

Alternative ways of working

John Hall and John Marzillier wrap up the opinion special with some constructive suggestions for moving the agenda on

The Layard analysis spawned the Improving Access to Psychological Therapies (IAPT) initiatives that are transforming the way psychological therapies are delivered in the NHS (Clark & Turpin, 2008). Their aim is to improve access to effective psychological therapies, particularly for the anxious and depressed who constitute the majority of those with mental health problems. This aim may be laudable but, as we showed in our first article, the analysis that led to it is significantly flawed.

In this article we pull together our own thoughts and some points from the other articles in this issue in order to suggest a constructive alternative to the IAPT programmes. The question we asked ourselves is what we, as psychologists, would do differently. Our answer is governed by four fundamental beliefs. Firstly, that psychological science should be the driving force in our understanding and treatment of people with mental health problems. Secondly, that psychological treatment should be not reduced to a set of techniques. Thirdly, that evidence-based psychotherapies, in particular the way the NICE guidelines are interpreted, should not distort the sort of service that people with mental health problems need. Fourthly, that people must have a genuine

choice of a range of possible interventions.

The importance of psychology

Psychology provides a knowledge base that has implications for mental health far beyond the quasi-medical models that underpin therapies like CBT (see Gilbert, this issue). For example, the assumption that mental health problems are exclusively attributes of the person ('symptoms' in the language of medicine) and that with appropriate help individuals can overcome their problems ('get better') needs to be challenged. The major mental health problems, anxiety and depression, should be seen in the context of growing income inequalities, changing patterns of family life, increasing job insecurity, the influence of the media on people's expectations and wants, social pressures and stresses, as well as a range of physical conditions and illnesses that directly and indirectly affect mood and well-being. Curiously, Richard Layard himself is far from unaware of the importance of social and economic factors as his popular book on happiness shows (Layard, 2005). It is important that psychologists point out that, for many, depression and anxiety are products of the society in which they live and are not an individual fault or pathology. A sense of powerlessness, commonly part of

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depression but also prevalent in many other conditions, is not just a problem of misattribution or faulty thinking. Sometimes it is a realistic perception resulting from social and economic deprivation or being trapped in an abusive relationship.

Focusing exclusively on a person's internal world fails to do justice to what it may be to also live in a difficult external world. One implication is that individual therapy is not always the best way of helping people. As Paul Gilbert noted, this has led some psychologists to work more with communities and social groups, seeking to empower individuals to affect social change (Orford, 2008). This is not necessarily an 'either-or' choice, as White (2008) has shown in his community work in Glasgow. Both can be done, at least at a basic level.

The role of attachment and the therapeutic alliance

The strength of psychology is that it offers a broad knowledge base that can be drawn upon to improve the way we understand and treat mental health problems. Consider attachment theory as one example. Research has shown how difficult attachments in early life can affect later ones and how current problematic attachments underpin a range of mental health conditions like agoraphobia, social anxiety, personality disorder and depression (Holmes, 2001). Equally, it has long been known that one of the key protections against depression and other mental health problems is having good social support. This underlines the huge importance of the social context, whatever might be done in individual therapy. Some forms of therapy incorporate the social context into the treatment, such as couples, group or family therapy. What this points to is an alternative to the medical paradigm that focuses primarily on symptom change. A consideration of attachments, both within and outside of therapy, provides a more psychologically sophisticated model

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of what help might be given and how it might work.

Prioritising techniques as the main (sometimes the only) factor in what works fails to acknowledge the importance of the therapeutic alliance. Therapists, CBT therapists among them, recognise that a strong working alliance is necessary whatever techniques are used. Psychodynamic therapists seek to explore the dynamics underlying the attachment history, paying careful attention to the therapeutic relationship (see Casement, this issue). The personal relationship between patient and therapist is not merely an incidental feature of delivering techniques but a key component in psychoanalytic work. It has been argued that most successful therapists are particularly attuned to the interpersonal relationship, whatever therapy they adopt (Miller et al., 2007). Helping people is a complex business. Communication between therapist and patient, as Casement shows, can at times be more than the rational process of the patient presenting a problem and the therapist offering a method of helping. There is another level of irrational, unconscious communication that psychodynamic therapists have long understood. One implication is that we should not simply assume that when a patient presents with a problem, this is all there is to the request for help. This is why, as we show below, care must be taken to arrive at a considered psychological understanding rather than plunge directly into therapy.

What may be done in practice

The knowledge, understanding and skills of applied psychologists (irrespective of whether they have initially trained as a clinical, counselling, health or other form of psychologist) are central to the application of psychological procedures. They should offer the capacity to draw upon the range of insights from the basic discipline (gained in their undergraduate degree), the range of competencies acquired in specialised postgraduate training, and the flexibility to adapt their practice in the light of new theory and evidence, as envisioned in *New Ways of Working for Applied Psychologists* (Lavender & Hope, 2007).

This translates into opportunities for a two-step process. First, clinicians should carry out a careful and broad-based assessment of the presenting problem or problems for all patients, leading to a formulation. The second step is then to create a branching decision tree that identifies possible intervention strategies and their consequences, informed by

patient choice, which is itself a current policy objective of the Department of Health.

Formulation

Formulation is the bedrock of any intervention. The aim is to make psychological sense of the problem or problems, taking the context into account. Arriving at a formulation occurs at or near the beginning of therapy, but to some degree goes on throughout it. The type of formulation will reflect the psychological model the therapist holds, though some features are common to all therapies. What is required is:

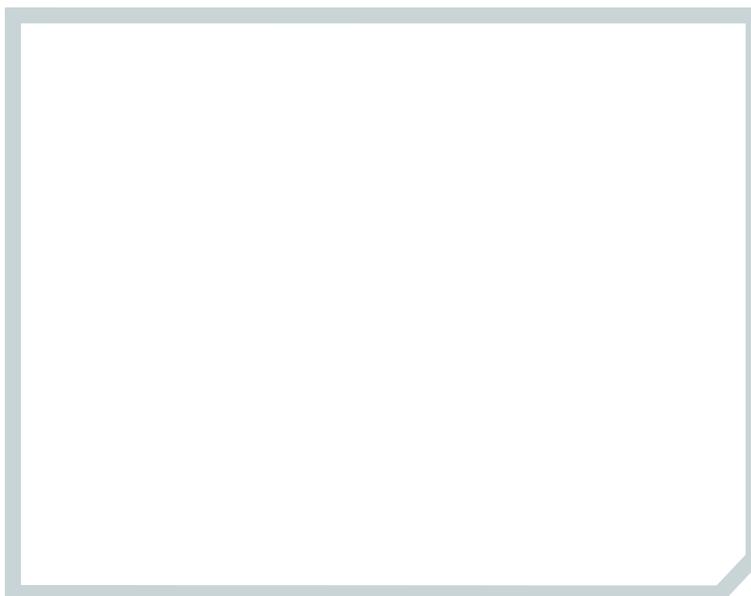
- | A comprehensive assessment of problems, including what may have caused them and what might be maintaining them, the possible contribution of key personal events and personal history, the influence of the family and the presence of financial and social constraints on change (such as unemployment), and the consequences of these problems for their everyday functioning.
- | An assessment of the patient's expectations, bearing in mind their history of contact with the helping services and how realistic or unrealistic those expectations may be. This leads to consideration of the degree to which a therapeutic alliance is possible.

Arriving at a formulation often takes more than one session, a contrast to the approach where patients are immediately assigned to therapy on the basis of a diagnostic label. We argue that a formulation can save time, for example, where patients are not taken on for therapy when they are unlikely to benefit from it or when it leads to a clearer idea of what will work best. Patient choice depends on informed consent and a formulation provides the information to make that choice.

Decision tree on possible interventions

There are five major options that arise after a formulation:

- | No treatment. It is important not to offer an intervention to people who do not require it, counteracting the pervasive myth that there is a psychological treatment for everything.
- | Creating a therapeutic alliance. One interpretation of psychological therapy research is that a therapeutic relationship is beneficial in itself, and crucially releases and facilitates the capacity of the individual to resolve their problems from their own resources, without needing to employ formal interventions.
- | Seeking social and community support. When financial or social factors are



prominent in the formulation, then they may need to be addressed directly by providing social and community support. This ensures that the person is accessing both the forms of economic support to which they are entitled and receiving support in the community.

- | A specific psychological intervention. Here the question of patient choice and the availability of diverse therapies comes into play (see below)
- | Help by another profession. The most obvious example is medical or psychiatric help, which will itself involve adequate assessment and formulation of diagnoses that incorporate physical, mental and social factors, and in turn lead to a range of possible medical treatments. A recent

'wake-up' article by a large number of psychiatrists makes this point most strikingly, adopting a line of argument strikingly complementary to this article (Craddock et al., 2008).

Psychological interventions – what may be offered and why

Offering a psychological therapy is not simply a technology: there is evidence that individual patients will engage better with a therapy that is conceptually consistent with their own values and beliefs, although those views and values may themselves be modified. For all these reasons, a comprehensive psychological therapy service should be able to offer a range of therapeutic modalities, in addition to CBT. Among the other most important alternative forms of psychological therapy are systemic family therapy and therapy informed by psychodynamic principles, including the hybrid cognitive-analytic therapy. In addition some innovative forms of therapy, such as the increasingly significant mindfulness therapy, should be available, and other problem-specific interventions for conditions such as psychological trauma. Moreover, the choice of therapies rests not only on their evidence base, but also on their value base. Current work on values-based practice in mental health suggests it helps to improve understanding of differences in values between team members, and also to understand the particular and often very different values of individual patients and carers (Woodbridge & Fulford, 2004). Values-based practice is complementary to evidence-based practice, but equally a values-based approach is adding something over and above evidence alone.

There is as yet no guidance on what proportion of the total therapeutic resource should be assigned to any one therapeutic approach, and this will obviously vary with local demography and with the nature of any local specialised services. Planning a balanced psychological therapy service involves weighing the evidence and values supporting different modalities, and the opportunity for some real choice for patients. If there is to be choice, there must be diversity.

Recognising diversity and complexity

Two groups present particular challenges. Eight per cent of the population of Britain is from an ethnic minority: this suggests that psychological therapists should be

available who can not only conduct therapy in at least the most common minority languages in their area, but also adopt and modify therapies to be more compatible with non-Western modes of thought. Others are 'socially excluded' for a variety of reasons, of which income poverty is one of the most common, but other factors are poor work skills, discrimination and poor housing. Those with severe mental health problems are at high risk of social exclusion; accordingly services should be proactive not only in offering initial contact, but also in maintaining engagement. Services for this latter group are now often based on a recovery model, with an emphasis on long-term contact that may not be aimed at achieving positive change in conventional outcome terms.

As the IAPT programme is rolling out, it is dominating the way in which mental health trusts and primary care trusts conceive of the pattern of their overall psychological therapies services. The privileging of primary care services distorts the allocation of psychological resources to these more complex cases, most seriously in the provision of psychological therapies within inpatient settings, where the lack of provision in some trusts is scandalous.

Therapeutic expertise

Whatever the evidence and values supporting an intervention, it must then be conducted by a therapist experienced at a level consistent with the severity of the presented problem. There is a place for less skilled therapists able to offer structured self-help and brief interventions for mild and moderate problems, where the assessment and formulation indicates that is likely to be beneficial. That is a strength of the IAPT programme. For more severe and complex problems, therapists must have the expertise both to deliver a formal intervention following the protocols of the approach, but also to modify that intervention when, after perhaps a few

sessions, a reformulation suggests that alternative strategies may be needed.

Summary

Psychologists offer more than therapeutic skills to the healthcare system. They offer the capacity to draw upon a range of ways of conceptualising human problems, and to formulate the presenting psychological problems of individuals – and communities – in a way that takes account of their unique multidimensional complexity. One outcome of a formulation may be that no psychological intervention is appropriate. Psychologists should not be colluding with the wish of either individuals or governments for a quick fix. They should be cooperating with other people and agencies to provide a mix of interventions that meets people at their point of need.

A range of psychological therapies is required to meet the multiple criteria of evidence-based and values-based practice, and to allow real choice for patients. Patient choice depends on informed consent, and a formulation provides the information to make that choice. If choices are to be equitably available, the allocation of psychological resources should be balanced

between those with mild and moderate problems, and those with severe and complex problems.

The IAPT agenda can be seen as an unparalleled opportunity to provide an accessible CBT service to many people through primary-care services. It can also be seen as carrying the risk of offering inappropriate interventions to those with other problems alongside a psychological problem. It creates a challenge to see beyond conventional ways of responding to some human problems, and it invigorates the debate on the provision of psychological therapies.

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