DISEASE AND PSYCHOTHERAPY

Inputs and Outcomes: The Medical Model and Professionalisation

Nick Totton

In a March 1996 article in the *Independent on Sunday* Dr Peter Fenwick, described as 'one of Britain's leading psychiatrists', had this to say: 'One in ten people will suffer some mental illness at some time in their lives. The other ninety per cent are, medically speaking, mentally healthy. Yet in practical terms, the fact that these people are not actually mentally ill tells us nothing about how well they are. It gives no indication of how fulfilling they find their lives, how successfully they actually run them... There are plenty of people who tolerate chronic, low-grade unhappiness in their jobs or relationships for years. Few of these people are ever likely to come to the attention of a psychiatrist, but their mental health is well below par.'

This is about as extreme a statement as one could easily imagine of the medical model of human psychology. Not satisfied with the claim of medicine to handle the ten per cent of people who get defined as 'mentally ill', Dr Fenwick makes an extended bid: '... the fact that these people are not actually mentally ill tells us nothing about how well they are.'

It's a nifty piece of footwork, borrowing from the discourse of holistic approaches: wellness is more than just not being ill. Very true; but only relevant to mental and emotional states if we grant the original claim, the assertion that 'medically speaking' is the appropriate way to speak about these states. And there's another discourse being touched on here: the business-oriented discourse of self-improvement, where what we do with our lives is 'run' them, successfully or otherwise. This dovetails with the practical moralism of the last phrase: 'their mental health is...' (here a regretful tut from the crusty-but-kindly

Nick Totton is a therapist and trainer based in Leeds. With Em Edmondson he is co-founder of Selfheal, an initiative in therapy and healing, and co-author of Reichian Growth Work *(Prism Press).*

practitioner, from the 'patient' a guilty hanging of the head) '. . . well below par.'

The psychiatrist proceeds to lay out his stall: 'But is there an equivalent of a healthy eating and exercise regime for the body to improve our mental state? I believe there is. We now know enough about how the mind works to make any necessary changes in our lives and thinking to achieve a sustained sense of what I call mental well-being.'

This is wonderful: psychiatrists, it turns out — the 'we' who 'know how the mind works' — are not only the people to go to if your life becomes difficult, they are also the experts on *how to live*. It is perfectly healthy,' Peter Fenwick tells us, 'occasionally to feel sad, lonely, irritated or valueless; it isn't healthy to have these feelings constantly.' Gee, thanks, Doc.

What we have to get a grip on here is that this sort of stuff is being taken seriously. Peter Fenwick's article (and Dr Fenwick is generally considered a radical anti-reductionist in his own field) launched a massive series on 'The Dynamics of Change', with flags and whistles. Representatives of Freudian, Jungian and other schools wrote in, not to question the good doctor's viewpoint ('characteristically fascinating', said Anne Zachary of the British Confederation of Psychotherapists) but simply to plug their own enterprises. One hundred years of psychotherapy, and we still don't seem to have grasped that it's different from 'healthy eating and exercise'.

Professionalisation

The reason why this is being taken seriously by people who quite certainly know better is, of course, 'professionalisation'. Those who wrote in to the *Independent on Sunday* did so in order to remain competitive in the market place which is trying to install itself at the centre of the psychotherapy and counselling world. There are now far too many trained practitioners out there looking for work and, if the bubble is not to burst, new markets must be opened up, new punters must be persuaded that they need the product. If the state and other institutions can be persuaded to pay for it so much the better; but for these things to happen, therapy and counselling must present themselves as medical.

One of the clearest opponents of the medical model in psychotherapy, oddly enough, was Freud — the man who started it off, and who in some ways loaded it with its freight of medical culture and terminology. Freud militantly opposed the idea that to be a psychoanalyst one should be required to have medical training; in the postscript to his work on the subject, *The Question of Lay Analysis*, he says most emphatically that psychoanalysis is not a specialised branch of medicine.

I cannot see how it is possible to dispute this. Many practitioners have done so, however, starting with a large proportion of Freud's colleagues; and here again the clear motive has always been professional status. One result is that those seen as most highly qualified to deal with the most extreme mental/emotional states are precisely those likely to have the least training in psychotherapy: psychiatrists. A more general result is the almost universal, almost automatic acceptance that an appropriate venue for state-funded counselling and psychotherapy is the National *Health* Service. 'Counselling in Primary Care' has become a major specialisation in the field, and I want to consider some of the effects of this development.

I need to say straight away that I have no personal experience of working in this context; and in no way do I want to seem dismissive of those who do. One very obvious and beneficial effect is that free-to-the-client counselling is getting to a lot of people who can benefit from it. The rise of counselling in GP practices, for example, is the result of a lot of hard work by very well-intentioned people (as well as by those concerned with status and income — and often, of course, good intentions and self-interest can run in tandem); and it is undoubtedly helping a large number of clients. Having said that, though, I want to look at some rather more subtle drawbacks and disadvantages of the phenomenon; and to use what is happening in the USA with 'managed care' as an example of the potential dangers of the situation.

The Medical Model

The fundamental problem with working in a medical context is that you are working within the medical model — however much you may personally disown and ignore that model, the institution which gives you a home and provides your pay cheque subscribes to it, and you cannot be immune to the effects of this on your work. For one thing, you become liable to forms of measurement of your effectiveness which may seem to you wholly irrelevant. (At first, anyway: you need a good deal of intellectual confidence to argue against this approach, and may find your views weakening.) You become subject to 'outcome research', which is widely held to be inapplicable to psychotherapy and counselling, in that the really relevant outcomes are not measurable. The effectiveness of your work will tend to be judged by how fast you can get rid of people, and how long they stay away.

This sort of measurement is perfectly appropriate to at least some forms of medicine. Medical practice really is more effective if someone with a chronic pain stops complaining of it and doesn't come back to surgery. (Though even here there is room for argument.) In a counselling context, however, we all know that it's not that simple. Counselling may be very effective and successful if a client starts complaining about a lot of things that they have endured or ignored for years. It may well be splendidly effective if after six sessions someone is 'feeling much worse' — that is, owning pain that they have previously been denying. And six sessions may be all you get.

This is one of the more obvious results of working in a medical context — or indeed any other publicly or institutionally funded context. There is tremendous pressure to finish with people quickly, that is, after six or twelve or if you are extremely lucky twenty-four sessions. An entire body of theory about 'Brief Therapy' has grown up, basically in order to justify the operational need for short-term work. (And, of course, to provide more jobs for trainers.) Claims that this work is as effective as, or even more effective than, long-term work are fundamentally circular, because they measure 'effectiveness' only in terms which are appropriate to short-term work, for example alleviation of symptoms or greater enthusiasm for life.

Now it is well known in the therapy world that after a few sessions people tend to feel either much better — because of the large amount of unconditional attention they're getting, because they're being taken seriously, because they can see new ways of starting to make sense of things; or

much worse — because they're opening up huge areas of pain and misery which they've been ignoring for years. These areas of pain may badly need opening up, as long as there's the opportunity for long-term work. But of course any competent practitioner will steer well away from such areas if they know they and the client only have a few hours to spend together. *Ergo* the client feels much better. Whether any real change has taken place is a different matter.

I don't believe that structural change can happen in human beings through a few weeks' work. Of course there is always the possibility than someone will arrive to see you at just the point when change is ready to take place; and either or both of you may believe it was the therapy that brought it about. But to alter structures we have built up over years generally takes further years, years of hard work.

We may conclude from this that therapy and counselling aren't worth much. It depends what we expected in the first place! In other words, it depends on our model of the therapeutic process, our understanding of human nature and its relation to society, and many other things that are neither obvious nor simple, but which are in my view enormously important in making sense of what we're doing and what we want to do.

Managed Care

We may be able to learn a lot from the US experience of 'managed care'. Howls of anguish have been appearing about this on the Internet for some time, on discussion lists for psychotherapy professionals of various kinds. The best account I have come across is on a Web page run by John A. Martin, a licensed clinical psychologist from California and 'author of well over 100 published papers and public presentations in the areas of developmental psychology, clinical psychology and research methodology'. According to him: 'In the 1970s, psychologists finally won recognition by insurance companies that had until that time been afforded only to psychiatrists . . . and thus became eligible for insurance reimbursement for their services. In entering into the world of third-party reimbursement, psychologists were required to adopt psychiatry's manual of mental disorders, the *Diagnostic and Statistical Manual*. Each time an invoice for a psychologist's services was submitted to an insurance company for reimbursement, a 5-digit diagnostic code was included [which] defined the client's problems within the disease model . . . Though many psychologists were uncomfortable with using disease classifications for many of their clients, insurance reimbursement demanded it.

'In an effort by insurers to contain costs, most insurance companies currently hire intermediary 'managed care' companies to . . . exercise control over how insurance money is spent for psychotherapy services. Psychologists . . . are under contract with the managed care companies to provide 'medically necessary treatment for mental and nervous disorders' for subscribers, that is, specifically to treat the disorders or conditions described in the diagnoses. In general, these managed care contracts set providers' fees and require providers (1) to provide treatment to any and all subscribers who are referred to them, (2) to submit detailed information about the course of treatment to the managed care company for evaluation and review, (3) to abide by the managed care company's final deci-

sion concerning whether treatment is in fact necessary, (4) to refrain from informing clients about alternative treatment options that may contradict the decisions of the managed care company, and (5) to absolve the managed care company of any legal or ethical responsibility in the event that the client believes that he or she has been harmed by failure to obtain adequate treatment.

'Providers are expected to design treatment strategies that help the managed care company to contain costs, whether or not the provider feels that lower-cost treatment strategies are appropriate. In essence, providers are expected to limit treatment to that which is deemed by the managed care company as being 'medically necessary', and are at risk for cancellation of their contracts if they fail to do so in a consistent and cost-effective way.

'Consequently, under the new managed care model, it's important to understand that psychotherapy clients are considered sick. It's also important to understand that the client–therapist relationship is not protected: clients now must sign away their right to confidentiality, and providers must give case-managers who are employed by the managed care companies detailed information about their clients' lives and the course of treatment.'

All this may be horrifying to us; but it is, of course, eminently logical and even fair from the point of view of the insurance companies. If the problems for which someone receives counselling or therapy are not medical — if they are not 'ill' — why should the insurance pay? This also seems to me to be the logic of primary care counselling. If the Health Service is paying, then the client must be presumed to be sick.

Guerrillas in the Marketplace

At this point I want to re-emphasise that I know this is not the view of most of those doing the counselling! Taking counselling into medical settings is, generally speaking, a guerrilla tactic: an opportunistic move (in the best sense of the word) to meet a genuine need, to work with people who cannot afford the cost of private practice, and who might well never find their way to it in any case. It may even be seen (as for instance by Richard House in an article in *Counselling*) as an opportunity to challenge and ultimately change the medical model itself.

I think we need to be very cautious with this sort of thinking. It used to be known as 'altering the system from within', or, less enthusiastically, as 'entryism'. We have to recognise, though, that while we are altering the system it is also altering us: working away subtly at our sense of priorities, our language, our style. How many of us, for example, have had the experience of applying for state or institutional funding for some project, and then over the months and years of the application process watching its radical and creative aspects being gradually whittled down to fit the bureaucratic model?

It is of course true that we all live within a capitalist hegemony; that, like it or not, we are struggling to uphold our own beliefs in an environment which is at best unsupportive of, and most of the time actively hostile to, human happiness and productivity. Therefore it can be argued that choosing to work in a system controlled by the medical model doesn't make things any worse! It only sharpens the ex-

isting conflict. There is clearly some force in this argument; but equally clearly there has to be a limit to it, or else we must decide that there is no point in even trying to find ourselves a good environment in which to live and work.

Actually, I am neither expecting nor hoping that if people start to think about the sorts of issue I am raising they will stream out of GP practices and other medical-model venues (student counselling, for example, is subject to many of the same problems as I have outlined). Primary care counselling is here to stay. What I do hope is that we can recognise it to be a 'site of contestation', as Foucault puts it: a place where different projects, different world views, are in conflict with each other — and where it is the other side that has the big battalions. We therefore need to think very hard and clearly about every detail of what we do and say in this environment.

A fair question would be: 'What are the alternatives?' If we want to reach people who (in our view) would greatly benefit from therapy/counselling, but have neither financial resources nor awareness of this sort of work how can we do it? There is a clash of two either/or choices here: medical model versus therapy/counselling model, and private versus public provision.

I have no easy answer. It's worth recognising a few things, though: firstly, that it is not just ignorance or poverty which keep people away from counselling and therapy. A large proportion of people are not accustomed to studying their own inner life, don't see the point, and don't want to do it. Or they may simply have other priorities. It's desperately frustrating trying to do psychotherapy with someone who basically needs some money and a new house. And there are drawbacks to someone coming to counselling because they have been persuaded that it is the answer to a medical problem. Are they truly volunteers in this situation? On the one hand, they will be looking for problem-solving; on the other hand, who are we to psychologise what they believe to be a physical issue? (Thomas Szasz has a lot to say in this area.)

It is probably true, though, that there are a number of people who would choose therapy or counselling but lack the financial resources. I have recently initiated a network of therapists and counsellors in Yorkshire who are offering one or two free or cheap sessions in their timetable. So far we haven't been inundated with calls. We can cross that bridge when we come to it.

Further Reading

Peter Fenwick, 'The Dynamics of Change', *Independent on Sunday*, 17th March 1996

Sigmund Freud, Postscript to *The Question of Lay Analysis*, Penguin Freud Library 15, 1927

John A. Martin, 'Psychotherapy in the 1990s', http://www.jamartin.com/jmphd.html

M. E. P. Seligman, 'The effectiveness of psychotherapy: The Consumer Reports study', *American Psychologist* 50, 965–74, 1995

Richard House 'General Practice Counselling: A plea for ideological engagement', *Counselling* 40–4, February 1996