

Introduction

This book is concerned with treatment strategies that facilitate recovery from mental illness. We have attempted to outline ideas and ways of thinking that assist in the development of clinical skills and the effective use of treatment technologies in the real world. This is not a primer on psychopharmacology, nor a guide to specific psychological or social therapies. Indeed, it is assumed that readers have some basic knowledge of these subjects. Instead, we explore the application of principles to everyday work, and the ways around the numerous complications, pitfalls and dilemmas that are the stuff of clinical practice.

In many ways, making treatments work for patients in the face of the complications and problems of real life is the most difficult aspect of the work of mental health professionals. It demands a good understanding of scientific evidence, combined with an empathic understanding of other people and an ability to constructively learn from clinical experience. Above all, clinicians have to be self-aware and conscious that treatment can do harm as well as good. At its heart, this book is about the difference between comprehensive knowledge and good clinical skills.

This text follows on from our previous work, *Psychiatric Interviewing and Assessment*, which was concerned with fundamental skills that lead to good quality assessment and facilitate a therapeutic relationship. However, although it is informed by the same values, this volume stands on its own. It aims to help clinicians to develop the ability to work with patients to create rational and strategic treatment plans, so that the overall intervention is user friendly and constructive. It is based on an understanding of the complexities and problems that arise in everyday practice, where the planning and implementation of treatment has to take account of a multitude of contextual factors and unexpected events.

As a consequence of our attempts to give the material a 'real life' quality, the text bears the clear imprint of our experience as practising psychiatrists. We have primarily addressed the book to psychiatrists in the UK who, having acquired the necessary technical knowledge, are dealing with the problems of autonomous clinical practice. However, we believe that the concepts herein have relevance to a wide group of clinicians, including mental health nurses, social workers, psychologists and occupational therapists. We also believe that very little in the book is unique to British practice, and we hope that it will be useful to clinicians in other countries. In order to reach a broad readership, we have tried to balance the authenticity that comes from writing from personal experience with a generalised approach to allow applicability across

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disciplines and countries. We should acknowledge, however, that this book will be useful mainly to mental health professionals who treat mental illness in people of working age.

There are numerous fictional clinical vignettes in the text. We have taken care to make these realistic, but they are not based on any individual patient's history or presentation. Where a story is true, we have said so. All of the others have been invented, albeit on the basis of situations that really do happen.

We have followed some conventions that might appear to be slightly at odds with our commitment to patient orientated, non-discriminatory, evidence-based practice. We have sometimes used the term 'patient' rather than 'service user'. We do not believe that the concept of the doctor-patient relationship is outmoded, and we set out one good reason for this in Chapter 17. We have used male pronouns generically, because, being men, we find it easier to write that way. We apologise to female colleagues for this. We have made some compromises in order to maintain readability. In particular, we have limited the number of references, mainly using them to direct readers towards important publications, or to provide evidence for points that might be contentious. We have avoided referencing well-recognised and widely accepted facts and concepts. We have expressed some very firm opinions, some of which may be controversial. This is not an attempt to press our idiosyncratic views on others. We believe that such opinions are inevitable, and we have tried to explain how our opinions have been formed, in order to illustrate the problem of balancing evidence, beliefs, values and rationality. We fully recognise that some of our dearly held opinions will eventually prove to be wrong.

In the past, it often seemed that the multidisciplinary team was a group of professionals with different ways of understanding mental disorder, who followed (or sometimes subverted) plans under the direction of a consultant psychiatrist. Lately British psychiatrists have been encouraged to adopt new ways of working, which really means fully embracing proper multidisciplinary teamwork. Modern teams are a group of professionals sharing a common, multifaceted understanding, who bring their different skills to a jointly owned plan. We both work in teams whose practices reflect the new patterns of work, and the book is strongly informed by this experience. However, we have also tried to address issues that arise in smaller teams or in the course of single-handed working.

In places, we have dwelt at length upon issues of control of patients and of the use of medication. We fully recognise that recovery can only be the result of treatment when clinicians get alongside patients rather than controlling them. We also recognise that medication is often a regrettable necessity. Interventions are likely to fail if medication is the predominant element. There are many problems associated with psychotropic medication, but it cannot be eliminated from clinical practice, and for this reason it has to receive some emphasis. However, the central tactic in most treatment strategies is stepwise problem solving, not medication.

We have written this book in the hope that it will be read rather than consulted. We do not suppose that we are exceptionally able clinicians who can put colleagues right through a didactic exposition of our ideas. To the best of our knowledge, the concepts

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set out here have not been the subject of a book before, but they are well known to many experienced clinicians of all disciplines. They are formed from experience, from discovering what works and what does not, and from what our patients tell us. We hope to help readers to develop skills. We have aimed to provoke rather than to inform, in the belief that the best teaching is thought provoking and entertaining.

Part I – Underlying principles

These first four chapters set out the underlying principles of rational, strategic treatment. Chapter 1 deals with some important values and reiterates some themes from our previous book. Chapter 2 is concerned with balancing contextual factors, scientific evidence and clinical experience to produce treatments that are rational and appropriate. Chapter 3 emphasises the importance of having clear and achievable treatment objectives in terms of improving people's lives. It considers the legitimate purposes of psychiatric treatment and it explores the concepts of rehabilitation and recovery. Chapter 4 draws these themes together and offers a model of strategic treatment planning.

1 Starting points

In 1981 a house physician sat on the bus on the way to work and opened the latest edition of the *British Medical Journal*. He was about to start training as a psychiatrist, so he was interested to find an editorial entitled 'The new psychiatry' (Anon., 1981). Recent research seemed to indicate that people with depressive illnesses showed neuroendocrine abnormalities that varied according to the type of depression that they were suffering from. The author was confident that in the future the use of specific and scientific tests, such as the dexamethasone suppression test, would allow more objective diagnosis of serious depression and better selection of treatment. Further research could be expected to lead to a variety of methods of measuring the physiological disturbances associated with mental illness. In the future psychiatric diagnosis would be less reliant on subjective judgements based on talking to patients. Psychiatrists, it seemed, could leave the periphery of medicine, don their white coats and enter the mainstream of the profession.

The young doctor was disheartened. He was drawn to psychiatry precisely because it involved close contact with patients and demanded a thorough understanding of their lives. The process of trying to understand patients and their problems in terms of test results and hormone assays was exactly what he disliked about general hospital medicine. His knowledge of psychiatry was absolutely rudimentary, but he was puzzled that anyone could suggest that people suffering from mental illness could be helped by a purely technological process. No matter how effectively an underlying physiological problem could be corrected, surely the human aspects of treatment would always be critical in helping the patient.

The young doctor went on to become a notoriously immodest psychiatrist. Sadly, even at this late stage, he cannot resist pointing out that he was right and that the anonymous author of the editorial was wrong. There was no breakthrough and the 'new psychiatry' never happened. Dexamethasone non-suppression is not a specific marker of severe depression. The idea that psychiatric treatment might be guided primarily by biochemical or genetic tests has not disappeared, but so far there have been no such developments of real clinical utility. Instead, clinical psychiatry has developed in a completely different, and much more constructive, direction. In our opinion, there is more cause for therapeutic optimism now than at any other time in the history of psychiatry, but that optimism does not rest on a dramatic change in the type of technical intervention available.

As the years have passed we have witnessed several similar episodes, with the announcement of an imminent or actual breakthrough in psychiatric treatment. For

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example, at the beginning of the 1990s rapid progress in neuroscience and the development of new drugs (the selective serotonin reuptake inhibitors and the so-called 'atypical' antipsychotics) were said to herald a new era of more effective and specific medications, which would transform the outcome of treatment. The pharmaceutical industry was so confident that a breakthrough was around the corner that it was announced that this was to be 'the decade of the CNS'. Needless to say, things did not really turn out as the industry had expected. We have yet to see a revolutionary change in clinical practice led by developments in neuroscience.

Looking back over nearly three decades of experience in mental health services, no major new treatment technologies have emerged. Certainly treatments have improved. There are many new drugs, some of which have different side effect profiles to the older medications. However, the only new medication that is demonstrably more effective than what went before is clozapine. This drug is important because it can be effective where all else fails, but there are major limitations to its usefulness. In the psychotherapies, traditional psychoanalytic approaches have been replaced by cognitive behaviour therapy and by briefer, more focused analytically based techniques. However, whilst there has been steady progress in improving psychotherapies, these techniques are essentially modifications of older technologies.

Although we recognise the limitations of technical progress we do not dismiss it. We do not point out the relative lack of technological progress in a spirit of therapeutic nihilism. On the contrary, looking back over our lengthy careers in psychiatry what is really striking is a dramatic improvement in the quality of mental health services. Whilst there is still plenty of room for improvement, interventions have become more user friendly, and the voices of patients and carers are beginning to inform both individual treatment plans and the development of services. With the slow emergence of community psychiatry we have developed new approaches to the delivery of care, such as psychiatric assertive community treatment. Most of all, the proportion of mental health professionals who are capable of forming true therapeutic alliances with patients appears to be increasing.

The old monolithic mental hospitals have closed, and as they have done so it has become increasingly apparent that, whilst the people who staffed them were largely well meaning, asylums actually caused a good deal of secondary handicap and harm. Those of us who trained in those institutions well remember the residents on the long-stay wards. They led their lives in an environment that was physically and socially bleak and impersonal. They displayed a range of deteriorated or bizarre behaviours that at the time were interpreted as symptoms of an underlying disease process, usually schizophrenia. However, as people moved out of the institutions and into smaller, homelier settings in the community, their behaviour altered. They did not suddenly stop being unwell, but many of them changed. Although some of them missed the routines and certainties of institutional life, others became more outgoing and gradually shed some of their peculiar behaviours. It seemed quite obvious to those of us who witnessed this process that some troublesome behaviours had not been symptoms of a disease at all, but a consequence of institutional care (Leff *et al.*, 2000).

We believe that this illustrates an important general principle. Our treatment technologies, both pharmacological and psychological, are not magic bullets. They may be a necessary part of treatment, but in most situations they are not sufficient on their own to help people to overcome mental illness. The way that treatment is delivered, and the relationship between professional and patient, is absolutely critical. This is as true of the office-based treatment of a patient with depression as it is of the community treatment of someone suffering from schizophrenia. An evidence-based treatment delivered in the wrong way can cause more harm than good. Hippocrates was absolutely right to make his first injunction *do no harm*.

We believe that there are some key values and principles that underpin good clinical practice. These create the main themes in the chapters that follow. We feel that it is important to clearly state some of them here at the beginning of the book. We aim to explore the ways in which the benefits of treatment can be optimised whilst avoiding the many pitfalls that can cause harm. This is informed by our particular understanding of the legitimate role of psychiatry in patients' lives and in society at large. The nature of this legitimate role is explored in various chapters, but needless to say, it is specifically scientific in nature. This does not mean it is necessarily technological or pharmaceutical, or that it is stripped of social meaning. '*Scientific*' implies independent minded, critical and skeptical, with an awareness of the nature of evidence. Evidence can only ever be drawn from multiple sources and it is always partial and subject to revision.

In this broadly scientific spirit, what follows is based on the literature and on careful critical reflection about our own practice. We have endeavoured to understand what we do well, but also what we do poorly, and how our many mistakes have occurred. We do not suppose that we can offer a detailed programme for the reader to follow that will automatically lead to good practice. We have attempted to understand principles, but simple understanding is not enough. We have also tried to relate these principles to real and identifiable everyday practice, with all its ragged ambiguities. We have tried to avoid abstract rhetoric and thus there are many fictional clinical vignettes in what follows. In places we do identify specific treatment strategies that seem to work in some difficult clinical situations. We are well aware that before long they will become out of date, and we warn readers against slavishly following them, especially as the book ages. However, without them the book would be less useful in the real world, and what we want to do above all is to offer younger colleagues a way of developing their everyday practice without the painful process of trial and error that our own patients have had to endure.

In psychiatry, we normally think of clinical skills as interpersonal abilities that are deployed during interactions with patients. These interpersonal clinical skills are certainly extremely important. However, there are also significant intellectual clinical skills (which involve developing particular ways of thinking about problems and treatment plans) and managerial clinical skills (that are concerned with the way in which we organise our work and treatments) that are equally important. The chapters that follow explore skills in each of these three domains.

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We make no apology for the reiteration of many of the themes from our previous book (Poole & Higgs, 2006), as they are critical to good practice. There are two objectives we described in that book that are especially important, because the outcome of treatment is rarely satisfactory without them:

- *Understanding context.* Mental illness occurs in a meaningful context, a personal constellation of life history, social environment and subjective experience. It is a psychiatric truism that these factors play a dominant role in causing mental illness and shaping its development. However, even when the illness is primarily biological in nature, for example, when a person has Alzheimer's disease, it is the understanding of context that allows the clinician to plan interventions that are likely to be helpful in the patient's life. Contextual understanding demands skilled history taking and observation, underpinned by an ability to empathise. This is not solely a matter of being able to appreciate what it might be like to lead a life different to one's own. Understanding context can be most difficult where the patient is similar to yourself, because there is an inevitable tendency to identify with the patient and hence overlook the important ways in which you differ.
- *Getting alongside the patient.* Psychiatric treatment works best where the professional has a relationship with the patient that is facilitative, where we support the person's ability to manage their mental disorder and hence to manage their life. Psychiatric treatment can work badly in quite a number of different ways, some of which are explored in this book. A relationship that is dominated by issues of dependency or control is bound to be of limited helpfulness, and can be positively harmful. However, dependency and control issues are bound to be present in some therapeutic relationships, either temporarily or permanently. Psychiatrists have to take responsibility for managing some aspects of risk and are often involved in treating people under compulsion. Although these roles are entirely appropriate, they can cause problems in therapeutic relationships. Even where such issues do not intrude, no therapeutic relationship can be facilitative from the outset. Getting alongside patients is a process which the psychiatrist has to manage. Therapeutic relationships that work well move from 'compliance' to 'concordance' and at any one time most relationships are in transit. Managing the journey is sometimes difficult, but it is a key clinical skill.

There are five other important ideas from our last book that we want to explain here, as readers may find our use of some words a little idiosyncratic:

- *Process.* Getting alongside the patient is just one of a number of processes that the clinician has to manage within a therapeutic relationship. All relationships have a beginning, middle and an end, and all relationships, no matter how good, can go wrong. It is not too difficult to have a good understanding of the treatment objectives within a therapeutic relationship. What takes skill is managing the process of getting there, and overcoming setbacks along the way.
- *Clinical skepticism.* Any account of one's self or someone else is affected by a range of value judgements and perceptions that can be drawn together under the heading of subjectivity. Some accounts are also influenced by a desire to withhold information or occasionally to actively mislead. Good clinicians have to maintain an attitude of skepticism, a critical and independent-minded quality that leads them to press

for clarity where something does not quite make sense or where an account seems implausible ('I was cooking dinner when the argument started, and I just lashed out without noticing that the knife was in my hand'). This is not the same as being an accusatory doubting inquisitor, and it sometimes means tolerating uncertainty about the truth until it can be clarified.

- *Hypothesising.* This term is borrowed from systemic family therapy, but it is an important general clinical concept. When a psychiatrist meets a patient for the first time, before the interview starts, he invariably has a general impression of the nature of the patient's problem. This is in effect an initial clinical hypothesis. In the course of assessment, a great deal of information is gathered which leads to a more complex understanding of the individual and their problems, and the factors that have caused, shaped and sustained their difficulties. If the psychiatrist fails to clearly identify his underlying hypothesis, it is difficult to test it and to identify the features that tend to support or contradict it. Consequently, we believe that it is important to recognise clinical hypotheses, and to keep in conscious awareness the degree to which the hypothesis is supported or undermined by the facts. This includes an awareness of possible alternative hypotheses. The hypothesising process is an important part of the dialogue within mental health teams, and at an individual level should be part of discussions during supervision (we are firmly of the view that all mental health professionals should have clinical supervision, no matter how experienced or elderly they might be). Hypothesising continues throughout a therapeutic relationship, because new and important information can emerge at any time, and in any case, people's lives go on and things change. Recognising the importance of hypothesising does not imply that clinicians should dither, fail to make diagnoses or be paralysed by uncertainty. Hypothesising is the best protection against becoming so convinced of a particular way of understanding the patient that you become rigid and lead yourself into errors, either individually or, within a team, collectively. This can happen to anyone and must be actively guarded against.
- *Trajectory.* No life situation is static. Life histories and clinical problems develop and unfold under the influence of a multitude of psychological and social processes. By tracking the evolution of a situation, it is often possible to make a reasonable assessment of the likely pattern of future events. This does not amount to a detailed prediction of the future, which is always impossible. However, important tasks such as risk management can be strongly informed by, for example, the recognition of progressive social isolation, accumulating loss and the gradual extinction of hope, even where the patient truthfully denies current suicidal intentions. Furthermore, identification of an ominous trajectory can suggest interventions that might alter the person's state of well being in the long term.
- *Self-awareness.* This is difficult to achieve, and tends to fluctuate over time. Nonetheless, in order to help people with mental health problems, it is important to be aware of the impact of your own attitudes and behaviours on other people. This is important when dealing with patients, but it is also important in the interactions within teams. Gaining self-awareness rests in part on seeking accurate feedback, especially from colleagues, and receiving it without excessive defensiveness. It also requires an

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acknowledgement of strong personal feelings in clinical situations. Strong positive or negative feelings towards individual patients, fear or nagging apprehension over a situation or a reluctance to challenge people can all impair your clinical judgement. You have to be aware of your particular social skills and personality strengths if you are going to use them as clinical tools. Breaches of the boundaries of a professional or therapeutic relationship are most likely to be avoided if you have a good awareness of your personal vulnerabilities. You do not need years of psychotherapy in order to develop sufficient self-awareness to become, and remain, a helpful clinician, but you do need a certain openness and to pay attention to it as a long-term issue. This is another good reason for seeking clinical supervision throughout your career.

Main points in this chapter

1. In helping people suffering from mental illness, the way that psychiatric treatment is delivered is as important as the effectiveness of specific technologies.
2. Patients benefit most from professionals who can respect their autonomy and get alongside them. This does not happen automatically and the process of getting alongside patients is a skill that has to be learned.
3. We do not offer a menu of technical treatments. We explore the principles behind effective therapeutic relationships that are unlikely to change as technical treatments improve.
4. Psychiatric treatment can cause harm, even when it is delivered by competent, well-intentioned professionals.