

BEYOND INDIVIDUAL THERAPY¹

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Psychological distress has increasingly been recognised as an important health and social problem – the 2014 Health Survey England reported that 26 per cent of adults said they had been given a diagnosis of ‘at least one mental illness’ in their lifetime (Bridges, 2015). The last 20 years have seen a significant increase in the availability of mental health interventions, primarily medication and individual psychological therapy. However, such interventions are predominantly reactive (rather than preventative) and focus at the level of the individual (rather than at the level of the family, community or society).

In this article I will argue that applied psychologists could draw on traditions like public health medicine and community psychology to develop proactive preventative interventions, and to inform public debate so as to address the distal causes of distress.

The rise of individualised mental health interventions

Recent decades have seen a year-on-year increase in the provision of primarily individually focused mental health interventions: psychiatric medication and psychological therapy. Psychiatric medication is still the default intervention in mental health – the Healthcare Commission (2007) noted that 92 per cent of their service-user sample had taken medication. The cost of antidepressant medication rose from over £50m in 1991 to nearly £400m in 2002 (Social Exclusion Unit, 2004). This cannot simply be due to an increase in the size of the population (the population in England increased by only 2 per cent between 1991 and 2001) or inflation (7.5 per cent in 1991 dropping relatively steadily to 1.3 per cent in 2002). This trend has continued: Ilyas and Moncrieff (2012) report that there were 15,000 prescriptions of antidepressants in 1998 but over 40,000 in 2010 (during this period the population increased by only 5.5 per cent), and they note that the total amount spent on all psychiatric drugs, adjusted for inflation, rose from over £544m in 1998 to £881m in 2010. There have been rapid increases in the prescription of other drugs too – prescriptions of methylphenidate for children (better known by one of its trade names: Ritalin) have risen from 6000 in 1994 (Timimi, 2004) to over 922,000 in 2014 – a 153-fold increase in just over 20 years – costing over £34m a year (Health & Social Care Information Centre, 2015a). It is important to note that these figures only relate to community prescribing (by GPs and as outpatients) and don’t cover medication prescribed in hospital.

Are we happy as citizens that we live in a society where there is an increasing reliance on medication, with its concomitant side-effects?

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What might be the causes of such an increase, and what alternatives might there be?

Comparable year-on-year figures aren't available for psychological therapy though we know that, in 2014–15, 1,250,126 people were referred and 815,665 people began receiving therapy under the Improving Access to Psychological Therapies initiative (Health and Social Care Information Centre, 2015b). As clinical psychologists predominantly provide individual therapy (Norcross & Karpiak, 2012), we can use the numbers of clinical psychologists as a proxy measure of the increasing availability of psychological therapy over time. There were 362 members of the British Psychological Society's Division of Clinical Psychology in 1970 (Hall et al., 2002) but this had risen to 10,202 by 2011 (British Psychological Society, 2012), a 28-fold increase. There were 11,279 clinical psychologists registered with the Health and Care Professions Council in January 2015 (HCPC, 2015).

Despite these increases, it is clear that many people still do not have access to psychological therapy (Mental Health Taskforce, 2016), a situation unlikely to change with ongoing cuts to public sector budgets. Whilst psychological therapy is relatively benign in comparison with the side-effects of many psychiatric medications, is it feasible to offer therapy to everyone who might need it? And how ethical is it for psychologists to focus primarily on providing reactive rather than preventative interventions and to fail to advocate for social and economic policies that might address the 'causes of the causes' of mental health problems? It is to these questions that we turn next.

The limitations of individualised and reactive interventions

There have been two primary sources of concern about an over-emphasis on psychological therapy as an intervention. First, whilst it might be effective on an individual level, it will never be available to all those who need it. Second, since therapies are reactive interventions, they do not proactively address the causes of distress. The late George Albee pithily summarised these concerns: 'Individual psychotherapy is available to a small number only. No mass disorder has ever been eliminated by treating one person at a time' (Albee, 1999, p.133).

Despite significant increases in spending on psychiatric medication and individual therapy, demand still outstrips supply. Rather than focusing our efforts on intervening once problems develop, perhaps we need to focus more effort on preventing problems arising in the first place. In the field of prevention a distinction is drawn between primary and secondary prevention. Secondary prevention refers to attempts to ameliorate problems at an early stage, once they have developed. This is the approach adopted by many early-intervention services with which applied psychologists are familiar. Primary prevention, on the other hand, aims to prevent problems before they arise, often through structural changes like social policy and legislation (e.g. the UK's legislation in 2007 to prevent smoking in enclosed public places). Keith Humphreys argued nearly 20 years ago that clinical psychology had over-emphasised psychological therapy at the expense of alternatives: Psychotherapy lured the field into an overemphasis on individual psychology and individual-level treatment as the best approach to society's ills and an underemphasis on preventive interventions and

sociocommunity-level conceptualizations of human behaviour. (1996, p.193)

If we are to intervene we need to understand the social patterning of distress. There is now substantial evidence that social inequality has a powerful effect on mental and physical health (Cromby et al., 2013; Friedli, 2009; Marmot, 2010; Mirowsky & Ross, 2003; Read & Sanders, 2010; Wilkinson & Pickett, 2009) – see Psychologists Against Austerity (2015) for a useful summary of this research. A recent survey indicates that men and women living in lower-income households are more likely to have received a psychiatric diagnosis than those living in higher-income households: 27 per cent of men and 42 per cent of women in the lowest income quintile compared with 15 per cent of men and 25 per cent of women in the highest (Bridges, 2015). Treatment is also socially patterned: Anderson et al. (2009) reported that 31 per cent of the poorest quarter of the population (i.e. a household income less than £12,000) have used medication, compared with only 17 per cent of the richest quarter (i.e. household income of £38,000 or more).

In their 2009 book *The Spirit Level: Why More Equal Societies Almost Always Do Better*, Wilkinson and Pickett show the strong correlation at a national level between income inequality (i.e. the difference between the richest and poorest in society) and WHO mental health surveys. Countries such as the UK or USA, with the highest levels of income inequality, have high levels of mental health problems; others such as Japan or Belgium, with more equality of income, have lower levels of distress (see www.equalitytrust.org.uk/mental-health). Of course, poverty itself is strongly correlated with a range of physical health and social problems, but Wilkinson and Pickett argue that the evidence is strongest for an association between the size of the income gap and mental and physical health (see also Burns, 2015). This is not to ignore the role of biology but, rather to emphasise that, as biological processes are in a constant interrelationship with the person and their environment, those processes can often arise as the result of environmental causal influences (Cromby et al., 2013).

The causal influences most applied psychologists encounter in their everyday lives tend to be what the late David Smail termed ‘proximal’ causes (e.g. personal relationships, domestic and work situation, education, family). We tend not to consider what Smail termed ‘distal’ causes – economic climate, dominant political ideologies and the media (see the April 2014 special issue of *The Psychologist* for further discussion: <http://thepsychologist.bps.org.uk/volume-27/edition-4/charting-mind-and-body-economic>).

The influence of social factors has been increasingly recognised by leading cognitive behavioural researchers. For instance, in their text on paranoia, Freeman and Freeman (2008) discuss links between income inequality and distrust and call for ‘governmental policies to reduce inequalities of wealth’, the benefits of which would be ‘lower levels of social exclusion, stress, insecurity – and paranoia’ (2008, p.141). Similarly in a debate about the merits of cognitive behavioural therapy in the *British Medical Journal*, Nick Tarrier notes: Much of mental distress no doubt has its roots in, or is at least exacerbated by, social deprivation and inequality and their psychological consequences. A good dose of social justice and redistribution of wealth would do the world’s health a lot of good. In the meantime, any

psychological treatment can only be a sticking plaster over the wound of such inequality... (Tarrier, 2002, p.292)

Why might income inequality be linked to psychological distress? Pickett and Wilkinson (2010) suggest that distress is affected by societal levels of trust and community life and that these, in turn, are worsened by income inequality. These processes are magnified in industrialised societies where the ability to consume is seen as a key aspect of identity and where a failure to meet perceived social status norms can lead to exclusion (e.g. Croghan et al., 2006). Worryingly, UK income inequality – the so-called Gini coefficient – rose sharply in the late 1970s and has plateaued at a high level since 1990 (see www.equalitytrust.org.uk/how-has-inequality-changed). A significant factor is that the income of the top 1 per cent and top 0.1 per cent of earners has outpaced other groups in society and, unfortunately, this money is often lost to the real economy. Given the substantial evidence for the influence of social factors and negative life events on psychological distress, how ethical is it to predominantly focus on this ‘sticking plaster’ approach of individual treatment, rather than attempting to prevent these problems in the first place? If psychologists were to respond to distress with a fuller range of interventions than individual psychotherapy, what might they have to offer?

Some suggestions

Although individual therapy is an important part of the tradition of applied therapeutic psychology, we are trained in a range of other skills. Jim White (2008, p.844) has argued: Why are we so hung up on individual therapy? What about equally important care areas (for which psychologists are eminently suited) such as mental health awareness raising, early intervention and prevention, working with others, and delivering mental health help in varied media?

Other suggestions could include:

Improve epidemiological methods

Identify patterns and take action

Develop a range of preventative strategies and evaluate them

Consider different ways of delivering services

Improve epidemiological methods

Much mental health epidemiology utilises functional psychiatric diagnostic categories, many of which are bedevilled by problems of reliability and validity. Psychologists could help improve epidemiological research by developing better survey methods, using more reliable and valid constructs.

Identify patterns and take action

At a population level, psychologists might follow the tradition of medical geography illustrated by the example of the physician John Snow in order to map the distribution of forms of distress. In the mid-19th century Snow was sceptical of the then dominant theory that diseases like cholera were caused by pollution or ‘bad air’, and following a number of deaths from cholera in the Soho district he talked to local residents in order to map the outbreak back to an infected water pump. His investigations helped to persuade the local council to disable the pump. If improving sanitation systems could lead to such improvements in

physical health, what might be the analogous change in relation to mental health?

Perhaps we could take up Paul Gilbert's (2002) suggestion 'to have a "Defeat abuse", rather than "Defeat depression" campaign' (Boyle, 2003, p.30). Richard Bentall and colleagues (2014, p.1011) write that 'childhood sexual abuse has been particularly implicated in auditory-verbal hallucinations, and attachment-disrupting events (e.g. neglect, being brought up in an institution) may have particular potency for the development of paranoid symptoms'. So as well as helping children to become more resilient, we could also try to reduce the incidence of childhood sexual abuse. How could we use our research-based knowledge and theory to achieve such a goal?

Psychologists could advocate for changes to policy and legislation much as physicians and health campaigners have done in relation to smoking. We could influence the current climate of ideas by engaging policymakers both directly and indirectly through think tanks and the media (including social media).

Of course, there are conceptual and methodological challenges associated with interpreting the implications for the individual of epidemiological research (Burns, 2015). We would need to work with local authorities (e.g. Kinderman, 2014) and a wide range of agencies and planning infrastructure. We can look to history for encouragement: in the mid-19th century Dr William Henry Duncan became the country's first Medical Officer of Health, appointed following the Liverpool Sanitary Act of 1846. He worked closely with engineers and public officials to improve sanitation so that 'the worst of the sanitary evils were swept away' (Chave, 1984, p.68), leading to dramatic reductions in mortality rates.

Develop a range of preventative strategies and evaluate them. Much exciting and innovative preventative work is going on (see, for example, Newton, 2013), but much more needs to be done in developing new approaches to prevention and evaluating them (e.g. in developing safer, more nurturing and trusting neighbourhoods). In order to facilitate this, though, research priorities and service commissioning incentives need to change.

A 2013 report by the government's Chief Medical Officer lamented the paucity of preventative research in mental health, but a key problem is that research funders do not prioritise it. The charity MQ (2015) recently reported that, in relation to depression research, £2.71m was spent on aetiology, £1.05m on treatment but only £0.3m on prevention. Similarly, for psychosis research, £1.67m went to aetiology, £0.3m on treatment with only £0.19m spent on prevention. A great deal of aetiological research is primarily bio-genetic rather than psychosocial, and Bentall and Varese (2012) have argued that the latter is judged by tougher standards than the former. If we are to understand interpersonal and social processes in families, groups and communities whilst remaining sensitive to the varied subjective personal and cultural meanings of experience, we will need to involve service users and engage in more pluralistic and multidisciplinary research. We will also need to influence NHS commissioning incentives so that community-based preventative initiatives are rewarded, not just individual therapy.

Consider different ways of delivering services. In the shorter term, psychologists from a range of theoretical traditions might also consider

ways in which they could deliver therapy differently – for example, what might a preventative intervention informed by a socially contextualised cognitive behaviour therapy look like? Could individual therapists adapt ideas from community psychology?

Psychologists could start by going out more to where people conduct their everyday lives (e.g. where they live, study or work). We could encourage more ‘bottom-up’ rather than expert-driven ‘top-down’ approaches, like supporting the development of self-help and peer support groups. And we could seek to reduce income inequality. This requires action in the political realm, not only as individual citizens but also using our knowledge and status as professionals who are familiar with this research and the pernicious effects social injustice has on the lives of those who use our services (Mallinckrodt et al., 2014). Of course, psychologists may feel powerless to influence such distal factors, but it is important to remind ourselves that change is possible. Think of the social changes that have occurred in recent years where new social norms have developed in relation to attitudes about sexuality or, in the health field, in relation to smoking. The public appears to hold unfounded and contradictory beliefs about income inequality, poverty and welfare fraud, perhaps influenced by negative media coverage. How might psychologists intervene to better inform public debate to support policy moves to reduce inequality? Psychologists Against Austerity (2016) offer some research-based suggestions.

Problems and prospects

It is important to note that I am not arguing for the abandonment of individual therapy – it has a legitimate place as an intervention. Rather, as others have argued, it is probably never going to be available for all those who need it for as long as they need it. My argument should also not be interpreted as a justification for cuts to current services. Rather, we need significant investment in prevention in addition to current services, together with a transformation in those services (e.g. so they are incentivised for preventative work as well as reactive ameliorative work). I am also not intending to criticise the work of the many psychologists involved in providing individual therapy. They are doing a difficult job in challenging circumstances – indeed, many psychological therapists themselves are feeling under significant stress as a result of increased targets and cuts to services (British Psychological Society, 2016).

Some psychologists may say that they do not have the skills to engage in these types of activities or they may feel that, without increasing demand for psychological therapy, there will be no funding for psychology posts. Jim White argues that psychologists ‘are worth the money as long as we exploit all our skills, not just the therapeutic ones’ (White, 2008, p.847). Many applied psychologists may see their disciplines as synonymous with individual psychological therapy, but our work has changed radically over time (Hall et al, 2002), and the increasing centrality of therapy is the result, at least in part, of advocacy by professional bodies and NGOs. Humphreys (1997) argues that we could engage policy makers in a similar fashion to advocate for the adequate funding of public mental health. The government’s recent announcement of a £200m cut to public health budgets (Price, 2015) makes the need for such advocacy even more urgent.

A community approach

Sue Holland is a clinical psychologist who developed a small women's mental health project on a council housing estate in White City in West London in the 1980s. It followed a three-stage model where individual therapy was nested within group- and community-based approaches:

1. Assessment followed by 10 weekly sessions of psychodynamic psychotherapy helping the women to understand their subjective experience and to understand the meaning of their 'symptoms' (e.g. as understandable reactions to their life experiences).
2. Groupwork with other women where each person's individual experiences were shared and often common themes in the women's experiences emerged.
3. In a more transformative stage, many of the project's participants set up a self-help counselling and advocacy group called Women's Action for Mental Health which enabled them to challenge the wider 'social systems and structures that... limit people's needs and choices' (Holland 1992, p.72).

Holmes's (2010) 'Psychology in the Real World' project adapted Holland's model as a way of conceptualising all types of groupwork: people learnt how to cope with individual problems but then moved on to exploring the roots of their problems, subsequently taking action to transform local communities and aspects of national and international policy that are 'the causes of the causes' of distress.

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