

## Correspondence

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## Expansion of psychological therapies

Working as a psychiatrist in crisis resolution/home treatment, where over 20% of our patients fall within the category of the population discussed by Summerfield & Veale,<sup>1</sup> I would like to express my opinion on their debate. Over 20% of patients with depression, anxiety and related disorders is a significant percentage, however not a surprise, as this is similar to the percentage reported by the Office for National Statistics.<sup>2</sup>

Summerfield's concerns about 'medicalising the problems of living', 'contribution of mental disorder to sickness absence' and the economic cost of disability benefits are indeed justified and alarming. However, these are associated and complicating factors, rather than the core issue of this debate.

The main issue is the expansion of psychological therapies, mainly cognitive-behavioural therapy (CBT), which is the recommended first-line treatment for mild to moderate depression, anxiety and related disorders. In fact one of the first key messages in the National Institute for Health and Clinical Excellence guidance for anxiety and related disorders is 'If left untreated, they are costly to both individual and society',<sup>3</sup> and any psychiatrist working in the community cannot deny this fact.

Although I agree with Summerfield that 'normal stress' and problems of living should not be medicalised and people should not be given a 'mental disorder card' to claim sick leave and unjustified benefits, hence promoting the culture of the 'sick role', equally care should be taken not to underestimate the need for short-term interventions which can prevent long-term disability. I believe that the key would be in balancing between non-medicalising and providing meaningful interventions where necessary.

Short-term psychological therapies such as CBT, which is backed by evidence, seem to be a very useful way of providing necessary interventions without medicalising or encouraging the sick-role culture. Medicalising would be the use of medications and hospital admissions, rather than the use of CBT, which aims to provide positive change in thinking and behaviour, and giving the responsibility back to the patient, thus preventing people from becoming 'cases' in the long term.

Working in the community in the crisis resolution/home treatment team, we receive a huge number of referrals from primary care of patients who are not suitable for specialist services yet whose mental health problems are not manageable within the primary care setting. Many of these patients are more suitable for short-term psychological therapy; however, because of a lack of quick access to such services and with waiting lists of 1 year, the risk of medicalisation and of patients becoming 'cases' increases.

In fact, the very reasons Summerfield has mentioned in his side of the debate are enough to suggest that the expansion of psychological therapies is essential, rather than unnecessary.

On the other hand, Veale's comment on the quality of psychological services is also very significant. The emphasis should not only be on expanding services and increasing access, but also on improving and monitoring the services provided. Truly, qualification as a clinical psychologist is not adequate to practise CBT, as CBT is a postgraduate qualification. At present, most services have a shortage of properly qualified CBT therapists.

- 1 Summerfield D, Veale D. Proposals for massive expansion of psychological therapies would be counterproductive across society. *Br J Psychiatry* 2008; **192**: 326–30.
- 2 Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H. *Psychiatric Morbidity Among Adults Living in Private Households, 2000*. Office for National Statistics, 2001 ([http://www.statistics.gov.uk/downloads/theme\\_health/psychmorb.pdf](http://www.statistics.gov.uk/downloads/theme_health/psychmorb.pdf)).
- 3 National Institute for Clinical Excellence. *Anxiety*. NICE, 2004 (<http://www.nice.org.uk/nicemedia/pdf/CG022NICEguideline.pdf>).

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In his criticism of the expansion of psychological therapies, Summerfield<sup>1</sup> contends quite reasonably that 'talking therapies are grounded in an ineffably Western version of a person'. Socio-demographic factors and cultural background influence the perception of symptoms of mental illness and, hence, engagement with services. As Veale<sup>1</sup> rightly points out, CBT does not ignore the social context of the illness but cultural adaptations and understanding of ethnic, cultural and religious interpretations is an area which currently remains underdeveloped.

We are seeking to address this by developing a qualitative methodology which can be used to produce culturally sensitive CBT for diverse ethnic groups. Two projects are underway: in Pakistan, we are assessing whether CBT for depression is compatible with local beliefs and values, and if so, what adaptation to manuals, training and practice is needed. In the UK, a similar project is tackling CBT for psychosis in Black and minority ethnic populations. Both projects involve interviewing lay groups, patients who have and have not had CBT, mental health professionals from the relevant ethnic groups and CBT therapists. Analysis of transcripts from the Pakistan project does endorse the use of CBT but has already indicated, for example, that presentation of depression is frequently somatic and CBT has to directly address this. Literal translation into Urdu of terms used in CBT may not be possible or can be misleading. Adaptation for different levels of literacy is needed. Family members tend to accompany patients and are essential to successful work. Often there is better engagement with local faith healers and religious leaders. Similarly, African and African-Caribbean people have more usually consulted their traditional healers for help. Often within similar African cultures, the concept of mental illness differs considerably.<sup>2</sup> Piloting of an adapted manual has begun and further evaluation of culturally sensitive CBT in Pakistan and the UK is planned. These measures are essential to the success of the CBT programme in a multicultural society.

- 1 Summerfield D, Veale D. Proposals for massive expansion of psychological therapies would be counterproductive across society. *Br J Psychiatry* 2008; **192**: 326–30.
- 2 Edgerton R. Conceptions of psychosis in four East African societies. *Am Anthropol* 1966; **68**: 408–25.