A Suitable Case for Treatment

Raising the Profile of the Humanistic Psychotherapies in the NHS

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Here are some of the cases referred to me by GPs from a health centre on a council estate in South Wales.

A single parent of 27 has self-harmed by overdosing for the umpteenth time since her teens. She has been seen by the duty psychiatrist, 'assessed' as inappropriate for psychiatric services and sent back. The GP is at her wits' end.

A rugby playing 'hard' man is referred because, 'unless he gets some help', his wife is going to leave him. The GP says the man has suffered a 'personality change' since a near-fatal car accident two years ago and that he has been treating him on and off ever since with medication. The patient is getting worse, not better, and thinks he's going mad. Mostly now he locks himself in the bedroom and watches TV; too afraid of his uncontrollable emotional state to socialise or go back to rugby, he is becoming unfit, overweight and

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depressed. He keeps bursting into tears at work and his self-image is shattered. He is taking it out on his wife, most recently by attacking her 'with an electric lawn mower'.

A mother is referred because she is having 'panic attacks'. Her adopted 11-year-old son has been truanting and stealing from her purse. A second-generation immigrant from Greece is distraught and falling apart, unshaven and unable to perform at work after finding out that his wife has been having an affair with his next-door neighbour. He had been working overtime to earn enough to give her and his daughter 'the top brick off the chimney'. He tried to throw himself under a car. A young man in his twenties is referred with 'anxiety disorder'. He has asked to see the counsellor to help him with his 'confidence'. He was taken into care in his teens but no one had ever spoken to him about was happening at home — though his bruises had been noted in his medical records. He had in fact been terrorised by his stepfather, suffering constant beatings about the head and body, locked in his room and starved. His nose is permanently damaged and he has trouble getting words out, as if punch-drunk.

These are examples of the hundred or more referrals made to me as a general practice counsellor over a two-year period. All responded positively to brief therapy, thus saving GP time and cutting down the NHS drug bill. They are not just typical of the cases referred by one particular practice; any counsellor in general practice could paint a similar picture. The average GP, according to Goldberg and Huxley's research, 'manages' 300 such cases a year. Many GPs will tell you that in around 90% of the patients they see, the presenting problems involve emotional and psychological distress.

These are not medical problems. They may be placed in diagnostic categories such as 'depression', 'anxiety disorder' or 'post traumatic stress disorder', but research evidence confirms what many GPs know only too well: that the medical solutions available in the form of psychotropic medication are mostly ineffective and in any case do not address and resolve the underlying issues.

Nor are these people 'the worried well', for whom tea and a sympathetic ear is an adequate response. Their distress is debilitating and its consequences far-reaching, not only for their own health and well-being but also that of their families and future generations of families. There is ample evidence that a skilled and appropriate psychotherapeutic response could go a long way towards alleviating their distress and enabling a greater sense of mastery over their lives.

Roth and Fonagy's recent comprehensive review of the research evidence for the effectiveness of psychotherapy concludes emphatically that 'there is sufficient evidence to support the growing acceptance and demand for psychotherapeutic interventions'. Unfortunately such interventions are still far from being generally available to the kind of people that present at primary care level.

Psychiatric morbidity in the population

Estimates of mental ill-health range between 10% and 70% of the adult population. These figures depend on where the line is drawn between 'mental distress' which affects daily living, 'mental disorder'

as an impairment of functioning which affects self or others, and 'mental illness' which conforms to a recognisable pattern and can be diagnosed as a discrete category. Estimates of the prevalence of 'distress' and 'disorder' are still very inaccurate.

More accurate information is available about 'mental illness' which is treated medically and comes under the remit of psychiatric services. A fairly stable figure of under 1% of the adult population is the calculated prevalence of schizophrenia. The same figure applies for affective psychosis. Of the population over 65, 6% suffer from dementia and 15% from 'clinical depression'.

It is Goldberg and Huxley who have most fully charted those sufferers from emotional distress who are not appropriate for psychiatric services. They calculate that a third of attenders in general practice suffer 'non-psychotic anxiety and depression'. This figure does not include those suffering distress described as 'psychosocial', those whose emotional problems relate to illness such as cancer, heart disease or diabetes, nor the 'psychosomatic' complaints such as eczema, irritable bowel syndrome and asthma where the emotional component is inextricably linked with the illness. If we add these to the equation we are contemplating large numbers of people for whom an appropriate psychotherapeutic response could make a significant difference to the quality of their lives. Mann, outlining the need for counselling in general practice, concludes that 'the non-psychotic disorders of primary care are a major public health problem because of their clinical severity and their high economic cost'.

GPs: the first port of call

The GP is still the first port of call for sufferers of all kinds of mental health problems. The current government's plans to make GPs responsible for the local commissioning of healthcare will go even further to establish a primary care-led health service. It is the GP's job to filter mental health problems and refer patients on to secondary services, specialist services or the voluntary and private sector. However, unless they can afford private therapy there is a gap in the provision of NHS services for these patients. The Community Mental Health Teams and psychiatric out-patient and in-patient services are targeted to deal with acute or chronic, psychotic and organic 'major' mental illnesses.

GPs have an average of six minutes consultation time with their patients. Their vocational training does not include therapeutic counselling or psychotherapy; in fact many are still not even taught counselling skills — their training includes no more than some input on the recognition of psychiatric illness and the psychological factors involved in physical illness. In a few cases GPs who are interested undertake further training in psychotherapy, often favouring the psychodynamic or systemic approaches. But on the whole the majority of GPs are poorly equipped to deal with emotional and psychological distress. There is evidence that they do not always recognise even severe mental illness.

More recent vocational training courses for GPs have included 'consultation skills' training, much of which is influenced by the person-centred counselling approach. While this may well have a positive impact on the doctor/patient rela-

tionship, it does not provide an adequate basis for responding to the kinds of emotional distress discussed here, yet these are the professionals most commonly dealing with them.

What is currently available?

Three major reports into the current state of psychotherapy services in the NHS have been published by the Department of Health in the last two years. The Parry report looked at current NHS psychotherapy services and strategic policy; Roth and Fonagy reviewed psychotherapy outcome research, while the Damon report incorporates the findings of the first two reports and makes recommendations regarding the commissioning and funding of training in psychotherapies for the NHS. My own research, commissioned in 1994 by a mental health and learning disabilities service NHS trust in the south-east, reviewed the psychotherapy and counselling components of their own qualified staff's work. My findings add meat to the bones of these national reports and verify on a local level the situation described by them.

The main findings confirm that current mental health services in this country offer very little response to emotional and psychological distress, disorder or illness in the population other than 'medication, containment and social support services for those with acute, severe and enduring mental illness'. They also find that 'the demand for psychotherapy in the broadest sense far exceeds the supply of competent practitioners within the NHS workforce' and that availability of psychotherapy services is 'extremely inequitable both geographically and socio-economically'. In addition the reports highlight 'widespread chaos and confusion' and a 'haphazard' approach to service development. The need for the raising of 'psychotherapeutic awareness' within both professional and managerial workforces is emphasised.

On a more positive note they find that 'a degree of appreciation of the complementary value of a range of approaches is now more widespread' and that 'mutual respect' may 'tentatively' be replacing 'previously high degrees of interprofessional rivalry and service fragmentation'.

Patients with the kinds of problems described above would not be considered 'severe' enough for referral to psychiatric services. In any case a psychiatric response emphasising a medical approach is fraught with the restrictions and stigma of mental illness. Psychiatrists are not trained to offer non-medical psychotherapeutic interventions; it is only recently that a 'basic exposure to some core psychotherapeutic approaches' has been mandatory for membership of the Royal College of Psychiatrists, and at the last count only 140 of a total of 4,550 psychiatrists had specialised in psychotherapy.

For these 'minor' mental health problems the alternative available to GPs is referral to psychology services. There were just over 2,000 clinical psychologists in Britain according to the British Psychological Society's 1994 figures. Behavioural and cognitive 'treatments' are still their preferred approaches and the battle against psychoanalysis and the psychodynamic approaches is still being waged, though not everywhere.

There is an average eight-month wait

for psychology services, a problem with the large number of patients who 'DNA' (do not attend), and a high fall-out rate. This seems to indicate that there is something wrong with the way the services are organised, and that in many cases a cognitive behavioural intervention is inappropriate or not addressing the perceived needs of those referred. Although masses of funding has been allocated to research these approaches and confirm their superiority over others, there is very little evidence to support their current near-monopoly.

A number of health and social care professionals, including registered mental nurses, community psychiatric nurses, occupational therapists and social workers, have also undertaken psychotherapy or counselling training. In a few cases these professionals are trained to UKCP or BAC standards, but far too often they have merely participated in one or two short courses. They may have an opportunity within their own professional role to offer 'therapeutic' contact or in some cases a more formal psychotherapeutic contract, but there are some problems associated with these dual-role therapeutic relationships. These include the contradictions involved in combining statutory obligations or medical responsibilities with a psychotherapeutic agenda. Health professionals in particular are deeply embedded in the medical model and may have difficulty shifting their own value-base. There is often an overwhelming workload, with administrative and managerial imperatives which limit the time for psychotherapeutic or counselling contact. Nevertheless good practitioners who are aware of these issues are sometimes able to offer a more human service.

The reports raise the question of how best to respond to the large group of people who are categorised in psychiatric terms as suffering minor mental health problems. They recommend building a 'psychotherapeutically competent workforce' which deploys 'all approaches to helping individuals which work directly with behaviour, thoughts and feelings through talking, therapeutic relationships and experiences'. They emphasise that 'proper psychotherapies will have a framework within which assessment and interventions are decided upon, carried out and evaluated'.

Where do the humanistic approaches fit in?

In Britain the humanistic psychotherapies have developed mainly outside the NHS and academic psychology and are still under-represented and undervalued in the public sector. Yet over the last 25 years large numbers of the public have voted with their feet by seeking out these kinds of therapies, either privately or through the voluntary sector. Humanistic approaches have much to offer helping professionals at all levels of practice. They have developed sophisticated and creative experiential training methods which are aimed at enhancing the interpersonal and communication skills central to a professional helping role. Such methods also promote skills of enabling 'therapeutic' contact within a variety of helping environments, including in-patient wards, mental health and learning disability residential group homes and day centres. The more formal humanistic psychotherapies are ideally suited to addressing the kinds of

psychosocial problems, or problems of living, that are under consideration here.

One of the key recommendations of the Department of Health's reports is that 'there should be more public and informed debate about the nature of mental ill-health and well-being, both how it may be understood and the range of ways of... working with it'. In particular they are critical of the predominantly physical approach to psychological perspectives on illness and emphasise that 'the evidence base suggests a much closer interconnection between mind and body than is conventionally considered'.

It is the humanistic theories that have most radically challenged the mind-body split. A central tenet of the humanistic approaches is the integration of the physical, emotional, intellectual and spiritual dimensions of personhood and the self-healing and self-regulating capacity that results from this. This is their unique contribution and provides a vital counterbalance to the medicalisation of distress. Distress is understood, not as an illness to be 'cured', but as a reflection of the way in which an individual is engaging with the world, the way that has meaning for their life process.

In the humanistic approaches it is the quality of the contact created between patient and therapist in the therapeutic relationship itself which activates this self-healing capacity, rather than modifications of behaviour and beliefs, or insight into the present influences of past patterns, though these may also be the discernible changes that result from therapy. Most approaches now accept that the therapeutic relationship is the medium through which therapeutic strategies are delivered, but it is the humanistic theories that have attempted to identify the dimensions of the relationship and that work with the variety of forms it can take: the 'working alliance', the 'real' or 'authentic, the 'transference', the 'intersubjective' and the 'transpersonal'.

With the current emphasis on 'evidence-based' medicine and psychotherapies that are 'scientifically validated' it is important that humanistic practitioners lay claim to the research which recognises that 'client agency' and 'therapist variables, in particular the ability to achieve effective therapeutic alliances', are the major factors in effective outcome and more important than techniques or theoretical approach.

The Damon report emphasises how important it is that psychotherapy should not be understood as referring only to specialist and psychoanalytically based approaches. It recommends the development of services for people with mental illness and distress which are 'person-sensitive' and 'individually oriented in a broader sense which goes beyond equity of access to a particular range of treatments'. Given that the humanistic psychotherapies are mentioned by name only once, and then only as a small footnote along with counselling (describing other approaches which are sometimes offered on a sessional basis), it is interesting to note how much all three reports are imbued with humanistic and integrative values and principles.

Respect for the individual as a sovereign being in humanistic terms offers an entirely different therapeutic relationship stance and provides a flexible framework for responding to need in an organic way. Rather than receiving a standardised

programme of 'intervention', as in the behavioural or cognitive behavioural approaches, a collaborative relationship is established, designed to create a dialogue through which needs can be articulated, distress shared and the individual can come to grips with their experience in their own way. It is this depth of respect for the individual — including both staff and patients — which is lacking in the current approach to mental health services, despite its potential for inspiring revolutionary change in the way humans organise themselves to live together and care for each other.

Humanistic psychotherapies as 'brief' therapy interventions

The pressure of numbers and the lack of funding endemic in a service such as the NHS dictate the need to share things out and provide time-limited and focused interventions. It is false economy, however, to address things inadequately or tinker around with 'symptoms' when by engaging with underlying issues qualitatively different and lasting changes may occur.

Humanistic interventions can be focused on specific issues in depth. The theories enable attitudes and patterns to be identified which limit an individual's response to particular life situations. They take into account transferential distortions in relationships, but do not depend on fostering and working through a 'transference relationship', as in the psychoanalytic and psychodynamic approaches. 'Transferences' are seen as an ongoing part of life, to be embraced into consciousness, not resolved for ever.

The organic nature of humanistic practice provides a natural cycle of phases which reach a succession of choice points, negotiable between patient and referrer according to individual and contextual needs. Brief therapy is therefore an option that does not jeopardise the depth of the work.

In conclusion, the NHS is a powerful institution, rich in resources of every kind: personpower, brainpower and finances. Despite the years of Tory rule it is still a triumph of the socialist ideal which sees the health and well-being of every individual as a basic right — a right which is good for all of us. I still believe in this principle, and I see no clash between it and humanistic values.

Currently there is no formal means of employing 'lay' psychotherapists (or counsellors) other than child psychotherapists in the NHS; there is, for example, no recognised pay scale or career structure. Inclusion of these kinds of interventions is dependent on the goodwill and preferences of heads of psychology departments, consultants and GPs. Funding is allocated from various other budgets such as preventative medicine or even research budgets. What little therapeutic counselling or lay adult psychotherapy is available is paid for on a sessional basis, and often very poorly.

When I first became involved in the humanistic movement in the early 1970s it was impossible to practise in the NHS. It was in the grip of a psychology still in the dark ages of behaviourism and psychoanalysis, locked into patriarchal rigidity and the heady intoxication of interpretation. There have been tremendous changes since then. All the approaches now recognise in their finer moments that we need each other — and if the humanistic voice is the one least often heard we

have ourselves to blame.

Partly due to the efforts of the UKCP and BAC and (ironically) partly since the Tories established the purchaser-provider ethos, there is at last a window of opportunity for humanistic practitioners to become service providers. The Damon report recommends funding of research and training for a range of psychotherapy approaches, for it is quite clear that the current monopolies are not conducive to quality services. Regional consortia are being set up and local humanistic organisations are being invited to participate in decisions relating to the commissioning of local psychotherapy services. We can make a contribution to changing attitudes to mental health and well-being and to addressing human misery; not, as Freud said, by transforming it into everyday unhappiness, but by putting the soul back into psyche and freeing the human spirit.

Further reading

S. Damon, *The Commissioning and Funding of Training in Psychotherapy for the NHS in England*, Department of Health, 1997

D. Goldberg and P. Huxley, *Common Mental Disorders*, Routledge, 1992

A. Mann, 'Public Health and Psychiatric Morbidity' in *Indicators for Mental Health in the Population*, ed. R. Jenkins and S. Griffiths, Dept of Health, 1991

G. Parry, *The Review on Strategic Policy on NHS Psychotherapy Services in England*, Dept of Health, 1996

A. Roth and P. Fonagy, *What works for whom? A critical review of psychotherapy research*, Guildford, 1996