WE CAN TALK ... BUT CAN WE COMMUNICATE?

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In 2006, the American Journal of Psychiatry published an editorial 'Are we still talking to our patients with schizophrenia?'[1] in response to a review article on cognitive therapy for schizophrenia. It supported engaging in direct discussions with people experiencing psychosis about what they said – why they believed the government or their neighbours were conspiring against them or what exactly the voices they heard were saying. Evidence now supports skilled intervention for psychosis using exploration, formulation and discussion [2,3] and this has been reinforced in the recently revised NICE guidelines[4].

However, do techniques developed in the UK with predominantly white patients work elsewhere - in the US, China, or Pakistan? How important is cultural influence on psychological intervention? In the UK, it has emerged that people from black & minority ethnic communities have not been doing as well with CBT as white patients[5]. In Pakistan, evidence has also emerged that simply applying unmodified CBT in depression can lead to high drop-out rates and poor response [6]. Successful modification is possible [7] but requires due attention to cultural factors. These factors can be advantageous, e.g. much greater involvement of families, as well as complicating, e.g. in development of a fully collaborative therapeutic relationship. Similarly work with Black & Ethnic Minority (BME) groups in the UK has shown that routes to services and models of psychosis differ and influence intervention[8]. Style of interaction also seems important, for example, with very differing expectations of therapist self-disclosure between the two groups studied – Black African/African-Caribbean & South East Asian Muslim. Self-disclosure was expected by the former but not the later.

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But how we talk and succeed in communicating goes beyond cultural issues. Stigmatisation and discrimination seriously affect people who are making recoveries from mental illnesses. We are trying to convince people that it is 'Time-to-Change' but are we communicating clearly what we want them to change to? Currently the way we talk about mental health issues may be increasing confusion and discrimination. We use terms like schizophrenia which are stigmatising through its erroneous associations and intensely disliked by most of those to whom the term is given[9]. 'Personality disorder' is no better: over-generalising, arguably insulting and degrading to people who have often suffered appalling trauma and distress in their lives. It is not a useful term in clinical practice, rarely used directly with patients. Even anxiety and depression are used in ways which confuse – is depression a mental illness or a normal reaction?

One conclusion coming from a session on 'Drop Schizophrenia?' at the 2009 Annual Conference of the American Psychiatric Association and from a debate in the British Journal of Psychiatry[10] is that we need to work with people who have used mental health services, and also the general public, to develop terms for the new revisions of ICD & DSM which are clear and acceptable to them.

We have been making the case for 'the schizophrenias' to be replaced by early-onset ('stress-sensitivity'), late-onset ('anxiety-precipitated'), drug-related and traumatic psychosis [9]. Kraepelin divided early onset schizophrenia from the late onset paranoid disorders but this distinction appears to have survived only in division of schizophrenia from delusional disorders. There is evidence to support 'stress-sensitivity' as being important in early schizophrenia possibly related to criticism or bullying in relatively shy or schizoid individuals. With later onset, personal relationships have developed but anxiety symptoms can be misinterpreted delusionally, e.g. stomach pains could be misperceived as poisoning or criticism at work as conspiracy, and systematised into broad self-perpetuating 'explanations'. There is also a group of patients who develop persistent symptoms after use of stimulant or hallucinogenic drugs at the time of their first psychotic episode. This group differs to some extent from the 'stress-sensitive' group in being more sociable with more prominent positive and less negative symptoms. Lastly trauma in childhood in the form of physical, sexual or emotional abuse occurs in some patients with a diagnosis of schizophrenia and the term 'traumatic' psychosis can be helpful in defining the relevant problems that require psychological work

We have also suggested substituting personality disorder with terms such as complex PTSD for the 'borderline' group [11] as Personality Disorder is a much misused term and over-inclusive. Depression also is broad and confusing: CBT studies in this area are suggesting that sub-division may be helpful into following categories. 'Social' depression where overwhelming life events have occurred, requiring a problem-solving and short-term supportive response: 'Perfectionist' depressed patients are those who strive to achieve but in failing in some way become self-blaming and depressed with persistent negative beliefs about themselves:

Whereas the dependent group have lost supports which they need to cope and become anxious, depressed and 'needy'. Work focuses on developing coping, relationship and life skills[12]. Maybe these terms can be useful or maybe not – there may be alternative concepts and terminology which are more acceptable and valid but at least we need to start the discussion.

Explanations also need to be refined and clarified using widely-accepted normalising vulnerability-stress models [13] 'We all get stressed, we just react differently': some get anxious, some depressed, and others drink too much, work too hard or get confused. Responses differ according to temperament, genetics, previous experiences, available supports and the type of stress: broadly whether the experience involves loss or threat.

Mental symptoms are rather like physical ones. We all get physical symptoms – a cold, the flu, or a cut, and we get mental symptoms – anxious, distressed, frightened even depressed. Usually it is transient and we get on with life: sometimes we make adjustments, take time off work or just ease back a bit. We may need help from friends and family if they can offer it – or treatment in which case being described as physically or mentally 'ill' is meaningful. We may have lasting effects from the physical or mental illness and be disabled by these effects – permanently or temporarily. But we should be able to expect care, consideration and support whether these problems, illnesses or disabilities are mental or physical.

We can talk. But we need to develop simple clear explanatory models of mental health issues, terms acceptable to those they affect and ways of communicating effectively.

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