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Contents

Expansion of psychological therapies

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

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

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

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

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

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

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

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

1 Summerfield D, Veale D. Proposals for massive expansion of psychological therapies would be counterproductive across society. *Br J Psychiatry* 2008; **192**: 326–30.

2 Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H. *Psychiatric Morbidity Among Adults Living in Private Households, 2000*. Office for National Statistics, 2001 (http://www.statistics.gov.uk/downloads/theme_health/psychmorb.pdf).

3 National Institute for Clinical Excellence. *Anxiety*. NICE, 2004 (http://www.nice.org.uk/nicemedia/pdf/CG022NICEguideline.pdf).

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

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

1 Summerfield D, Veale D. Proposals for massive expansion of psychological therapies would be counterproductive across society. *Br J Psychiatry* 2008; **192**: 326–30.

2 Edgerton R. Conceptions of psychosis in four East African societies. *Am Anthropol* 1966; **68**: 408–25.

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Author's reply: Mushtaq shares my concern about inappropriate medicalisation, but sees short-term interventions such as CBT as something apart. I must disagree: talk therapies delivered in the National Health Service by mental health professionals are part and parcel of what profession and public understands by 'medical'.

In working to produce 'culturally sensitive CBT' for depression in Pakistan, Rathod *et al* hope that mere adaptation of standard practices and manuals, and good translations, will do the trick. I'm afraid I challenge the assumption that Western psychiatric templates can generate a universally valid knowledge base.[1] Methodologies routinely fail the core test of scientific validity, which relates to the 'nature of reality' for the individuals under study.

Globalising Western psychiatric approaches is not value free. A telling example of the moral and political shifts to which I alluded in the debate is provided by the invasion of Latvia by the diagnosis of depression.[2] This was prompted by the translation of ICD into Latvian, and by conferences organised by pharmaceutical companies to educate psychiatrists and general practitioners (who in turn educated their patients) about this new diagnostic category. This was a radical departure from the traditional language of (largely somatic) distress – notably *nervi* – shared by doctors and lay public. To present *nervi* was to invite a life story, which could include a critical commentary on disorder or dysfunction outside the self, in wider society and politics. The doctor-mediated shift from *nervi* to depression is a shift away from the lived contexts that *nervi* embodied, the focus now inwards to the individual person. With this comes the internalisation of a heightened sense of personal accountability for life circumstances. However, at the same time post-Soviet Latvian society has lost much of its former sense of stability and security, and most people have in fact less control over their lives. The narrative structure of these new accounts of distress indicates that Latvians have internalised the values of capitalist enterprise culture and the responsibility for personal failure that goes with it. It is this shaping of a different kind of citizen that is evoked in the globalisation of depression.

1 Summerfield D. How scientifically valid is the knowledge base of global mental health? *BMJ* 2008; **336**: 992–4.

2 Skultans V. From damaged nerves to masked depression: inevitability and hope in Latvian psychiatric narratives. *Soc Sci Med* 2003; **56**: 2421–31.

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Integrated multidisciplinary diagnostic approach for dementia

Wolfs *et al* have described a cluster randomised controlled trial in The Netherlands in which patients with suspected dementia received integrated multidisciplinary assessment or usual care.[1] Input to the intervention group aimed to combine the hospital-based approach of a memory clinic with the care-oriented approach of a community mental health team. This intervention led to some modest improvements in outcome. Usual care during the trial was provided by the general practitioner, or involved referral to a regional memory clinic, a department of geriatric medicine or mental health service for the elderly.

The integrated approach only lasted for about 2 weeks, after which detailed diagnostic and therapeutic advice was given to general practitioners. Given that dementia is a progressive neurodegenerative disorder with constantly changing medical and social care needs, we would be surprised if this intervention could sustain superiority over ongoing care from any community mental health service for elderly people – no matter how rudimentary. Further details on treatment as usual would have been useful, as would a reanalysis of the results taking into account the different types of service received by the control patients.

We agree with Wolf *et al* that memory clinics need to integrate with multidisciplinary community services. We have argued previously that the sub-specialist memory clinics in the UK have not been useful in the overall management of dementia since they have distorted care priorities and have focused on the prescribing and monitoring of medication.[2] Wolf *et al*'s controlled trial has provided support for integration of services for the diagnosis and care of dementia. This has to be organised not only in the initial diagnostic stages but also on an ongoing basis, with close liaison between multidisciplinary health services, local social work departments and primary care throughout the course of patients' progressive illness.

1 Wolfs CAG, Kessels A, Dirksen CD, Severens JL, Verhey FRJ. Integrated multidisciplinary diagnostic approach for dementia care: randomised controlled trial. *Br J Psychiatry* 2008; **192**: 300–5.

2 Pelosi AJ, McNulty S, Jackson G. Role of cholinesterase inhibitors in dementia needs rethinking. *BMJ* 2006; **333**: 491–3.

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Authors' reply: Organisational models designed to create connectivity, alignment and collaboration within and between the cure and care sectors are needed, and our study provides the evidence to support this approach. Our diagnostic intervention indeed lasted only a few weeks, but in our view, dementia care is a chain of services, starting with a short but comprehensive diagnostic phase resulting in a treatment plan that lasts throughout the course of the illness. Our intervention was merely the beginning of that chain, and we acknowledge that this is an ongoing process.

In contrast to McNulty *et al*, who found the results of our study modest, we value a difference of almost 10% between groups regarding health-related quality of life as substantial and clinically relevant, and higher than found in any pharmacological study in dementia so far.

The suggestion of McNulty *et al* to compare different types of services would be interesting, but the design of our study was not appropriate for such a reanalysis, as it would be subject to confounding by indication.

Nevertheless, McNulty *et al* raise the important point that dementia care needs an integrated approach on an ongoing basis, and we agree wholeheartedly.

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