

Mind over Matter

Exploring the issues of Mental Ill Health

Chief Medical Officer's Report 2007

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Index to Sections

Introduction

4

Professor Michael O'Donnell
Chief Medical Officer - Unum

Mental Ill Health and Employment

8

Paul Corry
Director of Public Affairs - Rethink

Top Tips for dealing with Mental Illness

12

James Wooldridge

Good Therapy and How to Recognise it

14

Ruth Harrison
Insurance Nurse Specialist - Unum

The Interface Between Psychiatric and Physical Disorders

24

Dr. Chris Bass
Consultant, Liaison Psychiatry - John Radcliffe Hospital, Oxford

Why and When do Doctors Collude with Patients?

30

Professor Simon Wessely
Director, King's Centre for Military Health Research - Institute of Psychiatry, King's College London

Introduction

Professor Michael O'Donnell,
Chief Medical Officer - Unum

Welcome to the 2007 Unum Chief Medical Officer's Report, the sixth in the series. This year we focus on mental ill health - an important and frequently reported topic, and one where we have observed important new research over the last year, which Unum has been proud to help sponsor.

With mental ill health problems now accounting for around 30% of all our claims, and 40% of claims for Incapacity Benefit (**Mental health and the UK economy report, Oxford Economics/Unum, March 2007**), now is the time to really take stock and understand what is happening and consider what we, as employers, can do about the problem. Sickness absence is said by the CBI to cost the UK economy more than £13 billion per year, and mental ill-health could be costing the economy as much as £10 billion a year, with over £6 billion to be met by the UK Exchequer (**Mental health and the UK economy report, Oxford Economics/Unum, March 2007**).

Last year we helped sponsor the Shaw Trust's research into mental ill health in the workplace - **Mental Health - The Last Workplace Taboo** (www.shaw-trust.org.uk/mentalhealth). This showed that employers seriously underestimate

the incidence of mental ill health in the population in general, as well as among their employees. In fact almost three quarters of employers (71%) thought the incidence of mental ill health among their workforce would be 5% or less. Contrast this with the fact that around 25% of us will experience some form of mental health problem in our lifetime. Even worse than this level of ignorance was the fact that 9 out of 10 employers did not know if any of their employees suffered from any mental illness.

Take a look at some more of the findings:

- **One in five employers admitted to believing that employees who have been off work with stress, depression or some form of mental ill health for more than a few weeks are unlikely ever to fully recover.**
- **One in three employers think that people with any form of mental ill health are less reliable than other employees.**
- **A similar number said that negative attitudes from workplace colleagues are a major barrier to employing people with any form of mental ill health.**
- **Around one half thought that organisations take significant risks when employing them or keeping them in client facing roles. There was no significant difference between small and large employers.**

Clearly, such attitudes are not just a barrier to employment for people with mental health problems but they could severely limit the number of people available for firms to recruit.

Paul Corry, the Director of Public Affairs at Rethink, the charity for people with severe mental health problems, shows us that people with even severe mental health problems can be employable and describes some of the initiatives his organisation is making to overcome stigma and preconceptions. Included with his piece is an article by James

Wooldridge, who has had schizophrenia for the last 20 years. During this time, he has managed to hold down employment, and he passes on some of his tips on how to manage this. This is a motivational piece, which should make all of us profoundly rethink our attitudes to, and understanding of, people with mental illness and how they can contribute to Society.

Last year we commissioned a report by Oxford Economics - Mental Health and the UK Economy. Part of the findings showed that many of those with mental health conditions are suffering from common mental health problems, but that most traditional spending in this area is on those with severe conditions in need of very significant help and support. The report reveals that the average annual growth rate for mental and behavioural disorder claims since 2000 was 5.4%, outstripping the 0.8% growth of overall incapacity benefit claims. This represents one million incapacity claims for mental and behavioural disorders, 40% of total incapacity claimants and equates to a similar number of those claiming unemployment benefit for the same period.

However, the results do not just consider sufferers who are on incapacity benefit and are unable to work, but also lost working days. In total, it estimates that over 10 million working days were lost due to stress, depression and anxiety in 2005/06.



Introduction

Professor Michael O'Donnell



It is likely, therefore, that carefully targeted increases in Government spending on early intervention, specifically for stress, anxiety and depression, could help improve employees' chances of returning to work and result in obvious net benefits to both the economy and Exchequer. Cognitive Behavioural Therapy (CBT) has the best evidence base for effectiveness of all the talking therapies, and has been shown to be useful for other health problems such as back pain. Many of us read about CBT and such distinguished people as Lord Layard (**Happiness: Lessons from a New Science**) promote it. However, although much is written and said about it, how many of us know what it is? I believe that it can be a cost-effective intervention; and as long as its availability is limited on the NHS, employers need to consider whether to fund it. Indeed, many Occupational Health departments will now recommend it for employees. I believe that in order to make decisions, employers and others need good information and it is for this reason that I asked our own Ruth Harrison, an Insurance Nurse Specialist at Unum, to write an article for us explaining what CBT is, and how to identify good therapy.

Mental health is not just an issue for those people with an overt diagnosis of mental illness. In last year's Chief Medical Officer's Report (**Rehabilitation – Keeping people in work**), Professors Gordon Waddell and Kim Burton pointed out that a high proportion of people who have been off sick for longer than six months suffer from what are referred to as common health problems. In these, subjective symptoms predominate; and many other people with similar complaints continue with life

as normal and recover from them quickly. Research from the Unum Centre for Psychosocial and Disability Research at Cardiff University has shown that over 45% of people state they have experienced one form or another of health complaint in the last month. Waddell and Burton pointed out that it is as much psychosocial as biological issues that obstruct recovery, and that it is at least as important to understand these and address them as it is to treat the medical problem that led to the absence. In many cases, depression will become a perpetuating factor, leading to people feeling demotivated and worthless.

It is for this reason that I have asked Dr Chris Bass and Professor Simon Wessely to contribute to this year's report. Both are psychiatrists who work at the interface between psychological and physical health, so I asked them to write on what many others as well as me believe to be obstacles to recovery from ill health. They are both known for their firm beliefs and we have two challenging articles from them.

In the first article by Dr. Chris Bass, he explores why so much stigma is attached to a psychological diagnosis, and why people with physical problems can be so resistant to psychological therapies. He identifies that many psychological labels, such as psychosomatic are often interpreted to mean imaginary or made up. He also bemoans the split between conventional medicine and psychiatry, pointing out that psychological aspects of illness are largely ignored during the investigation process, and are rarely addressed even after serious ill health

has been excluded. As a consumer of medical services, I can recognise the anxiety created when being put through a diagnostic intervention and can imagine the feeling of being let down when you still have symptoms but doctors lose interest in you. Even worse is when doctors refuse to give up and enter a spiral of continuing investigation and trials of treatments which never work. This is typical of what can happen in some back pain clinics, and I am very pleased that the National Institute for Clinical Excellence has announced that it will review the evidence for effectiveness of interventions for back pain.

Dr Bass applauds the response of the insurance industry to the challenge, but points out that the NHS is very slow to provide funding for joint psychological and physical approaches for people, not only with common health problems, but also with what might be termed unconventional disorders, which can be just as debilitating as many conditions which are recognised to be severe, but physical.

It is disappointing that, as the medical profession is becoming increasingly aware of the psychosocial dimensions of illness, our NHS managers have apparently become fixated on providing those treatments which can be measured. Operations and injections are easy to monitor, with discharge and complication rates that can be compared with other providers. However, until return to work is included as the objective and final measure of success, it seems likely that the NHS will continue to miss the point.

Professor Simon Wessely has written a thought-provoking article on collusion. He points out that this can occur in many different settings, and that it can be part of the therapeutic process. Withholding a serious diagnosis from a patient who is not yet ready to accept his or her problem is one such form of collusion. Giving a person a diagnosis they can accept so that they engage with therapy is another. This has always been part of the way doctors interact with their patients and is part of the art as opposed to the science of medicine. Problems can occur when doctors, and others, have a financial interest in their clients remaining unwell and also

when doctors feel that they have to collude because of lack of time or fear of a complaint. I feel that it is incumbent on all professionals to ask whether what they are doing or saying is really helping their client, or is really more about making themselves feel better in some way.

I do hope that you will enjoy reading this report and find the articles useful and interesting, and I look forward to any comments you may have about its contents and suggestions for topics of interest.



Professor Michael O'Donnell

Michael is an accredited specialist in occupational medicine and has the Diploma of Disability Assessment Medicine. He qualified in 1975 and worked in hospital medicine and General Practice before moving to Occupational Medicine in 1984. He has now worked in Occupational Medicine for 21 years, with 6 of those years spent in the oil and petrochemical industries. He has experience in the public and private sectors in virtually all fields of operation.

His particular interests are in fitness for work, the biopsychosocial model of incapacity and presentation and assessment of risk - particularly in the area of psychosocial hazards.

He is honorary visiting professor in the School of Life and Environmental Sciences at Salford University.

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Mental Ill Health and Employment

Paul Corry,
Director of Public Affairs - Rethink

People with a severe mental illness have the highest want-to-work rate of any group of people with a disability – and the lowest in-work rate. Why should this be?

A popular stereotype of someone with, say, schizophrenia will provide one answer. They can't hold a sensible conversation, let alone a job, but have some grandiose ideas about being the de-throned King of England.

In short, people with a mental illness might say that they want to work, but they are totally incapable of doing so.

Real life is very different to the stereotype.

Rethink is a membership-based mental health charity that runs around 350 services in England and Northern Ireland, employing some 1,400 people in a range of highly-specialist, managerial, administrative and support roles.

We know from our own experience that people who have experienced a mental health problem can make excellent employees.

We believe that around 14 per cent of our staff have or have experienced in the past a mental

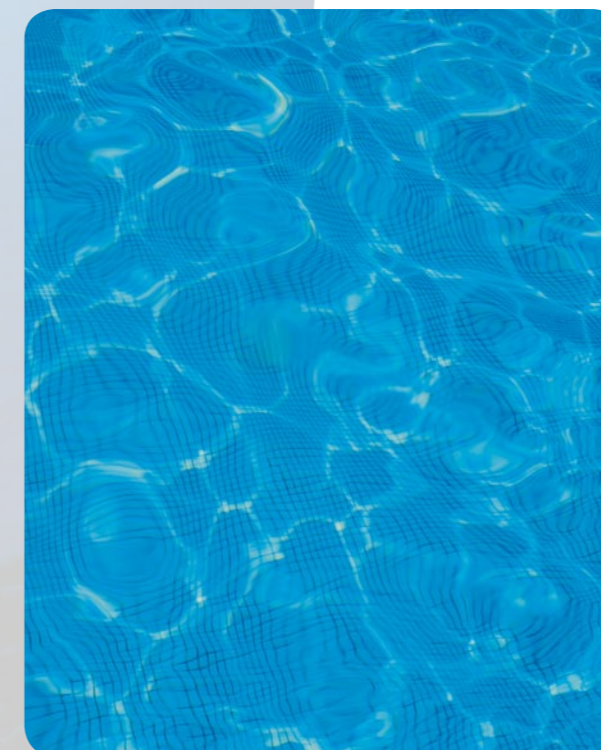
health problem. We also know that many of our own staff do not disclose to us that they have previously experienced a mental health problem until, in some cases, many years after taking up their role. So, in fact, the actual figure may be somewhat higher.

We ask during the application process, at interview and when people take up the jobs if they want the organisation to make any reasonable adjustments to take account of any health needs.

Yet many people don't take any of these opportunities to speak up.

What is going on here? We have a large group of people – one in four people will experience a mental health problem of some kind and around one in 50 will experience it in a severe form, such as schizophrenia or bi-polar disorder – who won't tell an employer about a mental health problem.

The truth is that many people have experienced real discrimination in the labour market – and many of those who have not, anticipate discrimination based on having experienced it from friends, neighbours, health and social care professionals.



Our own members tell us that the stigma and discrimination surrounding mental health are the major barriers they encounter along the road to recovering a full and meaningful life. There have been huge improvements in the last 20 years in the understanding and treatment of a wide range of mental illnesses. People can and do recover from mental illness and they are doing so in increasing numbers.

However, there has been no improvement in how the general public views mental illness - if anything negative attitudes have hardened. New research published this month by the Department of Health shows that compared to results from 1994:

- **8% less favoured a more tolerant attitude in society towards people with mental illness;**
- **Only 72% of those surveyed thought that people with mental health problems had been the subject of ridicule for too long - a drop of 10%;**
- **5% less thought that those with mental health problems were deserving of sympathy and that society has a responsibility to provide the best possible care;**
- **Slightly more people thought that those with mental health problems are a burden on society.**

Fears about people with mental illness have grown:

- **Only 63% said they would not mind living next door to someone who had been mentally ill, a drop of 11% from 13 years ago;**
- **The percentage of those agreeing those with mental health problems are "far less of a danger than most people supposed" dropped by 6% from its peak of 64% in 2000;**
- **This year 34% described people with mental health problems as prone to violence, an increase of 5% from 2003.**



Mental Ill Health and Employment

Paul Corry

The general public tends to associate mental ill health with helplessness and hopelessness at best, and dangerousness at worst. Over two-thirds of all media reporting mental health link it to violence.

What is true of the general public and the media is true of employers. Take one employer who rang in to a radio programme that I was appearing on to highlight that mental illness is covered by the Disability Discrimination Act.

“That’s all well and good”, he said, “but I’m also covered by the Health and Safety at Work Act and I can’t have mad people working for me who could run around the place with an axe attacking their work-mates.”

In fact, you are far more likely to be attacked by a partner at home, a fellow reveller in the pub or a young person who is high on drugs in the street, than you are by someone with a mental illness.

The shocking and horrific homicide cases that dominate media coverage of mental illness are real events, but they are incredibly rare events, involving around 40 of the 630,000 people who have a severe mental illness today. They account for a declining proportion of the more than 800 homicides that take place in the country each year. To set it in a further context, over 210 people died in work-related accidents in 2006.

But prejudice, ignorance and fear are real and need to be tackled.

That is why we are investing heavily in a range of programmes designed to tackle the prejudice, ignorance and fear that are too often the general public’s first response when thinking about mental health issues.

We believe that improving the public’s general perceptions of mental health will impact on the labour market.

It will give people who have experienced mental health problems confidence to be open when applying for jobs and speak up in the workplace when a mental health problem threatens an existing post. It will also

assist employers in taking an interest in promoting mentally healthy workplaces to retain existing staff members and attract new ones.

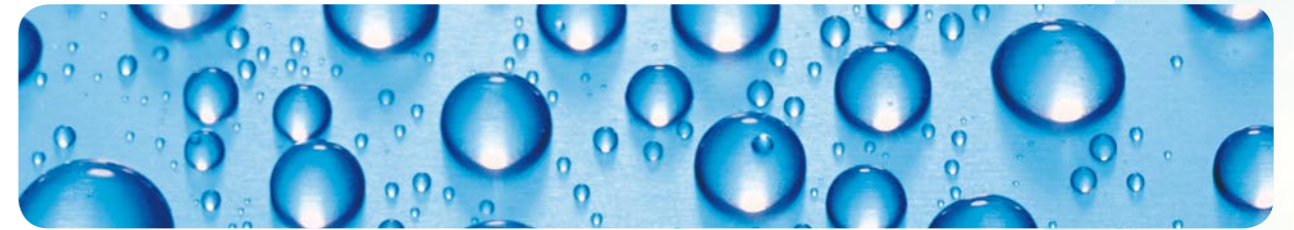
That is why we have been developing large-scale advertising campaigns backed up by local community-level activities designed to bring people with and without direct experiences of mental health problems together. Internationally, these approaches have proved hugely successful, particularly in New Zealand and Scotland where they have been given long-term support by government.

When we ran one such programme in Norwich, we were joined by the regional chair of the Federation of Small Businesses. He talked movingly about his own experience of contemplating suicide, and made a plea for other employers to recognise the huge contribution someone who has to delve deep into their inner resources to overcome such problems can make when they bring those skills to the workplace.

We are also interested in targeting programmes at particular groups of people who are key influencers. We have developed short interventions for school children, police officers, medical students and trainee psychiatrists that enable them to better see the world from the perspective of someone who has experienced mental illness and to make small adjustments in the way they work that can have a huge impact. Over the next few years we will be rolling these out with wider groups, including teachers and JobCentre staff, as well as employers.

We are also working with the Department for Work and Pensions to ensure that the reforms of Incapacity Benefit that are underway and the development of Pathways to Work as a route from long-term sickness to employment make it easy for employers – large and small – to recruit and retain people who have experienced a mental health problem.

Our existing employment services provide routes into all kinds of work, training and study for people who need to update skills and build confidence to face the labour market again.



As a mental health charity, we would like to think that we are a best practice employer, but that doesn’t mean that we always get it right or that we don’t need the advice of others to do things better. Internally, we have developed a new policy to support managers working with people with mental illness and we are developing a peer-support network for staff who have experienced mental health problems so that they can offer support to each other and help us make further changes.

We have also joined the Mindful Employer initiative (www.mindfulemployer.net) so that we can learn more from others.

Joining:

- shows others and your own staff that you are a good employer;
- expresses your corporate social responsibility;
- reduces recruitment and training costs;
- helps towards complying with legislation (e.g. DDA & HSE);
- reduces sickness levels;
- enhances customer service;
- improves productivity;
- makes you more attractive to people with mental health issues and others;
- helps you retain staff who have experienced discrimination in the past;
- makes yours a healthier workplace.

As Mindful Employer says: “Stress, depression and anxiety are the cause of more working days lost than any other work-related illness. Sick pay reduces profits. Covering absent workers adds more pressure. Loss of valued and talented people costs more than money.” People with mental health problems deserve to be treated as equal citizens in and out of the workplace. Happily, ensuring that happens makes great business sense too.



Paul Corry

Paul Corry joined the National Schizophrenia Fellowship as press officer in 1998. Prior to this, he had worked at a senior level in print journalism and as a social worker.

He was subsequently promoted to Media Manager, and co-ordinated the re-launch events when the charity changed its operating name to Rethink - Severe Mental Illness in July 2002.

Paul was appointed as Rethink’s Head of Policy and Campaigns in October 2002 and Director of Public Affairs in the spring of 2006.

The Director of Public Affairs role includes raising the charity’s public profile and ensuring that it maintains constructive relationships with national decision makers and opinion formers.

To find out more about Rethink, telephone 0845 456 0455, e-mail info@rethink.org or visit www.rethink.org.

Top Tips for dealing with Mental Illness

James Wooldridge has lived with schizophrenia for the last 20 years. He was first diagnosed with schizophrenia in 1984, aged 18, following some rather bizarre behaviour during Army officer training at the Royal Military Academy Sandhurst. Despite many relapses and sectionings since that initial breakdown, including a six month stay in a secure hospital, he has managed to remain largely employed, even spending eight years as a retained fire officer. He now works with Rethink on its anti-discrimination programme.

1. Be upfront and honest

Never try to hide past and present illnesses, as this will certainly jeopardise your position later. In the past and more recently I have been pleasantly surprised by the more enlightened approach of employers to those who have experienced mental health problems. An honest approach will always impress an employer as recognising possible weaknesses shows a positive attitude in itself. Don't be afraid of speaking about times spent on a psychiatric ward. We all know that once you open up to someone about this very often the reply isn't one of shock but a sympathetic "I have a friend who has been through something similar."

2. Don't underestimate yourself

Never feel intimidated at an interview because of your diagnosis. Being able to say that you've been through one of life's major challenges is a very positive attribute and there are many aspects of it that will help you in the future. For example, knowing your own personal limits, being able to talk and relate to people from many different walks of life and having an informed and empathic approach towards those who may be suffering themselves. Avoid the trap of applying for a job that is well beneath your abilities purely because your self-esteem may be low. Conversely, don't be afraid to apply for a position you are qualified for and would enjoy and benefit from just because you feel your illness would prevent you from being selected.

3. Don't overestimate yourself

Initially, you may need to start climbing the ladder again a rung or two lower than you were on before. I went from being a Sandhurst Officer Cadet to being a hotel porter in the space of six months. For me personally, keeping employed was important as I needed to have my time organised and structured.

4. At interviews maintain a smart appearance

Most interviews are over in the first 30 seconds. First impressions really do count and a smile, combined with a suitable look will all go in your favour. Unfortunately, many people assume that mental health patients are a fairly dishevelled group who perhaps do not take much care about their appearance. Proving this wrong will certainly go in your favour.

5. Be prepared for the "what happens when you get ill?" question

Every employer I've had has asked me this and the answer is different for everyone. I feel it's important to think of your answer prior to the interview. Once again, be honest but don't frighten them. Remember, employing a Sunday league footballer can be just as risky. A broken leg can take a long time to heal!



6. Involve your doctor/consultant

An employer will have to ask your permission if he/she wishes to contact your doctor/consultant. Personally, I recommend a health professional's involvement as firstly, a good GP/consultant will want to see his/her patient in gainful employment and secondly, it can certainly help reassure an employer to have someone who knows you medically, give a written assessment.

7. Be persistent

Keep on trying – many people with no mental health problems have difficulties finding a job. So don't give up at the first hurdle. It took me five medicals and about six months to be accepted by the Fire & Rescue Service and they turned out to be a great employer. Also, if you get turned down for a job for which you feel you were a well qualified and suitable applicant, ask for a reason why. A good employer should let you know the reasons and not only will this help you improve next time but may also dispel thoughts of "it was because of my illness."

8. Consider volunteering

A very good way to ease back into the workplace is to try voluntary work. Most will help with expenses and not only does this type of work give you confidence and the encouragement to move on to paid employment, but it also fills gaps between jobs and an employer will always look favourably on someone who, though out of work, has nevertheless kept themselves busy. Another advantage is that you may learn new skills that can be transferred to the workplace, not forgetting the fact that voluntary work is a rewarding way of helping those who may in some way be disadvantaged. They may even include those who have experienced mental illness and who better to help them than someone who has been down that road themselves.



James Wooldridge

James Wooldridge, 41, has worked in sales, run the print department for Mole Valley Farmers and worked as a retained fireman for eight years. He first experienced mental health problems while he was a cadet at Sandhurst, and was diagnosed with schizophrenia. James is now a mental health awareness trainer and motivator, and has won a national award for his work in speaking out in the media about mental health issues. His positive, engaging approach has made him a popular after dinner and motivational speaker.

Good Therapy and How to Recognise it

Ruth Harrison,
Insurance Nurse Specialist - Unum

With the explosion of absence from the workplace as a result of stress, anxiety and depression, the demand for psychological therapies has grown. Subjective disorders are of course difficult to measure, and can cause heated debate in terms of their clinical management. However, whatever your personal view is in terms of the existence of such disorders and their treatment, there is no denying that for some individuals, conditions such as these have an obvious influence on their ability to function.

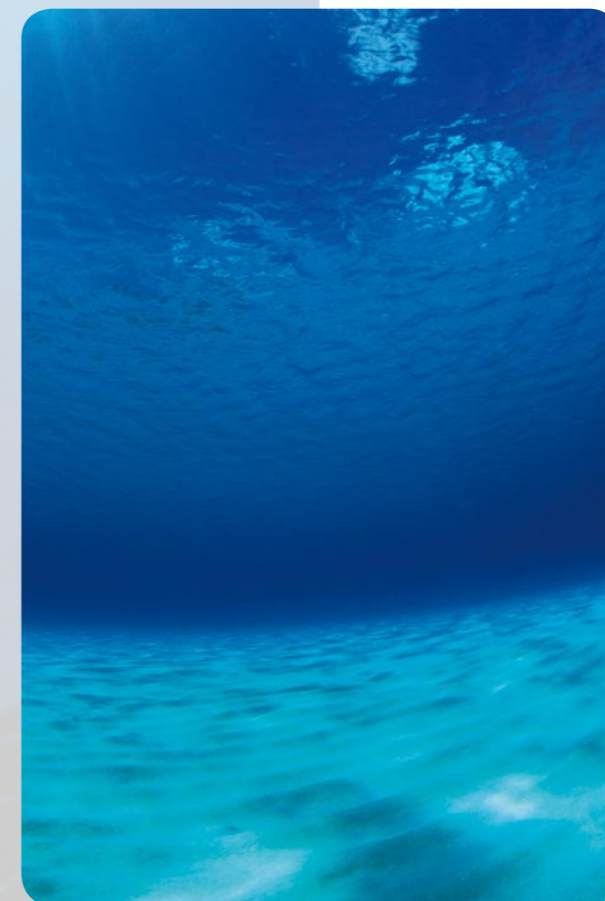
Perceptions as to how a particular condition affects individuals varies from person to person but, generally speaking, typical features include poor coping strategies, low self esteem and a general negative view of their own physical and psychiatric wellbeing. The combination of these observable symptoms will subsequently affect all aspects of life including the individual's perceived or actual ability to work.

The Confederation of British Industry (CBI) calculated in 2005 that 36% of all occupational absences were directly related to stress, anxiety and depression. These figures obviously translate into billions of pounds each year in lost productivity, but also in an

incalculable cost with regard to social and psychological impairment¹.

Stress, along with other emotional and cognitive disorders, usually manifests in a way which leaves individuals with the belief that they are ill and cannot function to their optimum level. However, this belief can be successfully challenged through psychological therapy and has been influential in shaping the Department of Work and Pensions' report (257) to explore the medical approaches that GPs might use in order to combat the increasing problem of sickness management and the steady rise in numbers of people certificated to become or remain absent from work².

The use of psychological therapies to assist with treating people with stress and depression is by no means new, but the uptake over the last five years has increased, even though provision in some areas of the British Isles remains very poor.



Therapies and their Trends

Sigmund Freud is considered the forefather of most, if not nearly all, psychological theories and subsequent therapies. His psychoanalytical approach was characterised by exploring normal and abnormal mental functioning. He particularly focussed upon the unconscious mind, for it was his opinion that the unconscious mind was where the seat of neurosis originated. Freud was passive in his approach to aiding people towards enlightenment but his insightful, some would say imaginative, assessments of their dreams and fantasies led him to provide an interpretation and explanation for a variety of clinical presentations, which were otherwise not understood. Freud went on to rationalise and explain behaviours that were at the time, considered to be abnormal or dysfunctional³.

Psychoanalysis is still used today as it offers a comprehensive and elaborate range of tools that purport to provide explanations for a number of clinical phenomena - however its usefulness is difficult to scientifically test and is open to significant debate. Controversy reigns and questions remain unanswered as to how the analysing of dreams, fantasies, memories and the like can actually assist with constructive practical solutions to problems that individuals may have associated to relationships and life events. Some would also argue that the exploration and investigations into these dreams and memories are actually more damaging than helpful. Nevertheless it is true to say that psychoanalysis underpins the foundations of more recent therapies including that of Cognitive Behavioural Therapy (CBT).

Psychological therapy is a broad-based umbrella term used to incorporate a plethora of different approaches to treat a variety of psychosocial conditions, including psychodynamic counselling. This therapy uses past experiences as a link to present difficulties. It is considered a useful type of therapy for those who need to understand why things are the way they are before being able to move forward. Where individuals do not necessarily need to know why, this therapy is less successful. It is also not considered appropriate for those individuals who have borderline or antisocial personalities.

Good Therapy and How to Recognise it

Ruth Harrison

Network therapy is used where the support from others is essential toward recovery. Network therapy uses the assistance of friends, family and work colleagues, as well as professional support agencies and charitable organisations. It encourages all parties to buy into a support package that challenges negative behaviours and improves social interaction. It is used where addictions are problematic, such as alcohol and drugs, as well as eating disorders. The focus and emphasis is that collusion between the various parties is not tolerated. The therapy works by providing a consistent and safe environment in which to support the individual into modifying their behaviours.

Motivational therapy uses rewards and 'pay offs' to change behaviours. Goals and targets are set and the individual buys into the fact that changing their behaviour actually promotes better lifestyle opportunities and general gains. By gaining an understanding as to how their existing behaviour causes high-energy expenditure, increased anxiety and/or depression, it can help them address the barriers that inhibit personal success.

Motivational therapy is used successfully where individuals have reached a point of dissatisfaction with current personal behaviours and see that this is a cause or a trigger of their personal growth and general ability to succeed.

Intensive psychotherapy is long term, more than nine months, and applies the theory of 'working through' thoughts, feelings and behaviour. Its focus is to create insight and understanding into conscious and unconscious behaviours that have become entrenched and are responsible for negative moods. Psychotherapy requires the individual to 're-

learn' more appropriate behaviours by exploring past events and accepting that change requires a shift in thought as well as actions. It is less structured and works at a pace that is largely dictated by the client.

There are about 40 recognised types of therapy and many more that are considered 'experimental' or 'alternative', which have little or no evidence base and no research to justify their claims. The range on offer to the individual will largely depend on a number of factors, including their geographical location, the local resources of the Primary Care Trust (PCT), the belief system of their treating team and the individual's ability to financially contribute towards or pay for their treatment.

CBT and its use

Cognitive Behavioural Therapy (CBT) is not new and was first introduced by Beck in the early 1960s. Beck developed CBT as a reaction against the theoretical excesses and practical limitation of psychoanalysis. It is based on the assumption that an individual's thoughts

are "automatic" and play an important role in determining mood and behaviour. Ordinarily, this "automatic" thought process is not a problem, but in times of emotional distress or depression the thoughts and behaviours surface too strongly and cause dysfunctional actions that seriously affect all aspects of life⁴.

Over more recent years CBT has been updated and is now considered one of the treatments of choice, endorsed

by NICE (National Institute for Health and Clinical Excellence)⁵. NICE is the independent body that advises the NHS on appropriate or acceptable treatments that

have proven clinical effect, which have demonstrated, through repeated use and evaluation, that they are worthy of investment and are cost-effective and appropriate for the majority of patients.

CBT is a relatively short-term (16 – 22 weeks) present-orientated therapy. It is used with individuals who are considered to have some insight into their difficulties. There must be a motivation to want to 'get better' and a level of cognitive function that would allow them to comprehend and assimilate information as well as be able to, with support, create and use strategies to resolve problems and challenge destructive behaviours that are responsible for decline in their mental health in the first place.

The therapy is considered proactive, collaborative and structured and works by assisting individuals to focus on recognising their negative thoughts (their cognitive approach), and associated behaviours (their actions), and challenge these using a toolkit of strategies and approaches in order to achieve specific goals.

For example, if an individual's automatic thought process is "I can't do this" and then their behaviour is to 'opt out', this can be challenged by offering the individual alternative thoughts and choices, such as:

- "I can do this but will need to identify some time, support and resources to do this", or
- "I might be able to do this but need further information first", or
- "I will need to investigate as to whether I can do this".

These thoughts are more positive and can then influence behaviour by enabling the individual to take responsibility. By taking responsibility and ownership individuals increase their confidence and self-esteem and this in turn improves their overall well-being.

The overall aim of CBT is to modify distorted and dysfunctional automated thoughts and actions, which cause depressive features and raised anxiety levels. Individuals are empowered and enlightened as to what they can achieve as opposed to what they feel they can't achieve, which then enables them to take control of their life and 'deal with' stress. Making the individual aware of choice in how they might manage things differently offers realistic, unemotional capacity to develop a framework from which to work from.

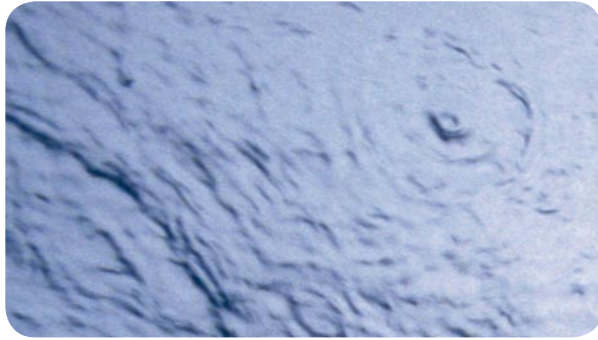
An important focus of the treatment is to help people see the futility and invalidity of negative thoughts and behaviours as well as to help them understand that the energy invested into positive thinking and behaviours is actually far less than those that are afforded to negative ones.

The development of insight and awareness need not take long, and once the principles have been understood the work is mainly around practicing and reinforcing new behaviours. Unfortunately, like a bad habit, negative thoughts and actions have to be continually confronted so that achievement remains progressive. The 'pay off' for the individual concerned is that in the long term the improvement in coping strategies elevates mood, improves social function and ultimately enhances the feel good factor, which challenges depression and reduces anxiety. By achieving these factors, capacity to function in everyday activities (including work) increases.



Good Therapy and How to Recognise it

Ruth Harrison



CBT is conducted on a sessional basis at either weekly or two weekly intervals. Continuity is essential and the frequency and timing of the sessions need to reflect the space and time needed to practice the 'homework'. When supporting people to return to work from a period of absence the homework is usually about managing tasks, targets and relationships with work colleagues that may have been, or potentially could be difficult.

Aids such as laminated prompt cards can keep a person focused and provide the support when the therapist is not there. The cards are simple reminders to remain positive and help the individual think through an action that will create the best solution. Examples of this might be:

- **What is the problem? Is it a problem?**
- **What am I thinking? What could I change my thoughts to?**
- **What are the possible solutions / alternative choices?**
- **What resources will I need?**
- **What action will I take?**
- **What are the possible consequences?**

Choice, flexibility and control arise from taking a positive attitude to situations that one might normally take a negative stance to. Boundaries are challenged and new initiatives that bring about change are practiced within the safety of counselling.

What is the Efficiency of CBT?

One of the questions considered by many people is "what constitutes a successful CBT treatment?" The answer of course is not straightforward and has several components.

Awareness constitutes a partial success and this is where the individual is able to recognise that their thought process and associated behaviours prior to treatment were counterproductive and responsible for their rising stress levels and inability to cope.

Secondly, success is achieved when the individual can challenge dysfunctional thoughts and behaviours on a regular basis (meaning 75% of the time) and can utilise mechanisms and strategies to overcome the problems that they may be faced with, irrespective of whether they are real or perceived. Individuals will confidently choose to take a pathway that would be considered by most to be productive⁶.

Thirdly, success is when stress, anxiety and depression are being 'managed' via CBT to be kept under control and, as a result of which, they do not negatively impact upon the individual's social, occupational and personal life.

Finally, total achievement can be considered when all three elements are experienced and observed over a period of time and where a general feeling of wellness has been restored to the individual, to the point that the individual operates unconsciously and equilibrium of appropriate positive thoughts and actions are the norm.

Sound and robust efficacy studies exploring the value of CBT are few and far between, and due to the subjective nature of the psychological conditions and the variables experienced in the provision of treatment, it is not surprising that such studies are not plentiful. However, CBT can be effective on a variety of levels and measuring this with accuracy is never going to be an exact science. The Department of Health (2001) commissioned research into the efficacy of CBT and The Royal College of Psychiatrists (2005), The Sainsbury Centre for Mental Health,

The Mental Health Foundation and The United Kingdom Council for Psychotherapy (UKCP) have all had researchers who have contributed to the discussions of efficacy. The evidence agreed by all is that:

- **CBT is one of the most effective treatments for conditions where anxiety, depression and stress are the main problem**
- **It is effective for individuals who have mild to moderate symptoms**
- **It is as effective as antidepressants and can be used alongside pharmacological treatments, but should not necessarily be used in place of antidepressants**
- **One-to-one therapy with an appropriate therapist is anecdotally more effective than group CBT**
- **CCBT (Computerised Cognitive Behavioural Therapy) is very effective but only with a specific group of individuals, largely those in the mild to moderate severity category and those who do not have a complex psychiatric overlay of other symptoms or have motivational problems⁷.**

Why CBT Doesn't Work

There are many theories as to why therapy doesn't work with some individuals, yet appears to be beneficial to others.

Too much time spent on analytical approaches rather than practical solutions could be seen as having a bearing. Some individuals in therapy seem to develop understanding and insight into their troubles but fail to change their behaviours. It could be that in these situations individuals, despite what they say, do not actually wish to change and are comfortable with their way of being. Possibly they have become so accustomed to operating in such a way that to give it up for another behaviour is something they are not ready for or choose not to do.

Poor engagement and lack of motivation are probably the most common reasons for failure, and this could be as a result of fearing the unknown. Some individuals are not ready to invest time, energy and effort into the process or have the misconception that the therapist will sort it all out.

Poor or insufficient funding is sometimes cited, and this is usually when financial funds are withdrawn mid-therapy.



Good Therapy and How to Recognise it

Ruth Harrison

A poorly skilled therapist is perhaps the most detrimental of all reasons and this can cause the individual more problems than when they commenced the therapy. Poor focus and direction and therapists who have ineffective, or worse, no objectives at all from which to assist the individual are generally not going to get positive results. Therapists who use the treatment of others as a way of addressing their own issues are not only a cause of failure but are unprofessional and dangerous.

Undertaking therapy and being in therapy does not necessarily need to be a deep and meaningful experience and can be just as effective when viewed as being a practical process to explore and develop different strategies to resolve problems. Often therapists create an illusion that therapy is an unexplainable and almost mysterious experience and a journey of enlightenment that will influence change by the experience alone. This unhelpful portrayal of therapy reinforces stereotypical images of being emotionally stripped whilst on a consultant's couch in some dark and dingy 'counselling' room.

Any number of reasons as to why therapy doesn't work can have justification and when embarking on therapy as an individual, people should be aware that enlisting the most appropriate 'helper' is the largest key to success⁸.

So What Makes A 'Good' Therapist?

Before even contemplating engaging a therapist, define the credentials that an appropriate therapist should have. These credentials must be vetted and validated. A combination of specific competencies, practiced skills and appropriate individual qualities is generally what makes a 'good' therapist.

Competencies

A competent therapist will usually be a health professional such as a psychologist, specialist mental health nurse, social worker, counsellor, or doctor. They will also be expected to have the minimum qualifications. The therapist should possess a Diploma of Counselling in Psychological Therapies, which is inclusive of CBT or a specific certificate of CBT counselling. Most therapists will also have a BSc or MSc in general counselling.

Any practicing CBT therapist will be expected to be registered with the Directory of Chartered Psychologists, The British Association for Behavioural and Cognitive Psychotherapies (BABCP) or with the United Kingdom Council for Psychotherapy. All of these organisations hold charters of good practice and endorse areas of Continuing Professional Development (CPD), assist with research projects and identify public safety with high regard. In order to hold full membership of these associations you must be qualified or be in training. Sadly at the

moment there is no legal requirement that all practitioners must be qualified, hence the need to cautiously assess the calibre of the therapist. Any therapist that has undergone training and has achieved a recognised qualification will have demonstrated having met a variety of learning outcomes through rigorous supervision and demonstration of ability.

Skills

The delivery of CBT requires an ability to engage clients in a collaborative working relationship. It is hard work and time consuming, and insists on the therapist having to use effective and comprehensive observational, analytical and assessment skills. The understanding of communication dynamics is essential as well as skills in coaching, confronting and supporting. The clinical environment is used to skilfully manipulate the client's participation towards self-help and assists in reshaping and reinforcing a much more robust and productive thought process. The client works with the therapist

"The delivery of CBT requires an ability to engage clients in a collaborative working relationship."

to challenge specific areas of thought and behaviour and eventually the individual becomes more confident, independent and resourceful to cope with issues that would have previously caused distress or even mental ill health.

A successful therapist will regularly evaluate their work through 'clinical supervision', which is a process where the therapist can discuss openly the dynamics of the communication with the client to another qualified but independent professional. The supervision enables professional reflection and objective evaluation of

where the therapy is going, what has been achieved and what direction is needed next.

All CBT therapists will be able to separate their personal issues from those of the client and avoid 'transference' of issues. This enables the

process of therapy to remain professional and on track. All 'good' therapists will be able to justify the interventions being used, and practice via a set of well researched and evidence-based tools and will skilfully acknowledge social and cultural diversity.

Qualities

Qualities are generally something that a therapist will not be able to learn and that no amount of training will improve. Qualities are inherent attributes of an individual that will enhance that of the skilled practitioner and will make the difference between a good therapist and a great therapist. Patience, kindness, understanding and compassion are qualities that in this context work efficiently so as to provide a relationship basis that is honest, empathic and productive.

Qualities are hard to define but are, generally speaking, those attributes that add charismatic elements to the client-therapist relationship and which are believed to enhance the client's experience and where 'success' is better observed.



Good Therapy and How to Recognise it
Ruth Harrison

Conclusion

The provision of psychological therapy is by no means the answer to all ills. It is, however, the expected and accepted treatment for people in distress or with mild to moderate anxiety and depression and whose coping mechanisms have failed them. It works with people who have lost confidence, direction and skills but who are still motivated and relatively insightful.

The type and breadth of psychological therapy is dependent on many factors, but what is clearly understood is that the client has to be willing to engage and be receptive to change. It is likely that any individual who enters into a contract of therapy will not be familiar with the process and therefore it is essential that expectations are defined and the process explained prior to the commencement of any treatment.

The client needs to be willing to learn to take responsibility and ownership of choice, as well as invest in working to change thoughts and behaviours that have been influential in causing the current status quo.

Therapists are available and accessible but care must be taken to ensure that skill competency and quality is proven.

When Unum agrees to support provision of psychological therapy to those claimants deemed appropriate, the process is carefully and closely managed in order to ensure appropriate referrals and maximum potential are achieved.

There are high financial, commercial, personal and general human costs associated with distress, stress or mental ill health. Government statistics show that mental health disorders are worthy of investment

and treatment, and there is a moral responsibility to ensure that, where possible, individuals are offered appropriate support to challenge such difficulties. By doing so, they can revert to 'normal' life and engage in meaningful occupational activity.

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“When Unum agrees to support provision of psychological therapy to those claimants deemed appropriate, the process is carefully and closely managed in order to ensure appropriate referrals and maximum potential are achieved”



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Ruth Harrison

Ruth holds a BSc in Psychology and Social Policy and originally trained as a social worker within the family services department in Hampshire. She then went on to complete training as a psychiatric nurse and a CBT therapist, and spent seven years working in a variety of mental health settings, both on the wards and in the community. In 1997 she undertook a management role in a Social Care trading arm and was responsible for organising and delivering care contracts between social services and Loddon NHS Trust. In 2000 she changed direction and after gaining a PGCE headed up the Health, Social Care and Early Years School within Basingstoke College with additional responsibilities to Winchester University.

Ruth has been with Unum since 2005 in her current role as an Insurance Nurse Specialist where she assists claims specialists in interpreting, assessing and, where appropriate, challenging medical evidence. She is also currently studying for a PhD in mental health.

The Interface Between Psychiatric and Physical Disorders

Dr. Chris Bass,
Consultant, Liaison Psychiatry
- John Radcliffe Hospital, Oxford

As a psychiatrist who has spent the last thirty years working exclusively in general hospitals, I am acutely aware of the firewall that continues to exist between psychological and physical services and/or disorders. 19th Century psychiatrists were not called alienists for nothing, tucked away in the asylums in the middle of the county, out of sight and out of mind. Has much changed in my lifetime?

Not much. Apart from the recent introduction of four-month psychiatric placements into the F1 and F2 training grades, the co-ordination of psychiatric and non-psychiatric services remains, with very few exceptions, underdeveloped. Why is this? There are many reasons, some of which I will touch on here, before going on to talk about the problematic word “psychosomatic”, the stigma of mental illness in patients with functional syndromes, and the ways in which the “interface” or the firewall can be removed.

Apart from obvious geographical factors, i.e. medical and psychiatric units generally being separate and segregated, the access to these services is very different, especially in the UK. General hospital physicians are always mystified by the “sectorisation” of patients by psychiatric services, and the

difficulty this sometimes leads to in gaining access to psychiatric treatment. The purchasers of healthcare also operate as if the firewall was a permanent fixture. Kathol has bemoaned this fact of “dis-integrated” care in the USA in a recent book (Kathol, 2007). He has pointed out that patients with medical disorders and co-existing psychiatric disorders (referred to as co-morbidity) have much worse clinical, functional and economic outcomes, but despite this very little is done by the purchasers of healthcare in both the US and UK to provide effective clinical care for these patients. Furthermore, most physicians are not trained to recognise or identify patients with concurrent physical and psychiatric illness; nor do they realise the impact the emotional problems have on the clinical, functional and economic outcomes for these patients. They are often discouraged from seeking out mental/behavioural health problems in their patients because they are usually overwhelmed with tasks in their own discipline. As a consequence it is still possible, in 2007, for highly trained doctors in centres of excellence to refer a patient to me with “please see - functional overlay” or “probable supratentorial elements”: phrases which are meaningless in themselves but are used euphemistically to suggest psychological issues. Such language represents a failure of the educational process in that it demonstrates the inability of these doctors to address these possible problems with their patients. Unless and until physicians have an incentive to address these co-morbidities, they will continue to ignore them.

Another major factor keeping the firewall in place is the word “psychosomatic”, which psychiatrists on both sides of the Atlantic struggled with for most of the 20th Century. Recent research has explored the contextual meaning of this word in US and UK newspapers and found that the word “psychosomatic” had a pejorative meaning (imaginary or “made up”) in one third of the articles in which the meaning could be judged. Most commonly, “psychosomatic” was used to describe a problem that was psychological or in which the mind affects the body (56%) rather than as a reciprocal interaction (5%). Clearly, more needs to be done to educate the media about its actual meaning to make it attractive to patients. In the meantime, however, we remain lumbered with it.

But it is not all doom and gloom. In the last decade high quality research has demonstrated the key role of psychosocial factors in a variety of diverse disorders that have previously been conceptualised as “medical”, such as fibromyalgia, whiplash and Chronic Fatigue Syndrome (CFS). Furthermore, these so called “somatoform disorders” are the third most common cause of workplace absence, which has forced the government and insurance companies to sit up and take notice. Recent figures have revealed that 70% of individuals in receipt of Incapacity Benefit have a combination of musculoskeletal symptoms and emotional distress i.e. non-organic disorders, which in my opinion represents a failure of not only the medical

“70% of individuals in receipt of Incapacity Benefit have a combination of musculoskeletal symptoms and emotional distress.”



The Interface Between Psychiatric and Physical Disorders

Dr. Chris Bass



model but also the training of doctors. Indeed, Hadler (a rheumatologist) has pointed out that the key difficulty with fibromyalgia lies in framing the problem as biomedical. He criticised the traditional medical approach that he describes as a “diagnostic contest” where the patient is compelled to focus on symptoms that defy explanation. The patient then feels blamed and let down when a psychological approach is suggested. Similar processes occur in patients with CFS and whiplash neck injury - the greatest predictors of persistent neck pain following a Road Traffic Accident (RTA) relate to psychological distress and aspects of pre-collision health rather than to various aspects of the collision itself (Atherton K. et al. *Emergency Medical Journal* 2006). These factors are not routinely addressed in medical or surgical clinics, or in medico-legal or insurance settings, which may contribute to the large number of individuals who end up unable to work and receiving Incapacity Benefit described above. These patients with non-organic complaints are overrepresented in the clinics of alternative practitioners, where they are often provided with explanations for their symptoms, that are (a) implausible, and (b) reinforce a “somatic” ailment where none exists. Patients do not need more complementary practitioners peddling non-evidence based treatments - doctors need to be better trained.

Regrettably, most physicians continue to be oblivious to the role of **illness perceptions and beliefs** in these disorders, which impact not only on outcome measures, but also on reassurance following negative medical testing and future healthcare use. It has always surprised me that physicians (and surgeons) are not routinely taught techniques to interview and manage the vast number of patients who leave their outpatient clinics with normal endoscopies, coronary angiograms, laparoscopies and laparotomies and normal video telemetry etc. (Petrie K. and Weinman J. *Clinical Medicine* 2006, vol 6, pp 536-539). It is well known that a high proportion of such patients continue to report pain and functional limitations and, if the symptoms do not resolve within 6-9 months, doctors like me will receive the brown envelope with a request to complete the forms for Disability Living Allowance.

Of course many patients do not like to be informed that psychosocial factors are more important than physical ones in the outcome of their often chronic musculo-skeletal and painful disorders, and there is evidence that patients with CFS report more stigma than comparison groups with medical disorders (Looper K. et al, 2004). But it is possible to explain the role of emotional factors in the maintenance of these patients’ illnesses without making the patient feel blamed, guilty, inadequate or helpless. The real challenge for the medical profession is to create an environment where patients feel comfortable in addressing factors such as depression and social difficulties which hinder their ability to cope; helping them to accept that poor coping is a key problem. The acquisition and use of these skills will have the advantage of “demedicalising” their distress.

Can anything be done to address these shortcomings in the organisation of medical and psychiatric services and the training of doctors? One resource I have always yearned for in our service is a joint physical/psychiatric unit within the general hospital (say four beds) for patients with combined physical/emotional disorders (or even patients with severe non-organic disabilities such as conversion disorder, severe disabling fibromyalgia, Korsakov’s syndrome and the like). Such units would be expensive to run, with high staffing ratios, combinations of medical and psychiatric nursing and ancillary staff, but the benefits to the hospital, the patients and the training of doctors would be considerable. Such a unit exists at Leeds General Infirmary, but this is the exception to the rule.

Another gross anomaly is the provision of funding of services for patients with not only co-morbid conditions mentioned earlier, but also disorders such as psychogenic non-epileptic seizures, disabling



“The real challenge for the medical profession is to create an environment where patients feel comfortable in addressing factors such as depression and social difficulties which hinder their ability to cope.”

The Interface Between Psychiatric and Physical Disorders

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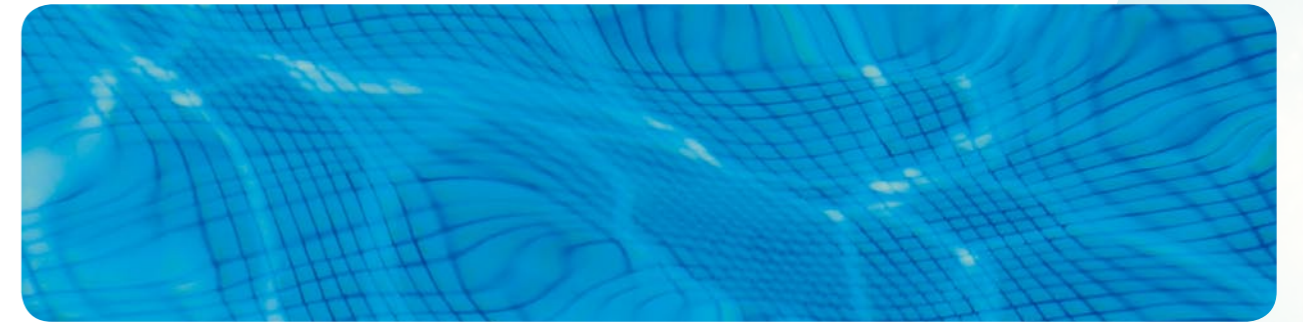
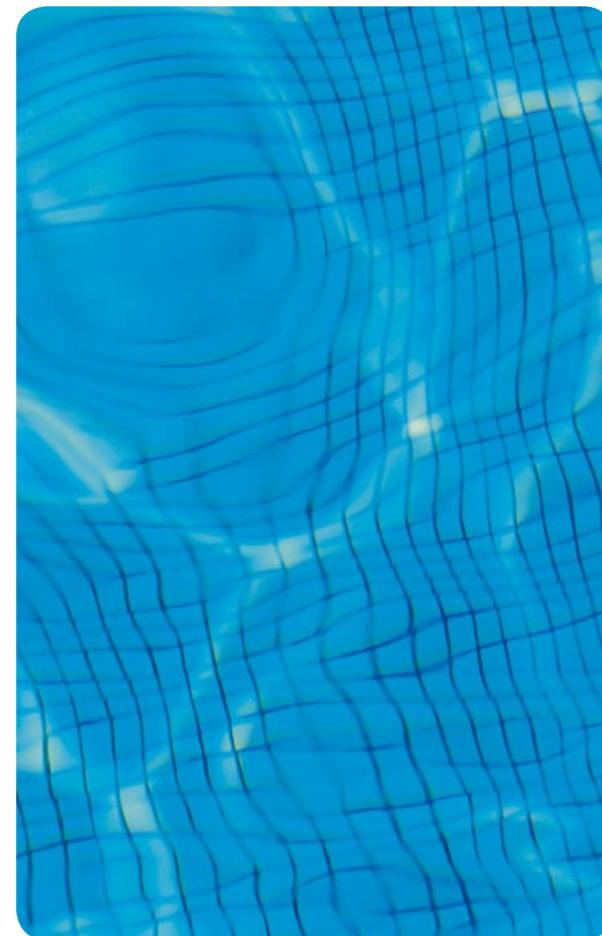
conversion disorders and other causes of “non-organic disability”. In our hospital there are designated services (usually specialist nurses) for patients with multiple sclerosis and epilepsy, but none for those with conversion disorders (which are as common as MS and arguably as disabling) or pseudo-seizures (extremely common, difficult to manage and often disabling). Why is this? The neurology service does not see these patients as being within their remit, and psychiatric services, preoccupied with serious mental illness, relegate patients like this to the margins. As a consequence many of these patients end up without appropriate help and gravitate to disability benefits at great cost to the nation. The purchasers of healthcare and the PCTs, who profess to follow the government agenda of “chronic disease management”, ignore these patients because they defy the narrow constraints of the biomedical model. In our hospital, patients with chronic fibromyalgia and common comorbidities used to be managed in a joint pain clinic by myself and pain clinicians. Last year the hospital trusts attempted to close both our unit (Liaison Psychiatry) and the Pain Clinic. So the omens do not look promising.

What is particularly galling is that the purchasers of healthcare do not appear to understand basic facts. Our Western culture predisposes us to frame any loss of a sense of wellbeing, or other form of psychosocial distress, into idioms of **physical** rather than **psychosocial** distress. In the workforce misconceptions about this fact, and about the physical cause of regional musculo-skeletal disorders, such as RSI and limb pains, have misled the occupational health and safety agenda for over sixty years (**Hadler, 2004**). Many physicians do not understand or recognise this. Indeed, in a recent article a rheumatologist suggested that by 2050 “neurotropic blockers will put an end to the problem of fibromyalgia and myalgic encephalomyelitis.” This is the medical model run riot, and it does not bode well.

Are there any other hopeful signs? The first is that evidence-based treatments (usually Cognitive Behavioural Therapy) have been shown to be helpful in controlled studies of disorders such as persistent widespread pain (fibromyalgia), chronic neck pain

(whiplash) and fatigue (CFS). Because these disorders are common causes of workplace absence, insurance companies have kept pace with these developments and services for treatment and rehabilitation have been established, but often in the private sector.

Second, my anecdotal impression (carrying out insurance medical exams for the last 10 years) is that some orthopaedic surgeons, rheumatologists and occupational physicians have become aware of the key importance of psychosocial factors in the maintenance and prognosis of these disorders. But when evidence-based treatments are recommended for these patients, resources are scarce. Finally, the publication of two books has been the cause of much cheer. Malleeson’s masterly book on “Whiplash and other useful illnesses” (2002) has raised the profile of some of the issues raised in this paper, and Hadler’s incisive account of the medicalisation of our lives (The Last Well Person) should be given to every medical student as they embark on their clinical training.



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Dr. Chris Bass

Chris trained in medicine at Cambridge University and St. Thomas’s Hospital in London and in Psychiatry at King’s College Hospital in London. He has been working as a Consultant in Liaison Psychiatry at the John Radcliffe Hospital in Oxford since 1991 where he has carried out collaborative research with many different hospital specialists. His main areas of research and clinical interest include patients with persistent medically unexplained physical symptoms and patients with fabricated illnesses. He is particularly interested in patients who exhibit “surgery prone behaviour,” for whom the medical model has little to offer. He is also very interested in child protection, and carries out assessments of parents with mental health problems.

Between 1993 and 1997 Chris was Chairman of the Liaison Psychiatry Section at the Royal College of Psychiatrists, and in 1997 he was co-chairman involved in the publication of a working party report on the psychological care of surgical patients jointly with the Royal College of Surgeons. Chris has edited or co-edited five books since 1990.

Why and When do Doctors Collude with Patients?

Professor Simon Wessely,
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Collusion – it must be a bad thing, mustn't it? Just recently, Conrad Black was found guilty of colluding with some fellow directors to defraud his shareholders, some airlines were accused of colluding in price fixing, as was the USA of colluding with China to bypass global warming targets. But doctors, as members of a highly prestigious 'helping' profession, couldn't possibly do such a thing.

But we do, and we do so every day. Sometimes we do so out of self-interest. But more often than not it is done from a genuine belief that it is in the interests of the patient. And sometimes it is even true.



What The Patient Doesn't Know Won't Hurt

All medical students nowadays have drummed into them the concepts of autonomy and shared decision making. Paternalism is as outdated as using a stethoscope to take a blood pressure or an oral thermometer to take a temperature. I sometimes tell our students that I am paternalistic towards my children, which doesn't mean that I don't love them, but it falls on deaf ears. So now if you are sick and faced with some tricky



“There remains a small minority of patients who genuinely do not want to know the bad news, at least not all of it and not right now.”

choices, there's no point in asking your young doctor what you should do - the response will be "what do you think?" The temptation to respond with "you're the one who went to medical school, not me" cuts no ice anymore. Our modern doctor will give the options, and then ask the patient to decide.

OK, so even an old cynic like me has to admit that this is progress. Most patients, most of the time, want to know the unvarnished truth. Thankfully the days when we withheld the diagnosis of cancer because we felt people couldn't cope have gone. And if it is bad news, so be it. A recent study showed that 87% of parents whose children had life threatening illness, namely cancer, desired as much information about the prognosis as possible. But the 13% who didn't want to know were not even spared distress - there was no association between distress and not wanting to know everything. So whatever else colluding with the parents was doing, it wasn't sparing their distress (Mack et al 2006).

But there remains a small minority of patients who genuinely do not want to know the bad news, at least not all of it and not right now. Faith, hope and

charity all play a part (Leydon et al, 2000). Sometimes it is because the patient

really does trust the expert, and doesn't want to know any more. Sometimes the patient wants to maintain hope, and avoiding distressing information can enable them to carry on with their lives for a while longer. And sometimes it is charity - thinking that there really isn't enough time for the doctor to tell them everything, and to do so will only make things harder for the rest of the patients in the queue (Leydon et al, 2000). And it is nothing to do with intelligence, background or training. A former editor of the New England Journal of Medicine, himself an oncologist, admitted that when he was diagnosed with cancer he did not want to know everything, nor to take all the decisions himself.

So gradually our ethically pure new doctors will learn just how in real life things are not neat and simple, but grey and ambiguous. As another study of cancer doctors and their patients showed - "The doctor did and did not want to pronounce a 'death sentence' and the patient did and did not want to hear it" (The et al 2000). Sometimes a little collusion can go a long way.

Why and When do Doctors Collude with Patients?

Professor Simon Wessely

Collusion and the Number Needed to Offend

So we collude out of a paternalistic belief that the patient's interests are not best served by sharing everything that we know. And sometimes we collude because we feel that any other course of action will lead to confrontation, and adversely affect not just our relationship with the patient, but the illness itself.

Take the example of hysteria. Despite being so often described as on the decline it is instead - as the authors of one study put it with tongue, one assumes, firmly in cheek - "alive and kicking". Slater's view that a diagnosis of hysteria merely reflected ignorance, and that most cases would turn out to have diagnosable disease if they were properly investigated or followed up for long enough, has been repeatedly disproved. Go to a neurology clinic and there will be a few patients unable to walk, or unable to see, and yet who quite clearly do not have any organic disease to account for this. Likewise, there exist those who have all the features of epilepsy but a normal Electro-encephalograph (EEG) even in the middle of what looks like a grand mal convulsion.

So when the scans, EEGs and nerve conduction tests are back, and the diagnosis clear, what happens next? Does our ethically trained doctor, embracing autonomy and avoiding paternalism, share this information with the patient? "Sir/Madam - there is no neurological reason why you cannot walk. You have what psychiatrists call conversion disorder, but everyone else calls hysteria". You can

bet your bottom dollar that they do not. In another study nearly every UK neurologist admitted seeing patients for whom the diagnosis of hysteria and/or conversion disorder was appropriate, but hardly any used that label in front of the patient. Instead most took refuge in a variety of euphemisms.

And who can blame them? In one of those papers that one wishes one had written oneself, Stone et al showed the importance of labels, and the hierarchy of euphemisms, devising a new metric - the 'Number Needed to Offend' (Table 1). You have to tell 43

patients who cannot walk that they have multiple sclerosis before one becomes offended, a mere 9 if you say it is "functional", but two is sufficient if you call it hysteria.

Source: British Medical Journal, Dec 21, 2002 - What should we say to patients with symptoms unexplained by disease? The "number needed to offend".

Or take the word 'psychosomatic'. Implying that there is a link between mind and body has a distinguished history, and is part of popular culture. Indeed, some lay models of illness are too psychosomatic - depression does not cause cancer, people do not die of broken hearts, nor do parental over-expectations cause autism. But on the other hand psychosomatic also scores highly on the Number Needed to Offend scale - not surprising, since when used in the media it usually means "imaginary" or "made up" (Stone et al, 2004).

So using labels, even if hallowed in textbooks and reference manuals, can threaten not just any chance

of a therapeutic relationship, but can trigger a battle of diagnosis, from which the patient themselves is the loser, determined to prove the doctor wrong in the only way possible - by staying ill. As rheumatologist Nortin Hadler put it - "if you have to prove you are ill, you can't get better".

So no wonder the doctor and patient both collude. Euphemisms can be important, if they allow the patient to address tangible clinical issues or engage in appropriate treatment and rehabilitation, but without endangering their self esteem. Let's hear it for collusion.

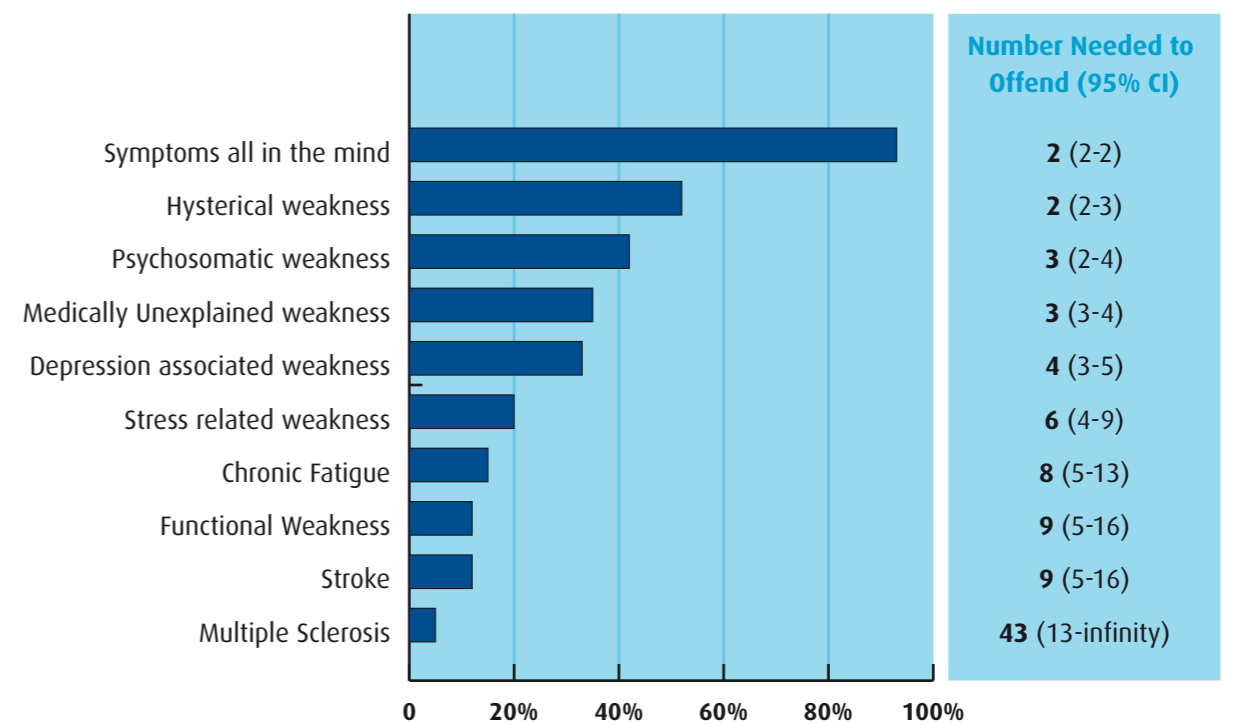


"You have to tell 43 patients who cannot walk that they have multiple sclerosis before one becomes offended, a mere 9 if you say it is "functional", but two is sufficient if you call it hysteria."

Stone et al, British Medical Journal, December 2002

Table 1

A doctor would be suggesting I was 'Putting it on', 'Mad' or 'Imagining symptoms' if I had a weak leg and they gave me this diagnosis (%)



Source: British Medical Journal, Dec 21, 2002 - What should we say to patients with symptoms unexplained by disease? The "number needed to offend".

Why and When do Doctors Collude with Patients?

Professor Simon Wessely

Collusion and Self-Interest

Finding a label that will not offend the patient whilst enabling them to engage in sensible treatment can be a good strategy. I know a number of neurologists who manage patients whom others might call depressed, anxious or somatising under a variety of labels such as neuralgia, chronic migraine, cervical arthralgia, or fibromyalgia. And they don't do too badly. Support is given. Antidepressants are prescribed, although rarely for 'depression', but for analgesia or sleep disturbance. Rest, but in moderation, is encouraged, and linked to some form of regular activity. "Collusion" some might and do say, but it can promote rehabilitative or psychological treatments which if taken head on, would only have led to offence.

And it's nothing new. When historian Edward Shorter reviewed the records of one Edwardian neurologist, Parkes Weber, with an extensive Harley Street practice, what was striking was just how little has changed. The newly affluent middle classes, more often than not women, flocked to his consulting room to be told that they were suffering from nervous exhaustion, that they lacked vital force, and that their nerves really were weak – in short they had what was at the time the perfectly respectable label of neurasthenia.

But there was also a dark side, evident in some of the writings of those on the other side of the couch. People such as Virginia Woolf or Charlotte Perkins Gilman, struggling to escape stifling marriages or the constraints of a society that refused to accept women as anything other than second class citizens. Women seeking to escape the confines of what the Germans would call "cake, church and kitchen" were instead given tonics and rest cures when what they wanted was recognition and independence.

And it got worse. At the same time as Parkes Weber practised north of the river, south of the river at the

newly opened King's College Hospital surgeon Willie Lane plied his trade. He too was interested in the problems of women with unexplained symptoms, most of which we would now ascribe to depression, anxiety or somatisation. But the life of the mind was not for Willie – he believed that the problems all came from the colon. To be precise, that all this "toxic" somatic symptoms were the result of the products of digestion leaking out of the colon and causing ill health. It was called "auto intoxication". It was nonsense, and it was dangerous nonsense. Willie was a surgeon, and surgeons are brought onto God's good earth with the desire to operate. And so Willie used to remove the colons of these unhappy young women. 10% of them died. In fact that was quite a good figure, lower than the standard mortality for abdominal surgery at the time, since Willie was a good surgeon. And amazingly, many of those who

survived got better, and used to write to Willie in appreciation. And so Willie ended his career in glory, as Sir Arbuthnot Lane, surgeon to the King, and still the only person with wards named after him in two separate

London teaching hospitals. Colluding had done him no harm at all. However, it is unlikely that he performed this surgery to cynically exploit his patients and more probable that he firmly believed that he was acting in his patients' best interests.

And whilst many modern Parkes Webers live on, there are also still many Willie Lanes as well. It is still possible to get one's 'autointoxicated' colon cleaned on a regular basis at several establishments near the modern Harley St and celebrities and minor royals have endorsed the treatment.

Whatever your problem, they have the solution. Every test they do is always positive – for some mysterious reason the labs they use always find deficiencies in one trace element or another. They diagnose allergies

using tests that NHS allergists and immunologists regard as at best flawed, and at worst, such as Vega testing, utterly nonsensical. They spout the language of science, but it is a parody language, mixing 'cod' immunology with pseudo radiation science interspersed with New Age homilies (see www.badsience.com). They portray themselves as brave pioneers, unable to practice within the dull, evidence based confines of the NHS, and only when freed from the shackles of NICE and prescribing committees who are only able to give their patients the kind of treatments they really need - at a cost of course. They replace hormones that don't need replacing – giving thyroxine to people with normal thyroid function is currently popular; and like Willie they remove things that don't need removing, dental amalgam from one's teeth being another current fashion. These medical entrepreneurs have a talent for converting the latest scares into opportunities. No sooner did Panorama identify Wi-Fi as one more cause of fatigue and malaise, a raft of Wi-Fi 'protection devices' sprang into being.

As soon as one diagnostic fad disappears, it is replaced by another. The word autointoxication has largely vanished, but colonic lavage and detoxification is a mainstay. We don't see much spontaneous hypoglycaemia these days, and chronic brucellosis has gone the way of all flesh, but candida, dental amalgam, food allergy and multiple chemical sensitivity continue to flourish, and the new electrical hypersensitivities are starting to make themselves felt.

To be honest, the exact label is not the issue, and many are interchangeable – what is important is that they provide an explanation for the stresses, strains and symptoms of life, and an explanation that almost invariably avoids any of the possible self blame, stigma and guilt of those diagnoses that more conventionally minded doctors use.

Surprisingly, in spite of the harm some treatments can cause, even if it is only by delaying access to effective medical treatment, few people seem to complain about these therapists. It's a form of

cognitive dissonance. Or perhaps it is just too painful to realise that the kindly, polite, charming doctor with the smart consulting room, the latest gadgets, and the utter conviction that he or she really does understand the cause of your problems is really giving you things you don't need for problems you don't have. And so the swings that you gain in having your complaints listened to and legitimised are lost on the roundabouts of continuing ill health and dependency on doctors.

Anything for the Quiet Life

I doubt there are few occasions in which doctors are more pressured to collude with their patients when the latter pushes across the desk a form that needs to be signed. I asked my wife, an inner city GP, what forms she has to complete in a typical week. OK, she said, there are the sick notes. I had thought of that. And fitness for work. Fair enough. And fitness to drive. OK, well, I can see that. But she said, yesterday I had to certify someone as fit to fly – as a passenger. Oh yes, and last week it was fitness to fly as a pilot, and on it goes. There are the insurance medicals and forms that the readers of this document will be more than familiar with. But gun ownership? Do doctors really know who is suitable to own a gun? I was once asked by a government department to devise a screening form to assess this. I proposed one question – "do you want to own a gun?" and if the answer was positive, then you were unsuitable. But GPs are supposed to know who is suitable to own a gun, just as they are supposed to know who is suitable to foster or adopt.

And then there are the exemptions – a GP needs to certify that you are unable to use a seat belt, pay off your debts or your council charge, need longer time in exams, or not be able to sit them all together. So the potential flash points mount up – forms to say you are not fit to go to court, do community service, or obey a probation order. Last week my wife had to certify that someone was fit to use a gym (and there was I thinking the reason you used a gym was because you were unfit).

"If you have to prove you are ill, you cant get better."

Nortin Hadler

Why and When do Doctors Collude with Patients?

Professor Simon Wessely

Most weeks my wife has to certify that a photo is a true likeness of one of her patients. And in nearly every case there is little to be gained and everything to lose by refusal to complete any of these forms. So who can blame the doctor for colluding with the patient? The GP may harbour lingering doubts about why nearly every child getting extra time in exams is middle class, or is adult attention deficit disorder really a reason not to be able to comply with a community treatment order? Or is it really 'work stress' when the doctor knows all about the divorce and difficulties with the kids? But what the heck – if I don't sign the chances are they will complain, and that will involve weeks of paperwork, bad publicity and an uncertain outcome. So it's anything for the quiet life.

Where did this all start? It all began with the introduction of Social Security benefits in Germany, particularly with the Sickness Insurance Act of 1883 in Germany under Count Otto Von Bismark. Clearly, if benefits were to be introduced a gatekeeper would be needed, and doctors were willing to undertake that role. When the legislation came to Britain doctors were similarly willing. Many would argue that doctors saw themselves as defenders of the State against the potential hordes of claimants of these new benefits.

So I am afraid we doctors have brought this on ourselves. But what no one envisaged was the sheer size of what would become the welfare state, nor the resources that it would eventually command. Now collusion is just about the only way my wife can cope with the bureaucracy, and who can blame her?

Conclusion

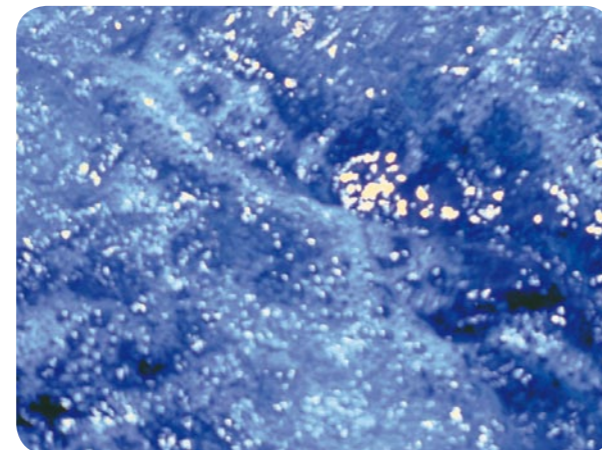
So doctors collude with their patients all the time. It's not such a bad thing after all. When I (briefly) trained in psychotherapy I was taught that, whatever

else, we should show positive therapeutic regard for our patients. Or to put it simply, we are on the patient's side. Sometimes in psychiatry we are the only people who are. If we are not for our patients, who else is going to be?

And often that means collusion in one shape or form. Sometimes we

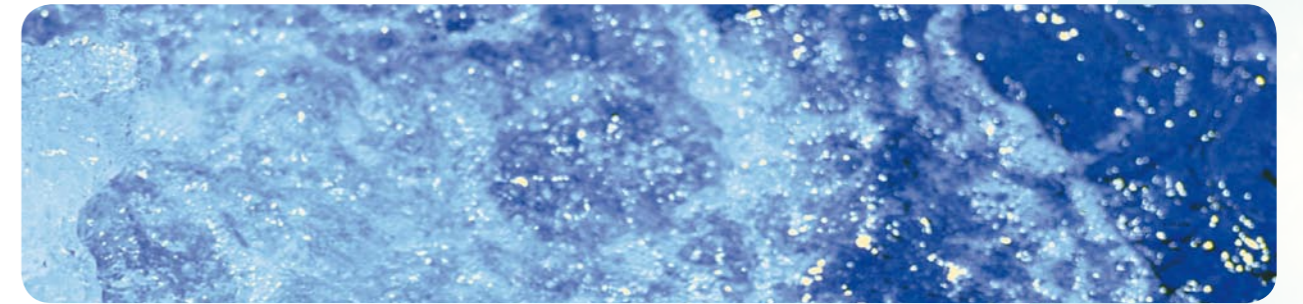
don't always "tell it as it is", if we pick up cues that a person really doesn't want to know the worst, at least not now. Sometimes we endorse diagnostic labels of dubious provenance – but what does that matter if at least it enables the person to get help? And so what if we sign a person off with 'work stress'? After all, their employer may well not be a paradigm of virtue, and the break might at least enable the patient to patch up an equally dodgy marriage.

But there are limits. Dubious labels can also lead to equally dubious treatments. Collusion is also easier to defend if one party gains nothing from the encounter – but when the doctor reaps a rich reward in fees, it is harder to claim a moral paternalistic high ground.



Around 22 million sick notes are requested in the UK each year - an average of 577 for each GP.

BBC News website,
April 2004



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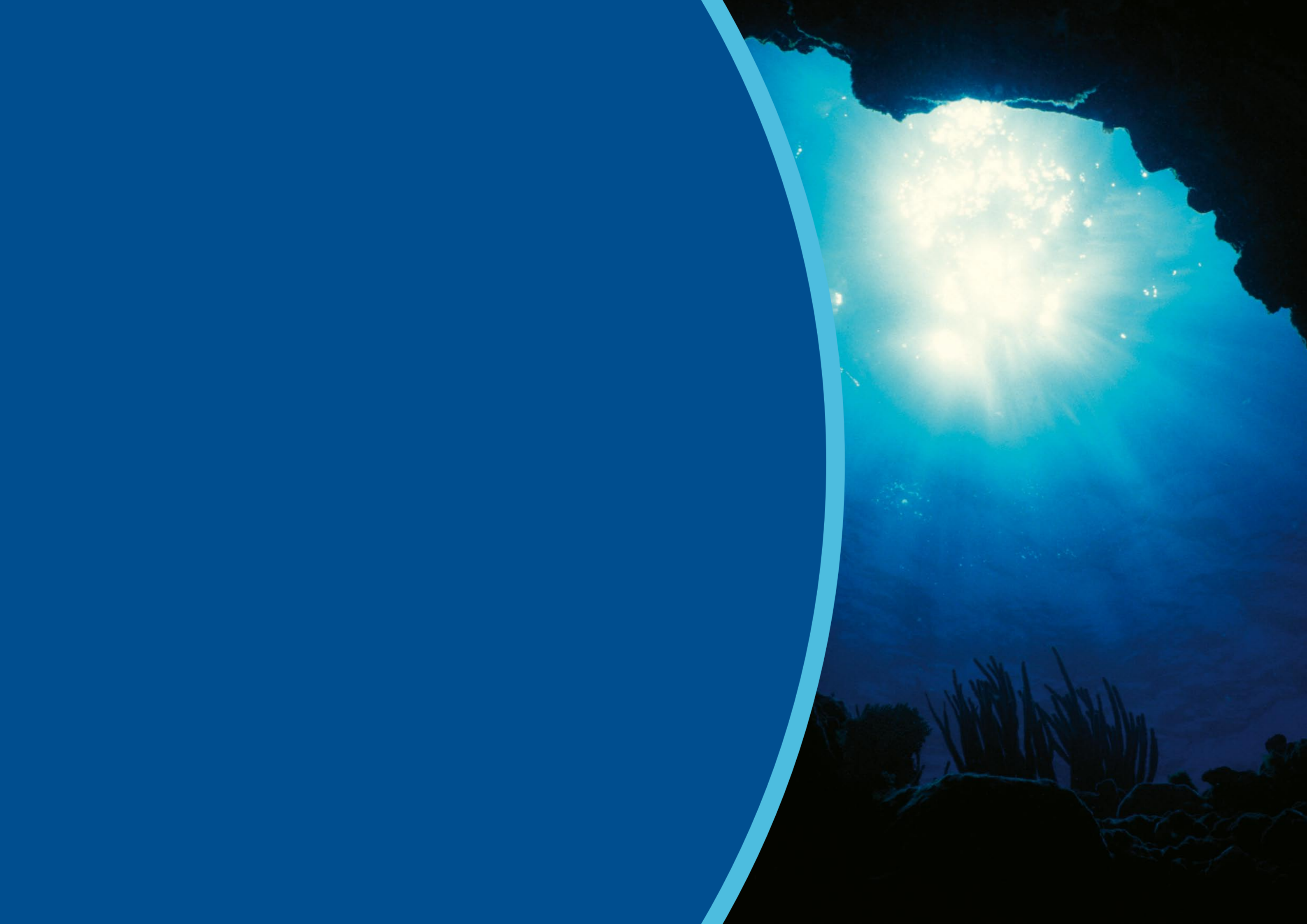
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Simon Wessely is Professor of Epidemiological and Liaison Psychiatry at the Institute of Psychiatry, King's College London, and Honorary Consultant Psychiatrist at King's and Maudsley Hospitals. He started his psychiatry training at the Maudsley in 1984, and has not really left Camberwell since, other than a year at the National Hospital for Neurology, and a year studying epidemiology at the London School of Hygiene.

Simon's research interests are in the grey areas between medicine and psychiatry, clinical epidemiology, psychiatric injury and military health. His first paper was called "Dementia and Mrs Thatcher", but since then he has published over 500 papers on many subjects, including epidemiology, post traumatic stress, psychological debriefing, chronic fatigue syndrome, history, chronic pain, somatisation, Gulf War illness, military health and terrorism.

Simon is also Director of the King's Centre for Military Health Research Unit at King's College London. In 2006 the unit published the first results of a study of the physical and psychological health of 12,000 UK military personnel, half of whom have served in the Iraq conflict.



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