Talking therapies: ‘the indispensability of ambivalence’

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My purpose in this talk

- My standpoint and dual identity
  - An academic social science researcher in mental health
  - Mental health service user – Received talking/psychological therapies (different modalities; individual/group) since 1992

- Draw on my personal experience of ***Beating the Blues;*** a computerised self-help CBT programme

- Reflect critically on and problematise key ideological/discursive underpinnings and practices evidently shared in varying degrees by psychological therapies at large

- Given the polarised discussions regarding talking/psychological therapies, call for the 'indispensability of ambivalence' **(Callard, 2014, 'Psychiatric diagnosis: the indispensability of ambivalence', *Journal of Medical Ethics*, 0:1-5)**

Before *Beating the Blues*…

- Severe and enduring mental health crisis since July 2008 (2008-2010); hospitalisation and detention under the Mental Health Act 2007 for 3 months in an acute ward in Manchester; January–April 2009; a diagnosis of ‘psychotic depression’
- According to my Care Co-ordinator, my hospitalisation did not improve my mental health state; I remained severely depressed and suicidal following my discharge
- **‘I do not want this life…’**

Before *Beating the Blues…*

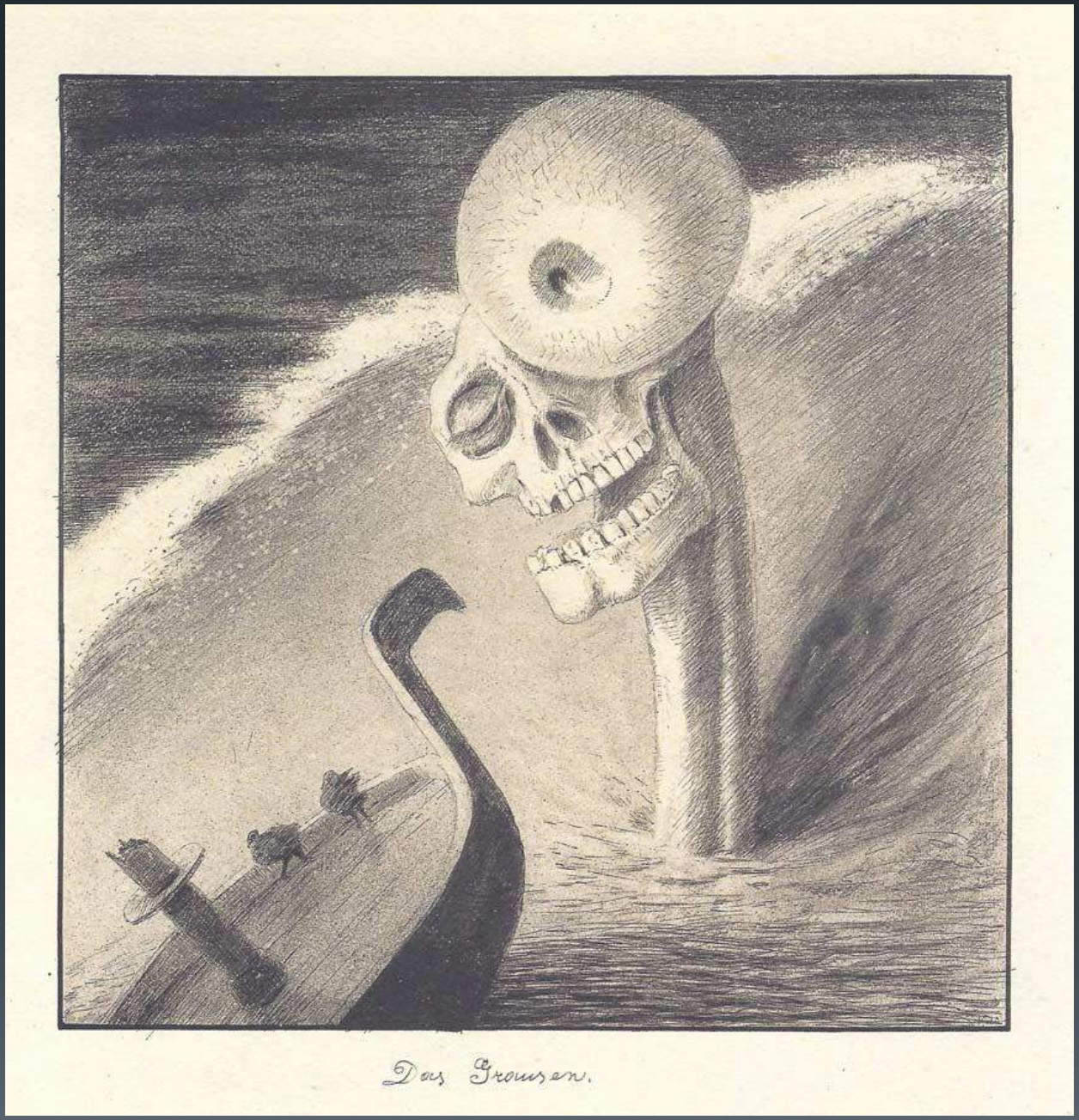
- ***'My latest mental health crisis and hospitalisation/sectioning were major biographical disruptions for me that entailed huge losses, traumas and suffering, having catastrophic consequences for every aspect of my life, which left me feeling a great deal of bitterness and anger, as well as deep sadness and an acute sense of loss. First and foremost, as a result of my very severe and persistent depression, for a couple of years, I lost what had always been a vital source of self-esteem and recognition for me-my capacity to think creatively and excel intellectually/academically. I could not think clearly, I could not concentrate and retain information, I could not process language, I could not read and understand what I was reading, I could not be intellectually creative. My head was constantly heavy and cloudy due to the potent medication I was prescribed- especially when I was on copious amounts of it. I was off work for nearly 2 years and thus away from opportunities for intellectual stimulation for far too long'***
- ***'All the above represented a huge blow to my confidence and a source of profound feelings of humiliation and shame, as well as a source of a deep sense of failure, unfairness/injustice and stigmatisation- all acutely disempowering emotions. In a nutshell, my mental health crisis and in particular my sectioning in 2009 were scarring, terrifying experiences whereby the very core of my existence was deeply shaken and all my certainties collapsed'***

(Monologue for INVOLVE Conference 2012)

Before *Beating the Blues…*

My care records covering the period of my detention in hospital (January-April 2009) portray me -among others- as

'dishevelled, retarded, highly agitated and characterised by suicidal ideation, lethargic and far from mentally alert, incontinent, odorous, occasionally subjected to physical restraint and possibly needing ECT treatment due to treatment-resistant severe psychotic depression'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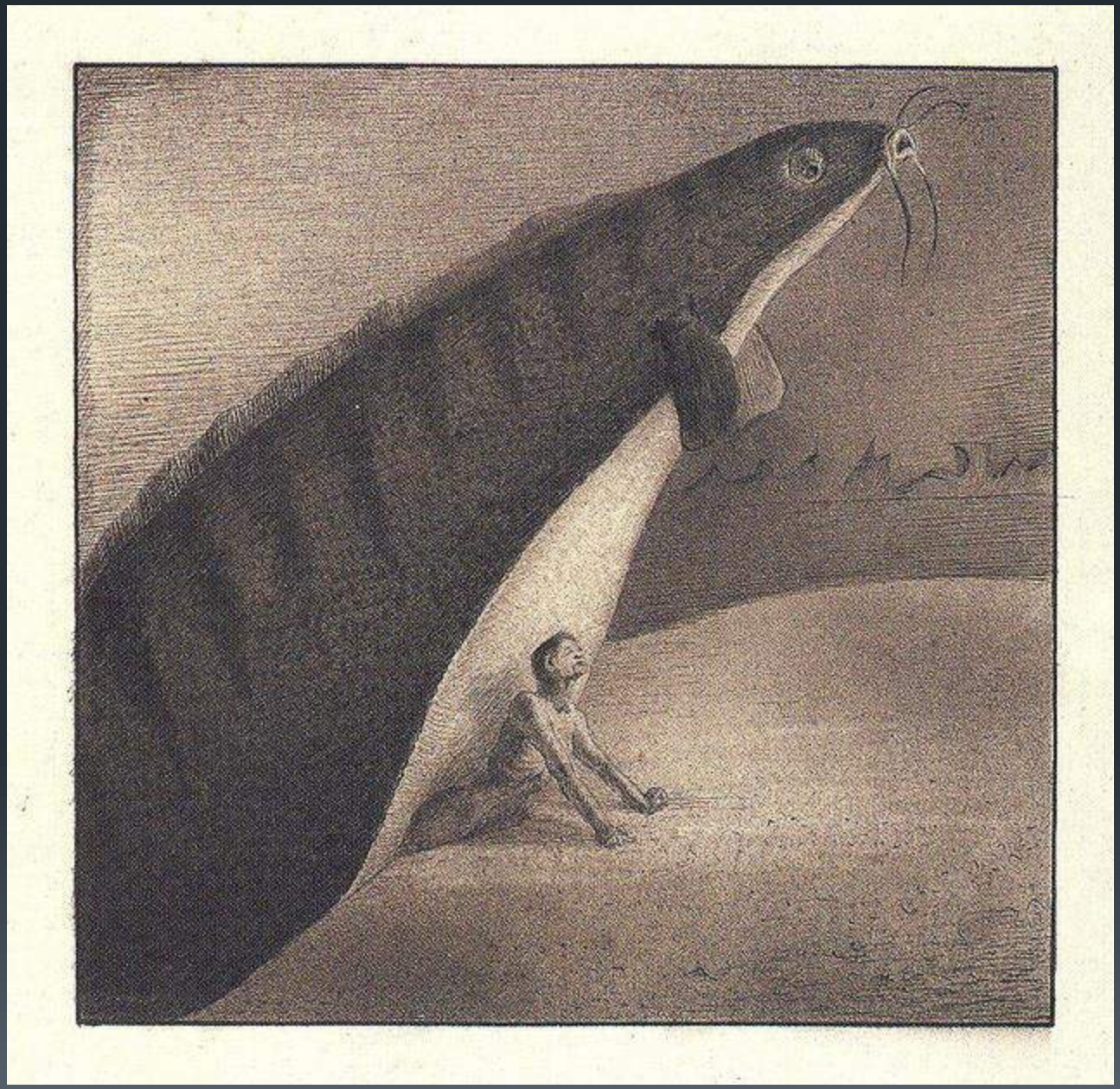

Beating the Blues I

- A CBT-based computer self-help course ‘for people with anxiety and/or depression’
- 8 1-hour interactive computer sessions
- Self-referral; I completed it at a community centre in Manchester where other therapies and self-help groups were available; attended a depression group; winter 2009
- **Hating every single minute of the course…**
- **Reductionism of CBT**; Reducing therapy to a set of one-dimensional techniques (Pilgrim, 2011); exploring linear linkages between thoughts, emotions and behaviour – Thought diaries; mental health problems as cognitive errors
- Highly structured, prescriptive, goal- and problem-orientated; **Like a straightjacket?** Very different from the emergent therapy modalities I was familiar with (psychoanalysis; psychodrama psychotherapy)

‘The stripped down self’ in CBT literature (Grant, 2011)

- ‘**A reductionist trend in the portrayal of suffering in CBT writing** that ‘continues to go largely unchallenged over the period of the rise of CBT in the 1970s to date. **It is difficult to spot a real, fleshed-out person in much of the mainstream British CBT research and policy-informed treatment literature**. Instead, individuals with problems are usually described in terms of **sanitised bundles of symptoms, emotions, thoughts, behaviours or treatment outcomes**’ (p.37)

- ‘An assumption of **a simplistic linear trajectory** of start (problem), middle (treatment), end (no problem). This fails to grasp the complexity and contextual basis of human lives and begs the question as to why many CBT practitioners have little problem with **stripped down representations of people**?’ (p.37)

Beating the Blues II

- **Privileging rationality**; 'Narrow and naïve rationalistic assumptions of CBT' (Pilgrim, 2011);
- **In my experience, rationality had collapsed…**
- **Not doing justice to my existential reality and complexity**
- No human contact
- **No emotional holding that a relationship with a therapist could have offered**
- **An impersonal computer voice telling me how awful it must be for me to be feeling suicidal!**
- No monitoring or follow up even though my depression and suicidality scores were going up…
- I should not have been allowed on the course
- UK National Institute for Health and Clinical Excellence Guidance, 2013 – '*Beating the Blues* could currently be recommended as an option for delivering CBT in the management of mild and moderate depression […] **CCBT would not be appropriate for the management of severe depression'**

It's like a war in your mind.
You can learn to fight the Poison Thoughts. And win.

© Autism Teaching Strategies, 2010

Beating the Blues in context

Locating *Beating the Blues* in the wider context of

- ‘the hegemony of cognitive behaviour therapy for depression in Anglo-American mental health policies’ (Pilgrim, 2011)
- the dominance of Evidence-Based Practice/Medicine framework (Pilgrim, 2011); Hierarchies of Evidence and Randomised Controlled Trials as ‘the gold standard’; Commitment of CBT to objective recording and outcome measurement – fit with the Evidence-Based Practice paradigm – hence the CBT claims to scientific legitimacy
- An example of the CBT hegemony – the **Improving Access to Psychological Therapies** (IAPT) programme commissioned by the UK government in 2006; mainly CBT and some forms of interpersonal psychotherapy for ‘common mental health problems’ (depression and anxiety) in primary care (Pilgrim and Carey, 2012)

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DRUG CO.
"Do a double-blind test. Give the new drug to rich patients and a placebo to the poor. No sense getting their hopes up. They couldn't afford it even if it works."

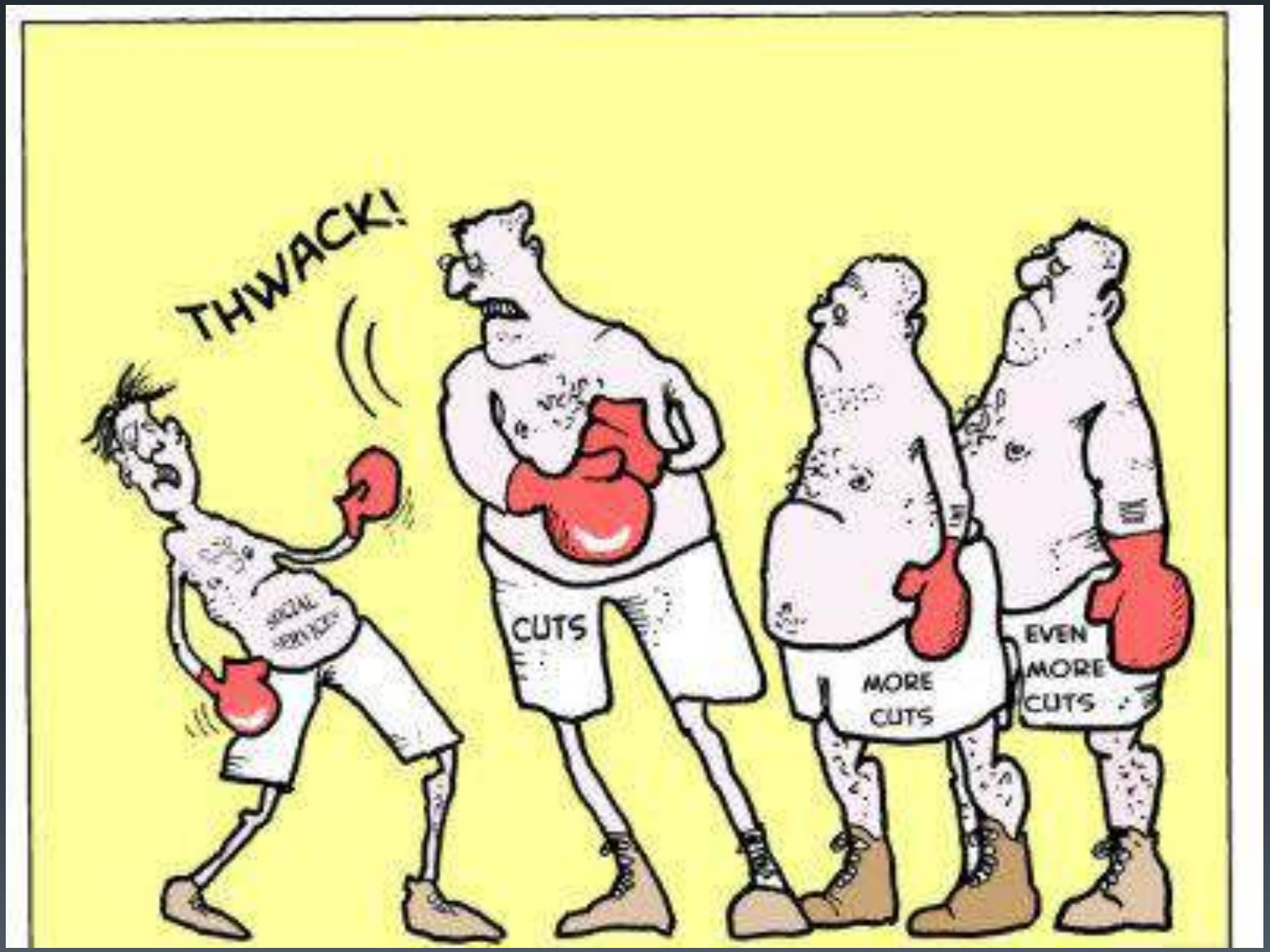
The neoliberal politics of recovery in mental health (McWade, 2015) I

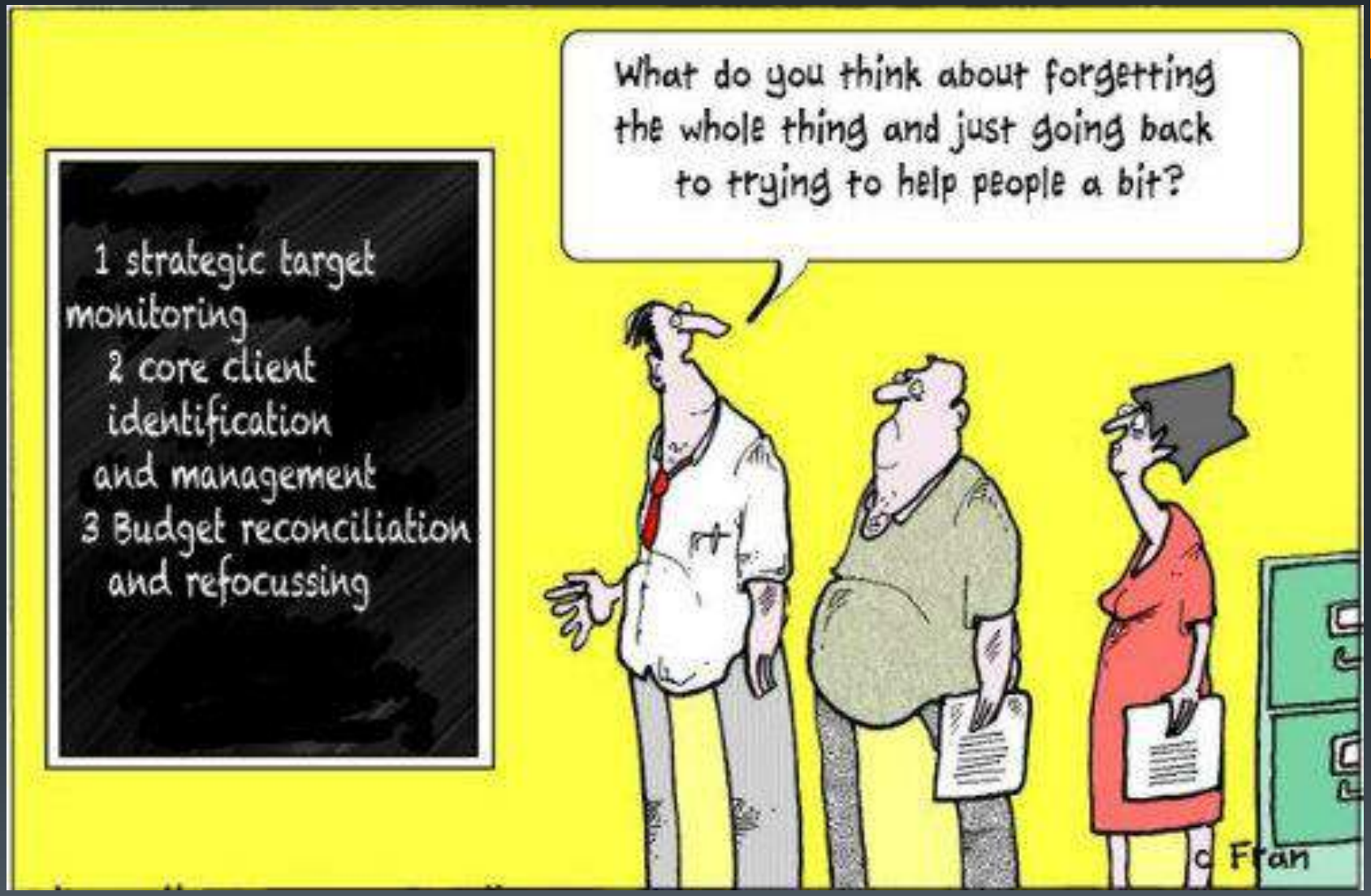
- **the marketisation of mental health care**-New Public Management health care reforms in UK (1990s); focus on efficiency, productivity and targets/outcomes (Ferlie et al., 2015)
- **the pervasive discourse of 'patient self-management'**
- the rhetoric of patients/service users as autonomous, self-reliant, responsible and rational consumers who can exercise free choice and control when it comes to their mental health care
- the proliferation of e-health and m-health (electronic and mobile health) interventions and devices in the field of mental health care to serve the purpose of 'patient self-management'

The neoliberal politics of recovery in mental health (McWade, 2015) II

- the pathologisation of interdependency and ‘dependency’ on (mental health) services
- the pre-occupation with cost-effectiveness and efficiency savings (welfare cuts), and subsequently with the speeding up of mental health care (promotion of brief therapies; CBT as a quick fix)
- the medicalisation of problems of living (Kinderman et al., 2013)
- the ‘privatisation of stress’/distress (Fisher, 2012), the ‘depoliticisation of pain’ (Filar, 2014) and the focus on individual psychopathology (Pilgrim, 2011) where the socio-political and material determinants of mental distress get obscured or ignored (Smail, 1995)

"We're encouraging people to become involved in their own rescue."


THWACK!
SOCIAL SERVICES
CUTS
MORE CUTS
EVEN MORE CUTS


1 strategic target monitoring
2 core client identification and management
3 Budget reconciliation and refocussing
What do you think about forgetting the whole thing and just going back to trying to help people a bit?
c Fran

Ambivalence

- Ambivalence as regards talking/psychological therapies – recognising the limitations and problems but also the huge potential of psychological/talking therapies to heal
- Discussions regarding talking/psychological therapies have tended to be polarised and often centre on whether such therapies are inherently good or bad **(Moloney, 2013, The therapy industry: The irresistible rise of the talking cure and why it doesn't work)**
- Calling for greater attention to the messiness, complexity and diversity of reactions to and positions regarding talking/psychological therapies
- **The need to develop 'greyer, more ambivalent accounts' of such therapies (*cf.* Callard, 2014) whilst keeping the dialogue open**
- **Potential benefits from maintaining an ambivalent stance** –rather than a stance of premature certainty and foreclosure of possibilities of interpretation - **involve the possibility of more open and balanced explorations of the achievements, limits and uses of talking/psychological therapies, as well as the possibility of doing justice to the multi-faceted ways in which those of us in receipt of talking/psychological therapies 'live with, through, against and beyond them' (*cf*. Callard, 2014)**

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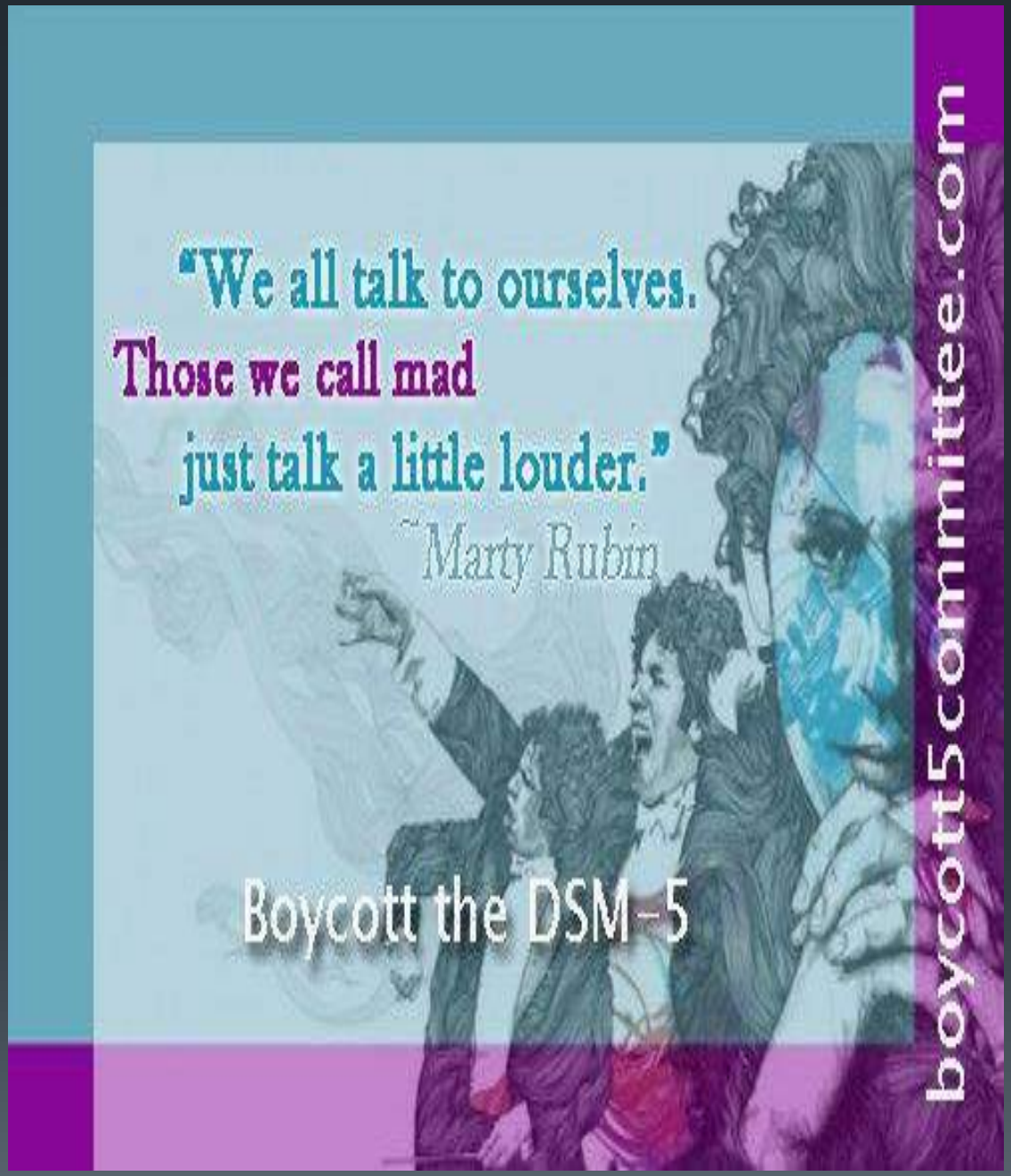
"We all talk to ourselves.
Those we call mad
just talk a little louder."
~Marty Rubin
Boycott the DSM-5
boycott5committee.com