

**Psychological Therapies, Psychological Therapists, Psychological Models
of Mental Disorder and the Role of Applied Psychologists**

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Abstract

Guidelines from NICE (the National Institute for Health and Clinical Excellence) and academic papers have repeatedly stressed the effectiveness and appropriateness of psychological therapies for a range of mental health problems. The Department of Health's and the Care Services Improvement Partnership's (CSIP) Programme *Improving Access to Psychological Therapies* (IAPT) sets out a framework for action, including two national demonstration sites, to address these issues in England. Clearly, as experts in conducting and delivering psychological interventions, clinical and applied psychologists have a key role here. Psychologists are the key profession delivering such therapies, but the IAPT programme envisages an expansion of psychological therapists more generally. This means commissioners contracting with NHS Trusts (and potentially other bodies) to employ a range of professionals, including new graduates, to be trained in specific therapies such as cognitive behavioural therapy (CBT). Therefore, psychologists are also important as managers, supervisors and trainers of such psychological therapists. Psychologists' training enables them to formulate individualised complex care plans where the application of manualised and deliverable packages of therapy can be integrated into more holistic care plans. This paper discusses the distinctive roles of psychologists and psychological perspectives in the light of these proposals. The paper is written from the perspective of one professional group – clinical psychology – and should be read in that context.

Background

A number of related policy initiatives within the Department of Health have emphasised the importance of psychological therapies in mental health (Department of Health 1996, 2001, 2004a, 2004b, 2006). Service users increasingly demand psychological therapies of a variety of forms (Sainsbury Centre for Mental Health 2006), which has been reflected in the media (Pidg 2006). Policy directives have resulted from evidence of the effectiveness of manualised psychological therapies such as cognitive behavioural therapy (CBT) in randomised controlled trials (summarised in numerous NICE recommendations) and the likely cost-effectiveness of investment in this area (Layard 2004, 2006; Centre for Economic Performance 2006; Layard 2006; Department of Work and Pensions, the Department of Health and the Health and Safety Executive 2006).

A major programme of work within the UK Department of Health – the *Improving Access to Psychological Therapies* (IAPT) Programme (Department of Health Press Release 2006) – is currently examining how best to manage the development of psychological therapy services. It is inevitable that this work will

integrate such psychological therapies in systems of care which involve both primary care services and more specialist mental health services. Such 'stepped' or collaborative care models appear to be best able to match services to need (Simon et al. 2001; Dietrich et al. 2004; Bower & Gilbody 2005).

Workforce Implications

Preliminary work has already occurred, under the auspices of the IAPT programme (Turpin, Hope, Duffy, Fossey & Seward 2006), into workforce planning in respect to psychological therapies. Although there are several thousand applied psychologists in England and Wales (British Psychological Society, Department of Health & Home Office 2005), most psychologists do not work in adult mental health, and those who do offer a wide range of psychological services in addition to psychological therapies. Estimates of the likely demand for psychological therapies based only on the epidemiological prevalence of mild to moderate anxiety and depression suggest that more than 10,000 additional therapists are needed (Boardman & Parsonage 2005; Turpin et al. 2006). These kinds of models typically assume that around 2.75 million patients consult their GP with a mental health problem per year, of whom a third would accept therapy. This would result in a requirement to treat 800,000 patients per year (Centre for Economic Performance 2006). These models also typically assume that perhaps half of the staff employed in a team offering psychological therapies might be applied psychologists (that is counselling or clinical psychologists), with the other half being specialists trained in therapies such as CBT. This second group would therefore consist of existing healthcare staff such as nurses and occupational therapists with additional training and graduate workers with necessary specialist training and experience (Lavender & Paxton 2004; Boardman & Parsonage 2005; Turpin et al. 2006).

Skills Mix, Stepped Care and Supervision

Turpin and colleagues (2006) acknowledge that these calculations "are based upon the effectiveness of randomised control trials conducted under stringent conditions whereby therapists are trained to a standard of competency, adopt manualised protocols and receive expert supervision" (Turpin et al. 2006). Because of the large scale of the investment envisioned under the IAPT programme, considerable work is underway to explore how to meet the demand for the necessary skills and competencies by using the existing workforce with appropriate skills, by enhancing the skills of existing staff and through further dedicated training programmes. Currently, Skills for Health is consulting with professional bodies and relevant stakeholders to validate the Knowledge and Skills Framework for mental health (Skills for Health 2006) as it relates to this issue, to develop a set of National Occupational Standards for psychological therapy, and to establish career frameworks for psychological therapists. This work is closely allied to the policies in respect to the regulation of medical and non-medical professions (Department of Health 2006).

With this work currently in development conclusions must be cautious. Nevertheless, it is highly likely that the general model will follow a "Stepped Care Model" of service provision (Simon et al. 2001; Dietrich et al. 2004; Bower &

Gilbody 2005). In this context, this means identifying the competencies required at the different steps or levels within the model. Thus workers competent to deliver interventions at the lower levels would have different (more limited) competencies than staff able to intervene at higher levels. Turpin and colleagues (2006) have suggested that the former appear better suited to graduate workers such as Primary Care Graduate Mental Health Workers (Harkness, Bower, Gask & Sibbald 2005) or Self-help Support Workers (Gilroy 2005; Whitfield & Williams 2003), whereas the latter would be experienced and specialist trained CBT therapists or applied psychologists.

The workforce planning calculations inherent in the IAPT programme therefore assume that therapists are not only trained to an appropriate standard of competency and can adopt manualised protocols but also that they receive expert supervision. Supervision requires institutional support; Brooker and Brabban (2004) found that graduates from training schemes in psychosocial interventions for psychosis relatively rarely employ their newly acquired skills within the workplace and that lack of supervision was a major problem.

The New Ways of Working Programme (National Institute for Mental Health in England 2004) has developed a series of brief documents outlining the distinctive contributions of a range of professions to multidisciplinary working in mental health. It is significant that these statements have been 'signed off' by all the major professional groups conjointly. In these documents, clinical psychologists are described as experts in psychological interventions. It is explicitly recognised that whilst many professions in mental health services are highly competent in the use of psychological interventions, psychologists are unique in having a single focus on psychological processes and the systematic study of mind and behaviour throughout a lengthy and high-level training path. Psychology, as a profession in mental health, has a longstanding tradition of skills-transfer to non-psychologists, and is keen to offer consultation, training and supervision in psychological interventions to other members in multidisciplinary teams. Increasingly clinical psychologists are providing group supervision to teams. Supervision may focus on how best to work with individual clients or may assist the multidisciplinary teams as a body to enable more effective working, often utilising psychodynamic models and principles. Clinical psychologists tend to supervise other professionals immediately post qualification, and are likely to supervise other trainee psychologists perhaps two years after qualifying before moving on to more general supervision in a consultant grade post after approximately six years minimum post-qualification experience.

Within the idea of psychological therapies as manualised brief interventions such as CBT, psychologists holding practising certificates at the 'chartered psychologist' level seem to emerge from most analyses with two distinct areas of expertise. Firstly as deliverers of services for people with more complex needs. This is likely to be at levels 3-5 of the stepped care model (Gilroy 2005). Secondly as teachers, trainers, supervisors and managers of other psychological therapists. But psychologists (again meaning people with doctoral qualifications in clinical or applied psychology holding practising certificates at the 'chartered psychologist' level) are likely to have wider roles. Not all psychological services involve the kinds of therapy envisioned within IAPT, delivered to adults of working age. Psychologists' roles are wider.

Breadth of Psychological Services

Rather surprisingly, the proposals to increase massively access to psychological therapies have received some criticisms from within the psychology discipline, at least in relation to the manner of their execution. Some psychologists have suggested that the IAPT programme, or more specifically Lord Layard, emphasises the benefits of CBT in an inappropriate manner (Moloney 2006). In this set of arguments, it is stressed that CBT is not the only form of psychological therapy available, and indeed that psychological interventions are not the only form of psychological service. Many people, additionally, are sceptical of the considerable emphasis placed (particularly by Lord Layard) on the economic benefits of CBT in addressing those psychological difficulties which are thought to prevent people from working (Layard 2006). The criticism, here, is that psychological therapies have not usually been seen as tools of maximising economic productivity. Medical perspectives tend to emphasise the concept of recovery from, or amelioration of, disorder. More psychosocial perspectives emphasise reducing personal distress, maximising personal well-being or developing individual potential. These traditions tend not to view people as units of economic productivity. Finally, and perhaps more saliently, these kinds of initiatives tend to continue to regard psychological therapies as 'treatments' for 'disorders', rather than sensible human responses to ordinary psychological and social events. Thus, while the benefits of CBT are acknowledged, many psychologists feel that applied psychologists also have things to offer in the field of community psychology and more widely in the field of social exclusion.

It must be stressed, however, that, while Lord Layard stresses the benefits of CBT (partly perhaps because CBT lends itself well to manualised forms of therapy that can be packaged nicely for delivery and economic evaluation) (Layard 2006), the IAPT programme is wider. Indeed, the IAPT programme discusses a wide range of therapies from computerised CBT, through classical CBT to family interventions and entry through the stepped care approach into holistic, multidisciplinary mental health services. This echoes one of the main sets of drivers for this programme; the recommendations of NICE, the National Institute for Clinical Excellence. These stress a wide range of psychological interventions across many different conditions, embedded in comprehensive multidisciplinary formulations.

There are good academic reasons for this. The available evidence from trials supports the clinical effectiveness of a wide variety of therapeutic approaches. From both the economic perspective (where what works is what is important) and the medical perspective (when any effective therapy is welcomed) this is important. In addition, however, psychological science suggests there are theoretical reasons for expecting such a variety of successful interventions.

The profile of cognitive behavioural therapy can, perhaps crudely, be seen to be founded on two pillars. First, it works. That is, a substantial series of research trials have established that CBT is effective in reducing distress in people experiencing a wide range of disorders (see for instance Morrison 2001). But CBT is also based on substantial academic psychological research. This research has established that a range of emotional and behavioural problems are associated with characteristic patterns of cognition, patterns of thoughts, beliefs

and interpretative frameworks (Brewin 1988). Cognitive behavioural therapy achieves its positive effects by helping people make beneficial changes to these cognitive abnormalities. Although cognitive psychology is an extremely important branch of psychology, it does not constitute the entire cannon.

Because of their particular training in the linkage of theory to practice, psychologists draw on a number of different explanatory models and so a formulation may comprise a number of provisional hypotheses. What makes this activity specifically psychological is the knowledge base and information on which these formulations draw. The background and training of clinical psychologists is rooted in the science of psychology, and clinical psychology is one of the applications of psychological science to help address human problems. The skills of psychologists as applied to intervention are therefore built on a body of psychological theory which is somewhat wider than the more limited avenue of cognitive theories and cognitive behavioural therapies, and this knowledge base is then applied to helping people solve personal, family, group, work or organisational problems. This perspective makes psychology distinctive in health and social care (Quality Assurance Agency for Higher Education 2004). For psychologists, psychological interventions such as CBT can be (or should be) incorporated into formulations and care plans that address the person's personal, social and interpersonal circumstances more fully.

The emphasis on doctoral-level research during the training of psychologists also means that the ability to design and carry out innovative applied research is a key skill, and is important for the development and delivery of evidence-based practice. Psychologists are competent in the critical evaluation of research activity; for instance in the development and testing of new interventions and activities, based on psychological theory. This includes both an appreciation of the evidence-base for CBT, and a consideration of that knowledge base in the context of research into a wide variety of psychological, and pharmacological, interventions in mental health (Quality Assurance Agency for Higher Education 2004; British Psychological Society Division of Clinical Psychology 2001).

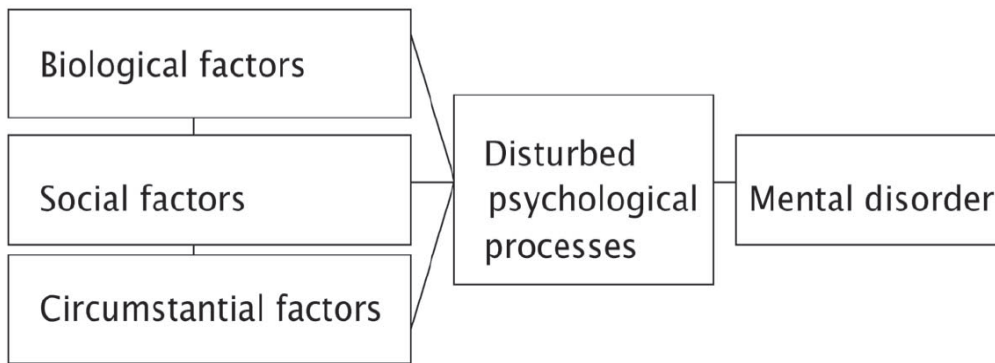
A Psychological Model of Mental Disorder

The mediating psychological processes model of mental disorder (Kinderman 2005) offers a comprehensive model of mental disorder applicable to those psychological and emotional disorders commonly addressed by the mental health services, although it has applicability to other areas of health and social care (Kinderman, Sellwood & Tai, in press). This model suggests that the final common pathway in the development of mental disorder is disruptions or dysfunctions in psychological processes. It is a robust and assertive account of the role of psychological issues in mental health.

The most common interpretations of the biopsychosocial model tend to assume either that social and psychological factors mediate the effects of biological processes, or that biological, social and psychological factors are co-equal partners in the aetiology of mental disorder (Pilgrim 2002). Instead, the mediating psychological processes model proposes that distal causative agents (biological abnormalities or physical insults, social factors such as poverty and social

deprivation, and circumstantial factors or life events such as childhood sexual, emotional or physical abuse) lead to mental disorder because those factors adversely affect psychological processes. The model is represented graphically in Figure 1.

Figure 1: The Mediating Psychological Processes Model



Kinderman and Tai (2006) discussed the clinical implications of this model for the individual therapist. They proposed that psychological formulations rather than diagnoses should predominate clinical planning; and such individualised formulations should detail the social, biological and circumstantial factors hypothesised to lead to the disruption of psychological processes or mechanisms and on the functional consequences of this (Kinderman & Tai 2006). Such a process is likely to be more person-centred and normalising than a diagnostic approach (Tarrier & Calam 2002; British Psychological Society Division of Clinical Psychology 2000). This approach is compatible with the “recovery” model of mental health care and consequently with expressed service user preferences (National Institute for Mental Health in England 2004, 2005).

Kinderman and Tai (2006) suggested that medical, social and even psychological interventions are most likely to be effective if they are designed on the basis of their likely beneficial impact on underlying psychological mechanisms. Medication might be targeted at problems and processes rather than putative “illnesses”, and could be more cautiously deployed than at present (Moncrieff & Kirsch 2005). Evaluating the clinical effectiveness of medications should examine not only their potential for symptomatic relief, but also their effect on functional outcome, acting in partnership with cognitive, behavioural, social, occupational and practical interventions. A possible consequence of this would be greater use of supplementary prescribing by nurses and pharmacists. Such developments are already part of NHS policy (Department of Health 2005).

One implication of the mediating psychological processes model, in the context of psychological therapies, is that these processes include, but are not limited to, cognitive processes. The mediating psychological processes model, of course, acknowledges both that cognitive processes are crucial to a full understanding of mental disorders, and that these cognitive processes can be biased by the experiences (in psychological jargon the learning history) of the individual (Kinderman 2005). It is not surprising, given the extent to which human

psychology is governed by learned cognitive schemas (Brewin 1988), that cognitive abnormalities are observed widely in emotional disorders. Equally, it is unsurprising that cognitive behavioural therapy is effective; since it manipulates, collaboratively and straightforwardly, these cognitions. But, in the mediating psychological processes model, such cognitive processes are not the whole story. Thus, psychodynamic processes are significant and are addressed through rather different psychological therapies. Behavioural processes are equally important and incorporated into cognitive behavioural therapy, but are traditionally contrasted with cognitive approaches.

Psychological therapies, or at least cognitive behavioural therapies, are therefore an important consequence of an application of the mediating psychological processes model. But they are not the only consequences. Therapeutic approaches such as more traditional behavioural approaches (Hopko, Lejuez, Ruggiero & Eifert 2003) and psychodynamic psychotherapy are fully integrated into NHS provision and the NSF for mental health (Department of Health 2004). But they are not (yet) part of the implementation plan for the Improving Access to Psychological Therapies Programme.

The mediating psychological processes model (as one example of a more comprehensive psychological approach) also has other implications. Kinderman, Sellwood and Tai (in press) outlined the implications of this psychological approach to service provision. They suggested that services should be planned on the basis of need and functional outcome rather than diagnostic categories and that, where residential care is necessary, a concept of “hospital” care should be avoided. An emphasis was placed on specialist teams, but with the suggestion that the focus of these teams be based on underlying psychological principles rather than putative diagnoses. These authors suggested that a psychological model emphasises a recovery approach to mental health care and that services should facilitate genuine service user involvement though an emphasis on “normalising” rather than “pathologising” approaches. As outlined here, Kinderman, Sellwood & Tai (in press) further suggested that access be improved to psychological therapies based on individual case formulations and that nurses, occupational therapists and social workers could develop increasing competencies in psychosocial interventions. Within this, the authors recommend, psychologists should be prepared to offer consultation and clinical leadership, and while psychiatry remains a key profession, the emphasis for psychiatrists could be a return to the key principles of the application of medical expertise as it assists a multidisciplinary team in the understanding and treatment of mental disorder.

Roles of Psychologists

Possessing competencies in the delivery of psychological therapies is different to being able to assess, formulate and develop a care plan which incorporates a number of therapeutic approaches. This is particularly salient in the case of people with complex needs involving multiple agencies. The competency in clinical case formulation is seen as central to a clinical psychologist's distinctive contribution to mental health care (Quality Assurance Agency for Higher Education 2004; National Institute for Mental Health in England 2004; British

Psychological Society Division of Clinical Psychology 2001). Of course, many professions in mental health care use “formulations”, and formulation is considered an integral part of CBT (Morrison 1991). It is not, therefore, the practice of formulation that makes psychologists distinctive, but the nature of the formulations that psychologists develop. Because of their particular training in the linkage of theory to practice, psychologists draw on a number of different explanatory models. What makes this activity distinctive for psychologists is the knowledge base and information on which they draw. The ability to access, review, critically evaluate, analyse and synthesise data and knowledge from a distinctively psychological perspective is important.

The proposals for widening access to psychological therapies are not the only policy developments pertinent to this discussion. The introduction of the Mental Capacity Act 2005 and the proposed changes to the Mental Health Act 1983 are both significant for psychology. In the case of the Mental Capacity Act 2005, substantial legal responsibilities will fall to clinical psychologists and neuropsychologists. These will be additional clinical roles, but also substantial legal responsibilities. Similarly, the proposals to replace the Responsible Medical Officer under the Mental Health Act 1983 with a Responsible Clinician – who may be a psychologist – are important for all employers. These changes are in keeping with best quality mental health care, and allow for proper multidisciplinary practice. Such an approach explicitly permits proper use of the skills and competencies of the workforce - including psychologists. A second controversial aspect of the proposed reforms – Supervised Community Treatment Orders, permitting compulsory care outside of hospitals – may also involved substantial changes in the roles of psychologists employed in health and social care (Kinderman 2006, 2007).

More generally, clinical and other applied psychologists work across a wide range of areas of key importance to health service targets in addition to their core activities in mental health. Within the NHS, psychologists work with individuals, couples, families, groups and at the organisational and community level. They work in a variety of settings, including hospital wards, day centres, Community Mental Health Teams, NHS Trusts, primary and social care contexts and forensic settings, and with all age groups from very young children to older people. They work with people with mild, moderate and severe mental health problems, developmental and learning disabilities, physical and sensory disability, and brain injury; people who have substance misuse problems and people with a range of physical health problems (e.g. HIV and AIDS, cancer, heart disease, pain, diabetes). Psychologists work with people with long term neurological and other conditions – conducting skilled neurological or other complex assessment, working to improve motivation and rehabilitation and coordinating pain management. Psychologists and psychological approaches are also important in helping combat anti-social behaviour; including the “respect” agenda in the community and helping address challenging behaviour in forensic and secure clinical settings. Health psychologists and specialist clinical psychologists also work in the public health arena and in assisting in health behaviour change (Quality Assurance Agency for Higher Education 2004).

Psychologists are therefore more than just psychological therapists. While many do practise psychotherapy at a high level, this is not a skill distinct to

psychologists, nor should it be. The background and training of psychologists enables them to apply the science of psychology to help address human problems. The ability to design and carry out innovative applied research is a key skill developed in applied psychologists' training and is important for the development and delivery of evidence-based practice. Psychologists are also, therefore, competent in the critical evaluation of research activity; for instance in the development and testing of new interventions and activities, based on psychological theory (Quality Assurance Agency for Higher Education 2004; British Psychological Society Division of Clinical Psychology 2001).

A key message for Department of Health policy leads and for senior NHS managers is to think beyond merely mental health and psychological therapies when considering the contribution of psychology. The "New Ways of Working" Programme of the Department of Health, National Institute for Mental Health in England (NIMHE) and the Care Services Improvement Partnership (CSIP) is designed to help professions working in mental health to become more modern and flexible.

Several Department of Health reports (Department of Health 1996, 2000, 2001, 2004) have collated evidence for the effectiveness of psychological therapies and offered practical guidance about how to drive forward the evidence based practice agenda. Good practice in the management, training, access, choice, and supervision of psychological therapists includes: improved access to therapies to avoid long waiting time, attention to the psychotherapeutic needs of different groups: for example, older people, people from minority groups, involvement of users in choosing the most appropriate therapy for their condition and situation, and systematic training in psychological therapies for mental health professionals supported by specialist supervision once they return to the workplace, and the recognition that clear leadership, both professionally and managerially, is best achieved through the development of an organisation wide body. The British Psychological Society further recommends that psychologists, by virtue of their training, competencies and experience, can lead and manage teams, and take "clinical responsibility" while supervising more junior staff. To support this, it is recommended that there should be specific Board-level representation for the delivery of Psychological Services, that services must be aligned with the vision of future service delivery and the key external drivers for organising Psychological Services. This includes the need to consider how psychological therapies and approaches are organised and delivered in multi-professional, multi-disciplinary context and that the overarching approach of applied psychologists is the application of psychology across whole of health and care system (British Psychological Society Division of Clinical Psychology 2007).

Conclusions

Current Government proposals to improve access to psychological therapies, as well as other strategic developments in mental health care and the employment of psychologists, have the potential to support the development of an increasing psychosocial dimension to mental health care. Clearly, as experts in conducting and delivering psychological interventions, psychologists are a key profession. Psychologists are therefore also important as managers, supervisors and trainers

of such psychological therapists. Psychologists' training enables them to formulate complex care plans where the application of manualised and deliverable packages of therapy can be integrated into more holistic care plans. Such complex care plans should be integrated into "stepped care" models. Psychological models of distress, such as the mediating psychological processes model (Kinderman 2005; Kinderman & Tai 2006; Kinderman, Sellwood & Tai, in press), have the potential to help support an unapologetically psychosocial manifesto for mental health care.

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