of qualified practitioners, as they work towards finding an integration of their values with a developing understanding and knowledge of theory, practice and research evidence. It concludes that this tension must be addressed head-on in the interests of best practice.

The book is made up of nine chapters: this introduction defines the scope of the book and the nature of the topic and addresses its tensions and debates. Seven subsequent chapters then focus on a specifically labelled area of experienced psychological distress or difficulty that is regularly seen within services. It is almost a paradox that the labels themselves form the proposed chapter headings. These include anxiety, depression, trauma and post trauma stress, bipolar, psychosis, borderline personality and eating disorders. The ninth and final chapter draws together the book's themes.

Each chapter addresses a specific named workplace/context and interweaves the historical context, theory, research, casework and inherent tensions in the work with clients. The topics included have been chosen because they represent the more frequent presenting problems encountered by trainee therapists and practitioners in their work with clients. Areas of practice which are perceived as more specialised, for example working with clients with a diagnosis of antisocial personality disorder, are excluded for pragmatic reasons of book size and on the basis that these provide less developmental potential for the wider readership within applied psychology, psychotherapy and counselling. We would acknowledge however that similar themes to those addressed in the included sections are likely to be of relevance to these other areas of practice.

For the purposes of this book we have chosen to use the phrase 'psychotherapeutic practice' to encompass those therapeutic relationships with clients with whom a range of professions engage. This includes counselling psychologists, clinical psychologists and counsellors as well as psychotherapists. Note also that the term 'psychologist' may refer to either clinical or counselling psychologists who are working psychotherapeutically, and the term 'counsellor' will refer to those who have undergone counselling training (they are also sometimes referred to as 'therapists'). Finally, the term 'psychotherapist' may refer to those who are trained as such, but also that the term's use in practice can be assumed by counsellors and psychologists. The authors suggest that this difference in naming has its origins in the historical context of psychotherapy: for example, the British Psychological Society's formation of a register of psychologists specialising in psychotherapy aims to collate those psychologists who are working in this way across the applied psychologies. In recent years, the British Association of Counselling has extended its description to become the British Association of Counselling and Psychotherapy.

## **Part 1: Exploring the Historical Context of Psychotherapy (Barbara Douglas)**

The contexts within which psychotherapy is practised are both time and place contextual. It would be naïve, for example, to consider that such 'founding fathers' of psychotherapy as Sigmund Freud, Carl Jung or Carl Rogers emerged independent of their historical contexts.

The early nineteenth-century Quaker development of Moral Therapy (Tuke, 2010 [1813]) could in many senses be considered the precursor of the practice of psychotherapy with the term 'moral' having a different meaning from our current understanding – one that held a broader sense of the psychological. The development of psychotherapy within the nineteenth century can be viewed as a drive to search for a more optimistic view of the human condition than that of the pervading and profound despair of social Darwinism with its concepts of tainted heredity and degeneration, propounded so influentially in England by Henry Maudsley and in France by Benedict Morel (Dowbiggin, 1985). Before Freud's major works appeared, discourses of European psychiatry and neurology were already evolving an embryonic language of dynamic psychiatry that included notions about hypnotism, hysteria and the power of the unconscious (Ellenberger, 1981).

With the work of Freud came the powerful theoretical development of psychoanalysis. While Freud's theories changed over time he has become known as the founder of a view of psychological problems that emphasises the evolving, developmental dynamic structures of the psyche. The early emergence of psychoanalysis was jealously contained within the medical profession but also influenced by social geography. The clearest example of this was the 1930s' interweaving of its various schools of thought that was brought about by the persecution of Jewish analysts in Europe and their migration to England and America. The Viennese, Berlin and London schools were forcibly brought together during the late 1920s and 30s, each having to engage (uncomfortably) with the conceptual and practice emphases of the others.

While the early emergence of psychoanalysis was contained within the medical profession, the wider growth of psychotherapy was subsequently – and profoundly – influenced by the growing discipline of psychology. By the 1930s this had rejected introspection in favour of the study of observable behaviour. The resulting emergent behaviourist tradition lent itself to a very different form of 'psychotherapy', one which emphasised behaviour change through various programmes of conditioning and modification. These first took root in practice through the development of training programmes for children, psychiatric patients, and those contemporaneously referred to as 'mental defectives'. Increasingly, however, frustrations emerged at the limitations imposed by such rigidity. As the twentieth century progressed the focus shifted increasingly towards a concern with meaning and subjective experience, with resulting psychological and psychotherapeutic challenges to the behaviourist movement.

The development of concepts such as learned helplessness (Seligman, 1975) furthered a need to consider the subjective world of the individual, and as such cognitive behaviour therapy (CBT), with its emphasis on the role of cognitions, arose out of behaviourism. More recently, with the shift towards a postmodern constructionist ethos (across disciplines), CBT is also shifting its approach, placing increased emphasis on

the construction of meaning as the link between thought processes and emotion, and acknowledgement of the importance of the therapeutic alliance and the breakdown of CBT concepts into devolved subsystems of thinking in psychotherapeutic practice (for example, in the current development of mindfulness as a practice for depression: see Kabat-Zinn et al., 2002).

In the mid-twentieth century a challenge came also from Carl Rogers and a developing humanistic ethos. While the conditions of empathy, congruence and acceptance were conceived within a positivist framework of psychological research and experimentation, they were fundamentally challenging the limitations of such an approach by emphasising the importance of hearing and understanding the subjective experience of the individual. Towards the end of his life Rogers took this further, grappling with a concept of 'presence' in which the inner spirit of the therapist would touch that of the client (Kirschenbaum and Henderson, 1990).

There emerged therefore a broad movement towards a relational, shared meaning place within the therapeutic relationship that evolved as part of a narrative development in the theory of knowledge, both within psychology and across other disciplines within the social sciences and humanities. The more recent emergence of narrative therapy with its ideas of shared meanings, re-storying and co-creating understanding within psychotherapy further exemplifies this shift.

Historically the locations of psychotherapeutic practice have also changed. While there was previously little place for psychotherapy within the financially constrained and bureaucratic world of institutional psychiatry, in recent years statutory and voluntary services have increasingly embraced forms of psychotherapy. Psychological services in these broad frameworks are all now considered stakeholders in the development of psychotherapeutic practice. Thus while changing theoretical models of the person have influenced the development and practice of psychotherapy, so shifting contextual factors – including issues surrounding the classification of psychological distress, and the need to provide services for much larger numbers of people – have played their parts as well.

The classification of mental disorders took a powerful turn at the beginning of the twentieth century with the work of German psychiatrist Emil Kraepelin (2011 [1904]). Much of our current classification of mental disorders, for which psychological therapies are being offered, is premised on Kraepelin's influential nosology of psychiatric illness. Underpinned by a medical model, this classificatory system stressed aetiology and disease process and was based upon Kraepelin's longitudinal research evidence for his proposed twin underlying axes of all mental illness i.e. manic depression and dementia praecox (Greene, 2007).

But while current versions of the *Diagnostic and Statistical Manual (DSM)* embrace a medical approach to the classification of psychological distress that reflects Kraepelin's work, early versions were influenced by psychoanalytic concepts of the

unconscious and by the psychiatrist Adolf Meyer (1866–1950). Initially immersed in Kraepelinian psychiatry, Meyer later argued for – and led the development of – a more socially-based view of mental illness, in which individual experiences were described as reactions, or responses to, individual circumstances, rather than biologically-based disease entities. It was this framework of individual response, continuum of experience and behaviours as manifestations of unconscious conflict that underpinned the original *DSM-I* (APA, 1952) and its successor *DSM-II* (APA, 1968).

Only with the *DSM-III* (APA, 1980) and its subsequent revisions was there a paradigmatic shift towards a categorical, and debatably descriptive, classification of psychological distress reframed as disorder (sometimes referred to as the rise of the second biological psychiatry: see Shorter, 1997: 239).

Much psychological distress, framed by the *DSM* as disorder, now has an associated treatment of choice psychological therapy approaches, and so medical model frameworks have increasingly become the framework within which psychologists, psychotherapists, counsellors and psychological therapists are being required to work (and sometimes resulting in tensions that are further discussed in Part 2 below). It could be argued that the development of manualised and prescribed therapy, introduced as an attempt to provide a service to all at the point of need, threatens the retention of an individual emphasis. The ideals of cost effective therapy for all who may benefit from it are to be applauded, but these also raise tensions that echo the very same dilemma experienced by institutional psychiatry in late-nineteenth and early-twentieth century psychiatry, when burgeoning numbers of patients resulted in the standardisation – and ultimately dilution – of the earlier aims of moral therapy.

Charles Mercier, a leading psychiatrist of the late nineteenth century, expressed the hope that ‘management of patients by the gross will give way to management of the individual’ (Mercier, 2011 [1894]: viii). Has this occurred or are we sometimes in danger of regarding science as linearly progressive towards ever greater knowledge and improved practice? Joan Busfield (1986: 18) expresses the view that ‘psychiatry’s history is viewed as basically linear and progressive, albeit at times halting (or even occasionally regressive), in which science and progress are seen as synonymous’. Foucault (1988) in his work on madness reframed the study of psychiatry within a much more critical analysis of madness, psychiatry and mental illness – their meanings within, and relationships to, contemporaneous society. Part 1 of each chapter in this book examines the history of each of the presenting issues with this in mind, inviting the reader to consider the interrelationships between practice and historical, social and political contexts.

While the above is a bald outline of the historical contextual development of psychotherapy, it serves to demonstrate that time and context sit side by side with theorists and practitioners as co-creators of any model of psychotherapeutic endeavour. It is to a discussion of the nature of current dilemmas in the practice of psychotherapy that this chapter now turns.

## Part 2: Exploring Dilemmas, Evidence and Practice (Pam James)

In each chapter, dilemmas are discussed arising from the tensions and differences in professional opinion that can occur in psychiatry, psychology and psychotherapy. Such dilemmas may be considered as places where there is more than one way of understanding an issue – where there are different views about the impact of situational and personal factors associated with mental health and the appropriate therapeutic response. The reader is asked to pause in this uncertain place, sometimes evaluating the evidence, sometimes appreciating that there is no one absolute truth.

Those compiling the National Institute for Health and Care Excellence (NICE) Guidelines will review and grade evidence supporting particular therapeutic approaches, and a hierarchy of types of evidence exists where randomised controlled trials will have priority. This has resulted in a lack of emphasis on information collected by qualitative methods which are seen as a less preferred way for finding out about clients' experience, whereas Corrie (2010) takes a more inclusive view as to what constitutes evidence, suggesting that a consideration of the widest appreciation of what is happening for the client (and therapist) at the therapeutic interface is acceptable, and that research is only one part of the enquiry process.

In the UK the field of mental health could be perceived as a stage on which there are many players. Currently these include psychiatrists, general practitioners, clinical and counselling psychologists, psychotherapists, counsellors, psychiatric social workers, psychological wellbeing practitioners, high intensity workers and mental health nurses. The people who make up this multi-professional group do not all share the same understanding and explanation of the concept of mental health. Indeed it is only in the last ten years that the field itself has been so described, preferring for many years the term 'mental illness'. Psychiatrists may also have a varying emphasis on a biological or psycho-social focus. They are licensed to prescribe medication – symptoms are seen as identifiable markers that provide a basis for categorisation and the treatment response. Over the years, iterations of the *DSM* have aimed to group the similar, giving a framework at the descriptive level, and providing a pathway though the complexity of human experiences. This is one area where dilemmas and tensions may arise resulting from the impact, effect and perception of the *DSM* by clients and non-psychiatrists.

Amongst psychologists and psychotherapists working at the boundary with psychiatrists, differences of opinion that are reflected in practice will occur related to the use of diagnosis. The emphasis on symptoms – their measurement, reduction and management, maintenance and perpetuation – is not consistent. A prescriptive approach matches type of therapy to presenting symptoms. It is proposed then that all those experiencing similar symptoms would receive similar therapy. A less prescriptive approach sees symptoms as expressions of underlying thought and feeling in

context. Here, various therapies are applicable: the therapist would take an exploratory approach and seek to respond to the individual's subjective experience in context. This latter approach is reflected in a recent text edited by Milton (2012) which illustrates change in therapy based on casework that emphasises relational constructs rather than a diagnostic focus.

### *Inter-professional differences*

In the Layard Report (2006) economic underpinning was described whereby evidence-based practice would address large-scale anxiety and depression. Consequently, the government introduced two newly described workers into the field of mental health, namely 'psychological wellbeing practitioners' and 'high intensity workers'. This movement – entitled Improving Access to Psychological Therapies – is now several years into its programme and accompanied by the investment of significant resources. High intensity workers have been trained to deliver cognitive behavioural therapy to work with anxiety and depression in adults and training is now underway to work with different client groups, namely children and young people, people with long-term conditions, and those with medically unexplained symptoms and severe and enduring problems. There has been a large increase in the investment for increased personnel whilst initially offering only one therapeutic path, namely cognitive behavioural therapy. More recently, Counselling for Depression (IAPT Programme, 2011) and three other modalities have been introduced. More clients have been able to access therapy; however, the introduction of this new resourced workforce has resulted in significant shifts in the previous workforce. In the National Health Service (NHS) Primary Care across England, there are now very few counsellors and psychotherapists remaining as they have been retrained as high intensity CBT therapists or have left the service to work in the voluntary or private sector. After the New Ways of Working for Applied Psychologists in Health and Social Care (BPS, 2007), psychologists migrated into secondary care, learning disabilities, and assessing clients who have presenting issues that have compounding factors, or more recently, into managing IAPT Services. Their therapeutic skills in the public sector have been found to be less in demand than the need to manage departments and promote psychological thinking in the multi-disciplinary arena. Their supervisory skills have been only employable when trained in the IAPT model. So where is the dilemma? It is at the level of available employment for the psychologist, counsellor and psychotherapist. It is the displacement of trained therapists working from a variety of therapeutic approaches from the public sector into the voluntary and private sector. Will these professionals be commissioned in the NHS under the Any Qualified Provider Scheme (DoH, 2012)? The answers to these questions will affect the availability of free (NHS) therapy and client choice, and the amount

of acceptable evidence that supports therapeutic change will most probably be a further deciding factor.

### *The client's perspective*

The client's perspective is multi-faceted: their predominant wish is to not experience uncomfortable symptoms. These range from anxiety to depression, fear and uncertainty, and sleeplessness, as well as many physical symptoms including unexplained pains in different parts of the body, often associated with the digestive tract. It is not surprising that clients often want to take medication as they are familiar with the concept of a pill to cure a symptom. The general practitioner prescribes anti-depressants and with the client's agreement places that individual on the waiting list for therapy, usually CBT. What is ameliorating the symptoms? Is it the medication or the therapy? A client/patient in secondary care may then ask: who is in charge of my case? If located in mental health teams this will often be the psychiatrist, who holds the power of prescription. This key role can in turn be contested in overt or covert discussions by psychologists who hold the power provided by a knowledge of theory and concepts of human behaviour.

All types of therapy require the active engagement of the client and this process often involves talking about issues that are emotionally painful. The dilemma here is that speaking about painful matters can often result in opening up an issue that has been set aside. It is precisely this setting aside of difficult issues that creates the hidden distress in the first place. The message of therapy is that the outcome is worth the journey – whether the result is described in terms of an increased understanding of their personality, a shift in their unhelpful thinking patterns, an increase in the use of techniques to manage stress, or an internalised caring relationship to support them through difficult times. The inherent dilemma is that the life experience does produce distress and this is an uncomfortable truth. Can we sometimes weather the storm and sit in emotional pain, or do we need to reach for pills that will blur our experience to make life more manageable? Our ongoing struggle with psychological distress has deep historical roots as explained in Part 1 of this chapter: for centuries protection from emotional pain has been sought, sometimes by using alcohol and other mood altering drugs. How much upset can be tolerated?

### *Holding the tensions created by dilemmas and seeking ways forward: the opportunity to think and build together*

When there are contradictory viewpoints about understanding a client's mental health, either at the level of causal origin or treatment, this is not helpful and can be exploited. There is the potential here for splitting – one professional may hold more client information than another, and the parents (professionals) are arguing about the child (client).



A battle for professional dominance or control of the client's mental health can then ensue. For example, the psychiatrist can change medication sometimes saying to the client that they will need to be on these pills for the rest of their life. Meanwhile the psychologist can be working collaboratively with the client to increase their understanding of their behaviour so they can learn to manage independently.

Many versions of the above can occur thereby creating a number of dilemmas which will not be helpful for the client. However, just as in any interpersonal situation with appropriate communication between the professionals concerned, who are respectful of each other's contribution and consistently open with the client, a helpful situation can be created. Like any relationship milieu, these connections need to be maintained via meetings and conversations which are time consuming. The focus must rest on the client's improved situation and not become a battlefield for inter-professional warfare.

There are various examples of inter-professional working where therapist and client realise together that the client cannot manage their experience without the help of the psychiatrist's prescription and a team of community mental health nurses. When meetings amongst professionals can occur about a client's case, then the stage can be set for something productive to occur. One of the hopeful aspects of such a relationship is that there is the opportunity for something to be created that is more than each person's individual contribution. Professionals are charged with holding the tensions of difference and yet must still work in clients' best interests.

In search of this productive meeting place, the chapter now turns to consider aspects of psychopathology as expressed by an NHS psychiatrist in conversation with the authors. Diagnosis, medication, care and cure make up the focus of the discussion and these concepts thread through subsequent chapters. It must be acknowledged here that this conversation could have been different if the psychiatrist had held views at other points along the continuum of a possible emphasis on biological and psycho-social factors. However, in the authors' views it is through the medium of shared inter-professional thinking and discussion that clients will benefit from enhanced practice. The psychiatrist was asked previously agreed questions, and these are highlighted in the larger type below.

### **Part 3: The Authors' Conversation with an NHS Psychiatrist Follows (Carole Lund)**

*Psychiatrists have different foci in their practice. Would you say that you have a particular emphasis? And is that as a result of your training and experience?*

I would say that I like to think that I have a fairly flexible approach personally. In the general field of psychiatry, yes there are some psychiatrists who you would say were definitely more biological, and some who are more psychological. I would certainly consider biological aspects of people's presentation, but also try to look at where they

are at psychologically, and also in terms of what stage of life they are at and their social situation. Issues are perhaps to do with housing, finances, or the criminal justice system, or immigration. I would like to feel that I have a fairly broad approach that could be adaptable depending on the person's presentation. In essence that does to some extent come from training and experience. I set out to work in as many different fields of psychiatry as I could, to get the widest training possible and I qualified in an age when training was slightly longer. Seeing different fields of expertise is helpful in enabling you then to be able to take a wider view of the problems that are presented to you.

### *Questions about diagnosis and formulation*

*How central is the concept of diagnosis to your work?*

Coming from a framework of psychiatry one is very much trained to make a diagnosis, and I think there are pros and cons to that. It is useful to have a framework to enable you to get your head around the patient's presenting problems and how you might help them. I would like to think that I made a diagnosis at a time when I felt comfortable doing so, and I wouldn't necessarily see a person for the first time and feel that I could make a diagnosis. There are risks of jumping in to making a diagnosis too soon without a thorough assessment and thoroughly thinking out what you are actually doing, because I think there is a risk of labelling somebody, and that then becomes set in concrete and follows them around. I think it is not to be taken lightly.

*I am also curious about formulation and where and how that sits in terms of your work or work with colleagues. Does it feature at all?*

I think both are important really. Part of my job is to come to a diagnosis. The diagnosis is not necessarily the be-all and end-all, the formulation is also important. In our training we have to make formulations of people's presentations, and we still talk about formulations of their presenting problems.

*So within your psychiatric training the concept of formulation is also present?*

Yes, I mean I was talking more about formulation in the sense of looking at the psychological, social, developmental, and biological, rather than from a theoretical model.

*Well I suppose in psychology, we might think of it as being model driven, for example as a psychodynamic or CBT formulation.*

Where I trained, the psychotherapy experience we had as junior doctors was more psychodynamically orientated, whereas I think that has been superseded now by more CBT formulations.

I would say that on the whole, I am generally surprised at how accepting most people are of their diagnosis. I think sometimes how you actually explain what you think the diagnosis is and how you come to it may influence how people accept your explanation.

*It seems that you are saying that the interaction around the explanation is nearly as important as the diagnosis?*

Yes, maybe some diagnoses are seen as undesirable or negative. However, if you can explain to somebody what that actually means in a sensitive way, then you can explain most things to most people if you are prepared to do it in a well thought out fashion and considerately. I've generally found when you do explain, that most people say 'gosh that is me'. I've actually read paragraphs out of the *International Classification of Diseases* (ICD) to people and they said 'that is me to a tee'; then I think they are quite relieved that they are not the only person feeling this way and there is help available.

Certain diagnoses are more fashionable. For example, people now come saying 'I've got bipolar disorder'. They will come with material from the internet; it is a mixed blessing. It can be helpful for some people to realise there are other people who self-harm, that they are not alone and relief is available. Equally, there can be unhelpful sites, telling people how to kill or harm themselves.

*What is your view of co-morbidity?*

People don't always present with clear-cut diagnoses and often have multi-factorial problems. I see more and more people who have multi-layered problems, co-morbidities and physical illness, psychological illness, psychiatric, drug and alcohol problems all together. Different aspects of the problem form interlocking circles that all fit together. I think it helps to have a framework. Whether you then digress from the framework as you get more knowledgeable and experienced, or you look at different approaches or whatever, it helps to have some kind of framework for what you are doing, so in that sense I think it is useful.

### *Questions about working with other professionals*

*What is your view on a referral for psychological work?*

I do refer people for psychological work. I would refer more people for psychology than other consultants in my position. I suppose I do feel that psychology has a lot to offer. It is very difficult to put people's problems simply and say 'your problem needs a pill' or 'your problem needs psychology'. So I would say that probably my referral rate for psychology is quite high. I think we desperately need more psychology, not only because of the complexity of the cases but also because of the complexity of the

psychological work and the time constraints. Even if I feel I can do some quite basic work myself, I don't always have the capacity to really do that in practice.

*It seems like many years ago psychiatrists carried out psychodynamic therapy and now there are all these psychological therapists around. Is there an element that psychiatry would like to reclaim some of that?*

Well, yes, I would actually agree with you. I'm not setting myself up as any kind of expert in psychological therapy, but I think there was more capacity at one time to have longer appointments to take on certain individual patients for more psychological work. Now I think the demands on time almost pigeon-hole you into being a prescribing doctor, as opposed to somebody who has wider skills, and that can be one of the most frustrating elements of this job.

If we had more multi-disciplinary working, and more time and less demands, then I think more of this kind of work could be done. I think it is useful and valuable to see different people's perspectives on patients' presenting problems.

Sometimes it can become quite isolating sitting in an out-patients clinic, seeing 10 to 12 people in a morning. It can be stimulating and refreshing to have others' perspectives and to formulate people's problems slightly differently. The important thing is flexibility: I think it only works well if people are not too dogmatic in their views.

I tend to feel there are different roads from A to B, and so long as you get from A to B, some roads will suit some people better than others, and some roads may get there more quickly than others. If there are people who are so entrenched in their own model or their own perspective that they are not prepared to be a little bit flexible it can be difficult. If somebody says 'I am not going to see anybody who is on medication' I think that sometimes that can be quite difficult. I might really feel that somebody actually really needs that medication.

The pressure to discharge is increasingly becoming an issue. It sometimes leads to tensions as to when people are exactly ready to be discharged. The community team may discharge, but then patients come back to the out-patients' clinic.

*Is it a modern-day equivalent of the revolving door?*

Well I suppose it is really. I think it pervades most of medicine now, the idea that if you go and make an appointment to see your GP, you go with one problem. One appointment equals one problem and you get so many minutes, then you have to go and make another appointment to talk about another problem. You come with this particular issue and we give you six sessions of this, and then you wait six months and if that is not enough you come back and have six sessions of that.

*Does that over-emphasise the problem?*

It is difficult because we go into areas of funding, and how that is developing and what you will get paid for, what your illness is and how soon you should get better. It's a bit like going into hospital for a gall-bladder operation. Most people are ready to go home in five days, so the budget is for that and if you stay longer, gosh! That's coming into psychiatry too: if you come with depression you should have six sessions of the psychiatrist's time, two different anti-depressants, and so many sessions of CBT, and you should be better by then. I am not sure with people it is always as easy as that, really.

*Questions about the use of medication*

*Medication is the province of the psychiatrist. Do you think that psychologists should know about medication and its possible effects?*

I don't think psychologists need a huge in-depth knowledge of medication, but it must be helpful to have some idea of what people are talking about, an idea that this could be something to do with medication, or maybe they need to ask somebody who knows about medication. I think a basic knowledge would be helpful.

I am not sure that psychologists want to actually be dealing with other people's medication and side effects, or physical investigations. Where does it begin and end? It is helpful though to have an understanding of what patients say, for example, 'I'm on such a drug.'

I don't think we can all be experts in every field, can we? There is a risk of making everybody a generic worker so that you actually de-skill people in the fields in which they really need the expertise. I would prefer to work with a psychologist who was really good at doing psychology, than somebody who was prescribing medication.

*In your view, do some patients think that medication will cure them?*

The basic answer is yes. Some people do come along with the expectation that you will give them a pill and that would be the answer to all their problems and everything would go away with the pill. I do have to spend time explaining to people that it is not as simple as that, that it is not a magic cure, a magic pill, which it is not going to take all the ills away. It will help, it will help control some of the symptoms, but it is not the whole story, it is not black and white. Comparing in the sense maybe to asthma and diabetes, medication controls the illness, it does not always cure it as such. You can get rid of the respiratory distress or the high blood sugar in the first instance. Without the medication, your symptoms would come back.

*In therapy sessions the medication can form quite a focal point.*

Some people do focus very much on the medication and not on other issues, rather than talk maybe about what they could do to help themselves, or maybe where some of the problems come from and how they could address some of the difficulties either psychologically or practically. Sometimes to focus on the pill is less threatening. Many people feel that you can give them an answer, whether it is a pill or a few magic words.

*Is there a different understanding about medication amongst members of the Community Mental Health Team (CMHT)?*

I think it is complicated really. Certainly in terms of the social workers, the Community Psychiatric Nurses (CPNs), the occupational therapists, some of them (particularly the nurses) obviously have a good understanding of medication, side effects and use of medication, and in fact they are advising on and delivering medication. It can be very helpful to have people doing that role who understand medication, and I think sometimes problems do arise, maybe with some colleagues from other disciplines who don't really understand medication and haven't a huge interest in understanding it. Medication management is quite a big part of the CMHT's role. Sometimes questions are referred back to me, whereas someone with a little more knowledge of medication could answer without necessarily needing me.

*The way you are describing it, it's like medication becomes one part of a complex story. Moving on then, what do you find is the most challenging patient presenting issue?*

I am not sure how I would answer that in terms of patient presenting issues, I think the most challenging issues to do with patients are availability and access to community resources, timing, the availability of a psychology intervention; more political and funding issues. The biggest challenges to me personally are to do with the politics of service provision rather than the patient's presenting issues.

*Someone might fall between two services: for example, borderline, wouldn't be accepted onto an IAPT service, or secondary care wasn't prepared to see them either. Almost the politics of practice?*

This can be the case.

### *Questions about care or cure*

*What expectancies of getting better do you have for the patient? Do you hold a model of symptom management or recovery and relapse?*

This is difficult isn't it, what is getting better? I really believe that everybody who we see can be helped in the right kind of way, and that with the right kind of help

and support from the system, people can improve. People can not only improve in terms of their health, they can also improve in terms of where they are in their life, in terms of what they are doing, the path that they are taking, the decisions they are making. I do think that people can improve, they can make positive changes. It is this issue of cure. Although we can be positive, we have to accept there are some people who have long-term disabilities related to their mental health. To expect that everybody will get cured or better or recover completely is not realistic, and in a sense this can do people rather a disservice. Long-term illnesses like schizophrenia have long-term consequences, and I think sometimes that people can be done a disservice by not recognising that really.

For some people, it is unrealistic to think they will be able to return to full-time paid employment, or that they will be able to become self-sufficient in all aspects of caring for themselves. I sometimes worry that people who are disabled by their illnesses are not going to get the recognition or the help that they need to make the best of their lives, as if we are somehow putting an expectation on them that they will get better and somehow that if they don't get better it is some kind of failure almost either of them or of the system.

*It sounds as if you're saying let's take the emphasis off getting better or cure, let's look at how help means more comfortable living.*

If somebody is obviously presenting and complaining of hearing voices, then that is what they want to address. However, they may be living in totally unhygienic, squalid conditions. Getting better for them might mean getting rid of the voices, but maybe getting better for you is an element of improved social living conditions and care. I think that sometimes it is important to listen to somebody's opinion of getting better. Sometimes there are other dimensions of getting better, aren't there, that maybe the professional sees but the patient doesn't?

*So it is not just the meaning to the patient, it is the meaning in a more professional overview?*

I suppose, yes, without necessarily wanting to inflict your standards and perceptions on somebody else, but making sure they are not living in conditions which are totally unsanitary or putting themselves at risk.

*So what might trigger a relapse?*

Increased stress, non-compliance with medication, drug and alcohol issues, adverse life events, a lack of social support. Stress is a big trigger. They often all go together too: if you are more stressed maybe you drink more, maybe you don't take your tablets. Physical ill-health with chronic pain and disability can have a knock-on effect.

*To what extent do you think that knowledge of those things you have just said, how can these be preventative, is there some psycho-educational aspect?*

I think certainly: talking to people about the importance of not misusing drugs, keeping their alcohol use in check, making sure that they eat nutritionally balanced meals, take exercise, rest, don't take on too many commitments. Also looking out for early warning signs such as not coping as well as usual, and then getting help sooner rather than later, rather than leaving it until there is a crisis.

### *Questions about guidelines and protocols*

*So, turning now to the NICE Guidelines ...*

They can be a double-edged sword, helpful, and also issues can arise. For example, my own personal view would be that the pendulum has swung maybe a little too far in terms of CBT, so that this is seen as the therapy for everything. I do really think that other therapies, interpersonal therapy, brief psychodynamic therapy, can be useful for people, and it is a shame that choice is almost being narrowed down to just CBT.

*So there is a certain tension there?*

We have touched upon what we said about patients and their relatives researching on the internet, coming in with articles and information. Some people come along saying that they have read that they should be having this and can you provide it? Is this or that available, can everybody have CBT, can everybody have this particular medication? There is publicity from drug companies too, saying for example that this medication you only have once a month, so can we have that? And why isn't your particular Trust giving it? Increasingly there are these kinds of issues.

I don't think it is altogether a bad thing if people challenge you about what you are doing, and what you are providing, and what the service is providing. It can be quite a good thing, because it can actually make you think about what you are doing, go and look at the research, and go and look at some of the ideas that maybe you have not heard of before, consider again what is in the NICE Guidelines. It actually can be more satisfying to have a discussion about the pros and cons of this and that approach, this and that medication. It's not necessarily a bad thing, but it is time consuming.

*In a relationship can you build a little collaboration?*

If people participate a little more in the decision, they can take better ownership.

In terms of making changes for the benefit of patients this is a humanitarian approach. I suppose I can become concerned about us becoming too assessment,



tick box, packages of care orientated that we miss out on the basic humanity of dealing with distressed people. We are not just dealing with a commodity that can be shunted from A to B, and given C, and sent off into D. We are dealing with real people with real lives, and real families and real distress. While I think, as I have said, some frameworks and guidelines can be helpful, sometimes staff can become frustrated with the demands that are placed on them. There is a risk of losing an element of caring and that should be what actually informs the decisions you make. I don't think it is just in psychiatry, maybe even more in the general hospital.

*Some of the protocols can get in the way?*

I think they can almost become the focus. We must have all this paperwork filled in, and such angst goes into that, rather than really going into the bread and butter of what the service is about, which is about treating ill people, not filling in swathes of paperwork. It is important to keep coming back to the person, not to lose the focus.

*In conclusion*

Our conversation ended at this point, aware that a number of professions are located in a working context that brings its own perspectives on the politics of care. Wehowsky (2000) is perhaps primarily concerned with the debates around the use and misuse of diagnosis, however he does recognise the association with the resource that can be generated by appropriate diagnosis. At times in the conversation there were parallels between psychology, psychotherapy and psychiatry in the pressures coming from time constraints and resourcing, differing theoretical models, and protocols of practice.

In each of the preceding parts, there are references made to the politics of care and how this can overlay what was described in the dialogue as a humanitarian approach. It is from this point that the chapters that follow now turn to consider seven presenting issues that people experience and bring to psychotherapy in a range of contexts, and establish the history, dilemmas, practice and research relevant to each. The practice and research sections (Part 3) of each chapter have been written by seven different practitioners in order that the reader is exposed to a range of contexts and models in which therapy takes place. The ways in which these influence, and are reflected in, the nature of the therapeutic endeavour are something that as practitioners we often overlook within the immediacy of the therapy room. We hope this is something that the reader may wish to consider.

### REFLECTION BOX

- 1 Do you think that Mercier's statement about nineteenth-century psychiatry has any relevance for current psychological therapies' provision?
- 2 How does the cultural and organisational context in which you and your client work together impact on, and reflect, your values and therapeutic relationship?
- 3 In your working experience, what terminology is used to describe those who work therapeutically with clients/patients? Do you think that the naming of professionals is a concern for clients?
- 4 What kinds of dilemmas have arisen in your multi-professional working context?
- 5 What do you understand by the terms 'diagnosis' and 'formulation' and their uses?
- 6 What perspective do you have on the use of medication in your practice with clients?