Some further critical mental health reading for GPs

Some references

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Some Blogs and websites:

https://www.madinamerica.com/2019/09/is-remaking-psychiatric-care-possible/

https://www.madinamerica.com/2019/11/screening-drug-treatment-increase-veteran-suicides/

https://www.madinamerica.com/2018/10/results-world-largest-antidepressant-study-look-dismal/

https://www.madinamerica.com/2016/01/what-disability-benefit-trends-tell-us-about-psychiatric-treatments-and-the-economy/

https://www.madinamerica.com/2018/01/the-scientism-of-psychiatry/

https://www.theinnercompass.org/

https://withdrawal.theinnercompass.org/

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http://www.adisorder4everyone.com/

A quick introduction to a solution focussed approach to healing

Rooted in a social constructionist approach. Social construction can be thought of as the idea that no one person or approach has the definitive answer to personal problems. We socially construct our understanding of how our lives and the world around us should function through a multitude of influences from our personal history to the media stories we are exposed to. The doctor/practitioner is no longer able to view himself or herself as the expert who knows how people should behave, think, feel, and solve their difficulties. Instead, she/he is committed to a side-by-side, less hierarchical therapeutic relationship, with the practitioner finding ways to honour and privilege the patient's own abilities to locate fresh directions and solutions to their problems. They focus less on what they assume to be abnormal or pathological and more on alternatives to the 'problem-saturated' story that the patient will tell. This does not mean ignoring the reality of patients' suffering, but remembering that stories of suffering are also stories of survival. We can choose which we pay more attention to – how we broke down or how we coped.

***Basic Assumptions*:**

We develop stories/narratives to make sense of what is happening. When we feel 'bad' the stories we tell ourselves focus on all the bad things that confirm how we are feeling. We then go and see a doctor/practitioner/therapist and recount what we can think of as a 'problem-saturated' story, that can overshadow other less problematic aspects of our life.

Future is created/negotiated and not a slave to past events (we don't need to understanding the cause to make progress).

All patients have resources, skills, and knowledge needed to enable them to make their lives better.

Language shapes what kind of conversations/messages the doctor/practitioner will provide (some types of conversation are more useful to patients than others).

Small changes can lead to big ones.

***The basic therapeutic process*:**

1. Listening to the story: Open and non-judgmental. Take a 'not-knowing' stance. In reflecting can turn generalizations into specifics. For example, patient says,

"Everything's gone wrong, I'm a disaster"- reflect back "I hear that what your saying is *that right now you feel like* things are going disastrously wrong".

Instead of preaching, assume there are good reasons for things going wrong. Example,

"Even though it might not be clear why right now, there is likely to be a good reason for you feeling you need to harm yourself".

2. Search for exceptions: Discover what the person is already doing which might be outside the problem-saturated story they have come with. Try questions like:

“Tell me about times when (the problem) seems just a little bit better”, “How did you manage to make this happen? What else?”, “What is different about those times when things are a little bit better?”, “What would your best friend (mother, father, sister etc.) tell you when things are going a little bit better? What would they notice about you?”

If they can’t think of such exceptions, then try coping questions like,

“How have you kept going while (description of the problem)?”, “Given how you feel how do you manage to do these things (e.g. get up in the morning, get dressed, come to this appointment, etc.).”

Try to notice examples that happen spontaneously in the appointment,

“I’m so impressed with how you have thought carefully about what is happening, you have somehow kept up the ability to communicate, concentrate and explain”, “I’m curious as to how you think you re-discovered this ability to concentrate here today in our meeting?”

Label any example of better moments or coping as examples of the patient’s **natural resilience** coming through.

3. Find out the patient’s goal(s): A good way to do this is ‘**The Miracle Question**’:

“I want you to imagine that after this appointment the rest of the day goes just like the last few days, then after you go to bed tonight, for some reason, you don’t know how and you don’t know why, but a miracle happens and everything you’d like to see change in your life changes to exactly what you want. However, because its happened while you were asleep you don’t know this miracle has happened. So let’s imagine this miracle happens tonight. What would be the first thing you noticed that would make you think ‘oh today seems a little different’? What else would be different about tomorrow?”

The point of the miracle question is to get the patient to start **visualising** what things being better would look like. You need to get beyond feelings to more concrete examples, which can help develop concrete behavioural goals that the patient wants.

Therefore In the answers help the patient move from general statements to **specific** ones, from statements about what wouldn’t be there to **what would** and to **observable behaviours** that would be different. For example:

Patient: “If this miracle happened I would be happier”,

Doctor: “Could you help me understand what being happier looks like for you, as everybody has different ways of showing that they’re happy”,

Patient: “Well I wouldn’t be losing my temper with everyone”,

Doctor: “Right, so what would you be doing instead of losing your temper if you felt happier?”,

Patient: “I’d be smiling a lot more”,

Doctor: “I see smiling more often, what else might you be doing differently?”

Patient: “I suppose I’d go out with my friends more often”,

Doctor: “Right, so if you went out with your friends more often, which friend might you start with? Where would you go?” and so on.

4. Scaling: Once you have a list of potential different behaviours the patient has visualised if things got better, you may just ask them to do a ‘noticing’ task,

“I wonder if you might, between now and the next time we meet, just make a mental note of those times you manage to do even just a small bit of the goals your miracle question answers showed”.

You could also use individual goals (of specific observable behaviours that would be present if the goal was achieved) developed from the miracle question answers. See if they can rate these behaviours on a scale of 0 to 10, where 0 is the problem at its worst and 10 is the goal with complete absence of the problem. Example,

“So one of the things you said would be different is that you would see your friend Sara more often. I wonder if you could rate how often you see Sara is at the moment, where 0 is you never see her and 10 is you see her as often as you would like.”

Whenever a person scores themselves higher than 0 it gives the doctor/practitioner an opportunity to search for exceptions,

“So I see you scored 2 on this issue of seeing Sara, I’m interested to know what this 2 means as it’s not a 0”.

5. Plan for small changes: For example:

“Can you think of one thing that you could do differently that might take your score from 2 to 2 ½? Perhaps its one thing that you already do that you could do more of.”

Generate a conversation to co-construct an intervention. Emphasise that it is only a small change that they should focus on because a familiar pitfall that drains people of hope, is trying to do too much too quickly and then feeling they will never conquer the problem when it re-emerges.

6. Follow up sessions: Be curious about difference, looking for small differences and specific examples, whether that has anything to do with the goal or not. Ask about what has changed. As soon as you spot one example, however small, amplify it. Discuss how they did that, what have they reconnected with in themselves, what did they notice about this – essentially analyse the solution/progress in the same detail you would normally analyse a problem/disorder. Keep using and supporting the notion of **emerging resilience** in the face of adversity as you discuss what next they wish to work on.

7. When change starts to happen: keep the intervention brief, just a few sessions. Explain setbacks are learning opportunities and that it’s common to feel down when a setback happens, but they should remember what they achieved already. Recovery is usually a process involving better days and worse days and that’s just how it is.

8. Discharge: from that treatment as soon as you can. You want your patients to engage their community support network and own resilience rather than professional ‘wisdom’ as soon as possible.