'I used to think that they were all abnormal. And I was the normal one':

Conceptualising Mental Health and Mental Health Treatment under Improving Access to Psychological Therapies (IAPT)

Abstract

Background: Improving Access to Psychological Therapies (IAPT) was introduced in the United Kingdom in 2006 to provide more effective and efficient services to people experiencing mild to moderate mental ill health. The model represents a paradigm shift in how we provide psychological care to large populations.

Aims: We wanted to document how the IAPT programme impacted on patients' understanding of their mental health, and mental health treatment.

Methods: We used Foucauldian Discourse Analysis to analyse six semi-structured research interviews with patients from one IAPT service in a major UK city.

Results: Participants constructed their mental health problems as individual pathologies. Constructions of mental health and of treatment evidenced the privileging of personal responsibility and social productivity over dependency on others and the state.

Conclusions: Services are functioning well for some. The role of IAPT in pathologising those who are dependent on people and services requires further commentary and action.

Declaration of interest: The first author was employed by the same organisation that delivered the IAPT service, although through a separate staffing and management line.

Introduction

The Depression Report argued the case for mass investment in psychological therapies as statutory sick pay and benefits for mental ill health, use of mental health care services and time away from work became an economic burden, amounting to 2% of the UK's GDP (Gross Domestic Product) (Layard, 2006). Funding had previously focused heavily on the 1% of patients with psychotic features meaning that those experiencing depression or anxiety were left with little treatment outside of brief medical interventions from their GP. The UK National Institute for Health and Care Excellence (NICE) recommended short-term cognitive behavioural techniques for the latter clinical group, arguing for efficacy and efficiency in treating symptoms alongside, or instead of, medication. Layard's premise was that investment in psychological therapies would show returns through reduced spending on sick pay, benefits and alternative care.

The Improving Access to Psychological Therapies (IAPT) programme followed swiftly. IAPT is a stepped care model, meaning a model by which patients are processed through a standardized system of treatment according to the perceived level of need, with the majority of patients receiving a low intensity intervention and being 'stepped up' to the next level only if the first intervention is deemed ineffective. Following 'watchful waiting', IAPT treatment begins at Step 2 with guided self-help based on cognitive behavioural techniques via computer; over the telephone or face-to-face in a group; or in up to 7 one-to-one sessions (Clark et al., 2009; Ghosh, 2009). Those requiring further input are referred onto Step 3, receiving up to twenty sessions of individual therapy (Clark et al., 2009; Ghosh, 2009). By 2011, IAPT services were being accessed by approximately 310,000 individuals per year and by the completion of roll out in 2015, the target number will reach 900,000 (Clark, 2011).

By creating a systemised programme of short-term psychological intervention IAPT represents a paradigm shift in mental health treatment. Quantitative data demonstrates early success in terms of patient numbers, treatment efficacy and return to work (Clark et al., 2009; Richards & Suckling, 2009). Measured as the percentage of people who move from above to below the clinical cut-off point on the Patient Health Questionnaire (PHQ-9), a review of trial sites reported a mean recovery rate of 56% (Clark et al., 2009). A Royal College of Psychiatrists National Audit (2013) reported a median recovery rate of 46% at point of discharge. Similarly early indicators suggest efficacy in supporting people back into employment with a 5% increase in the number of patients moving from sick pay and back into work across the two trial sites (Clark et al., 2009). Patient research also points to success in meeting needs. Patients highlighted the value of having space to talk about concerns (Royal College of Psychiatrists, 2011), and expressed gratitude that such a space existed, free of charge (Hamilton et al., 2011). In the mental health charity Rethink's 2011 survey (Hamilton et al.) 45% of participants stated that the service had "helped them a lot" and a further 26%, "it helped quite a bit" (p. 30).

However concerns have arisen regarding the veracity of the early data. In particular data is missing for those who do not complete treatment (Clark et al., 2009: Richards & Suckling, 2009). Although Clark et al.'s (2009) review of trial sites collected some limited follow up data, more extensive longitudinal research is required in order to understand the longer term efficacy of IAPT. Clark et al., (2009) noted a trend towards deterioration at follow up suggesting that early successes may give an inflated sense of IAPT's efficacy beyond the treatment stage. This is echoed in patient research, with people articulating fear of relapse, and emphasising the importance of being able to return for further treatment should they feel it necessary (Royal College of Psychiatrists, 2011; Hamilton et al., 2011). Recovery rates may also be distorted by the effect of natural recovery (Richards & Suckling, 2009). Furthermore, clinical recovery rates are based on self-report measures which are open to the distortions of patients who may wish to emphasise their ill health, please their therapist with positive

results or become over familiar with repeated measures (Richards & Suckling, 2009; Stiles, Barkham,

Mellor-Clark & Connell, 2007).

The therapeutic model of IAPT has also drawn criticism.   It has been viewed as mechanistic, reducing

the complexity of CBT, homogenising therapeutic interventions and under-promoting collaborative

and dialogically oriented therapy (Ballatt & Campling, 2011; Mollon, 2009; Murphy & Perera-Delcourt,

2014).   The standardized intervention and insistence on performance indicators may be seen as re-

packaging human suffering using discourses of clinical protocol and market economy (Rizq, 2012a).   In

light of the conflicting literature this study sought to consider particular understandings of mental ill

health and treatment from the accounts of individuals who had experienced IAPT.

Methods

Participants: Six participants were recruited through email via one participating IAPT service in a

metropolitan borough.   All were working age adults treated under Step 2 IAPT within the last 12

months (February, 2013 to February, 2014). 'Treated' was understood to mean completion of at least

4 one-to-one guided self-help sessions either in person or over the telephone.   The participants' ages

ranged between 36 and 61 years.   There were four female and two male participants.   Five

participants identified as White British and one participant as White European.

Design: Data was analysed using Foucauldian Discourse Analysis (FDA).   FDA is an epistemological

approach which focuses on knowledge construction and subjectivity formation.   As such it enables an

analysis which moves beyond a description of experience to interrogate the ways in which patients

make meaning *from* and *through* their experience.   FDA enabled the authors to draw attention to the

ways in which participants constructed their mental health and their mental health treatment and the potential implications of these constructions.

Procedure: The University of East London ethics committee and the service provider granted ethical consent. Prior to interview, participants were informed of the research topic, the right of withdrawal and confidentiality of the data. Written consent was collected and the service provider arranged payment independently. A semi-structured interview based on 12 questions covering content, experience and effect of treatment was conducted with each participant   Participants were allocated pseudonyms.

Data Analysis: The interviews were transcribed verbatim according to recommendations set out by Parker (2005). The transcripts were analysed by the first author annotating first constructions of mental health and mental health treatment, then relationship to current literature, and finally relationship to Foucauldian theory.   To limit priming, transcripts were read in differing orders until theoretical saturation was reached. Repeated and contradictory themes were grouped. Themes for discussion were selected according to prevalence within and between transcripts (See Appendix).

Analysis and Discussion

We present two main discourses from analysing the research interviews - constructions of mental health and constructions of mental health treatment.

Constructions of Mental Health

Within constructions of mental health, mental health was firstly constructed as a pathology located within the individual. Secondly, mental health was constructed as a phenomenon that could be measured.

Mental health as an individual pathology

Participants constructed accounts that firmly located the cause of ill health in their own essential being. Mental health was constructed using biomedical and disease laden terms. IAPT treatment enabled them to address problems that were in their 'nature' (Katie) and to understand 'the physical thing' (Keith). Cami comments:

> It's not a lifestyle choice it's an illness, it's like breaking a leg or having arthritis so it is an illness.

Whilst biological causality was implicit in the participants' accounts, they more explicitly located their mental ill health in negative and ineffective patterns of thought. IAPT treatment invited participants to turn the psychological gaze on their cognitions, and place these in a hierarchy in which rational thoughts were normalised and linked with recovery in contrast to unhealthy, 'emotional' thoughts. Nadia comments:

> You feel like you can't stop your thoughts. But after a certain point, I say, 'Nadia, stop being negative. OK? Let's stop and focus on what you can do. How can you do this? How can you react to this?'

As such the participants constructed a Cartesian, rational mind able to exert control over negative, meaning emotionally driven actions and behaviour. As Michelle notes:

It has helped in work as well because I can sort of think more logically about things rather than emotionally you know. I can obviously I still respond emotionally to all kinds of things but I can sort of think really, is that really the best way forward?

The emphasis on cognition is reflective of the principles of CBT which underpin IAPT. Alternative theoretical models, for example Freudian psychoanalysis or embodied approaches were notable in their absence in participants' accounts. IAPT's lack of theoretical diversity is problematic, limiting the sense that individuals can make of their distress, and potentially their recovery (Mollon, 2009). There appears little space for a more complex self in which cognition, emotion and physiology interrelate and as such IAPT may pathologise those for whom emotion is, both experientially and discursively, central to their identity.

Furthermore, by locating the pathology at the level of the individual it is the patient that must best fit the IAPT model, a value implicit in official IAPT discourse which describes patients who "fail to recover" (IAPT, 2011, p.2). It is the patient that fails the system, and not the system that fails the patient.

Participants constructed ideas and ideals of self as productive beings, participating in the social world. Mental ill health limited social functioning and as such was positioned as a less acceptable way of being in the world as Keith tells us:

I've got a family, a wife, a house, I've got a job, I'm a member of a professional organisation etcetera, etcetera. I suppose you would describe me as a pillar of society, you know. I'd like

> to think I'm honest and a decent enough person. You can't turn around and go I'm a jabbering wreck now, I'm not to work and can you feed me, change my pants for me.

Socioeconomic discourses are reproduced through the personal constructions of IAPT treatment, and, at this level attach themselves to moral discourses of guilt. Not taking the opportunity to participate in IAPT programme may result in fecklessness, distress and dependence on others. This raises concerns as to what it might mean for people who are experiencing profound emotional distress, to frame this distress in terms of 'burden' and 'deficit'. As a function of power relations, IAPT promotes the individual who aims to return to work. IAPT can therefore be seen to directly contribute to the commodification of the self that is subservient to a market agenda (Rizq, 2012b). By proxy, this serves to stigmatise those for whom work is simply not an option by privileging employment as the primary way in which the individual can contribute to society.

Mental health as measurable

Output scales are integrated into all stages of IAPT treatment through the GAD-7 (Generalized Anxiety Disorder scale) and PHQ-9 (Patient Health Questionnaire) (Clark, 2011). Whilst seemingly pragmatic in intent, these impacted directly upon the therapeutic process and constructions of mental health. Mental health was understood as a measureable entity in which recovery was framed in terms of a reducing score as Calum comments:

> We started off with some very high scores at the very beginning. In fact, on the last page they were all maximum scores and it's almost not knowing that you may be feeling better when you don't circle number five and you think, 'Oh okay I think I'll do number four on this one'. You gradually feel that your line of numbers is moving. So at the end, she [the therapist] used to add them all up and say, 'Well yeah that's fine look at how *we're* [our emphasis] improving'. I think *they* [our emphasis] say 'It's okay, you're on the mend'.

Rather than the patient spontaneously experiencing and so reporting the impact of therapy the measurement informed patients of therapeutic benefit. As such the quantification process was not simply a reflection of recovery but a constituent of it.

Further undermining the purely reflective purpose of the outcome measures was the potential for patients to manipulate the scores. As Michelle explained:

> I was feeling a bit of a fraud really thinking I'm not really depressed and I have to make these measurement scales look as though I'm more depressed than I am because what's somebody with four out of ten doing in this session?

Here the participant used the measurement tools in order to compare herself with others and validate her need for treatment. In this way the tools for big data collection became re-appropriated by the participants and used instead as idiosyncratic modes of self analysis. The IAPT patients thus disrupted and so challenged the aim of using data to generalise from personal experience, a challenge which may be usefully understood alongside studies of the Quantified Self Movement (Nafus & Sherman, 2014; Wolf, 2010). Certainly the use of the tools further evidences the need for caution regarding reported recovery rates for IAPT, where movement on the GAD-7 and PHQ-9 exists as a primary tool for capturing this information (Richards & Suckling, 2009; Stiles, Barkham, Mellor-Clark & Connell, 2007).

Whilst many participants constructed the use of the measurement scales as positive, there appeared some challenge in translating experiences into numerical form. Nadia finds scoring her mental health somewhat awkward:

> Scoring, yeah it was strange because these are personal questions and there is a score for
> every kind of situation so yeah, a bit weird. I didn't quite understand.

Whilst some patients may appreciate the opportunity to reflect on progress through the filter of an outcome measure others may find them a crude reduction of their particular experience (Hamilton et al., 2011; Royal College of Psychiatrists, 2011). Advocates and critics alike also recognise the inconvenience, even intrusion of such tools during the process of therapy (Richards & Suckling, 2009). The construction of mental health which can be measured, manipulated and minimized through processes of quantification is an ongoing concern in terms of the impact on the therapeutic alliance and efficacy of psychological interventions (Rizq, 2011).

Constructions of Treatment

Treatment was firstly established as a process of self-help in which the participant had primary responsibility for their recovery. Secondly, treatment became a form of self-regulation.

Treatment as self-help

Consistent with the low intensity design of IAPT (Clark, 2009) participants clearly constructed treatment as self-help. Keith says:

> I thought there's only one way, there's only one possible result from this is, getting the
> information that I need and then self-help.

This placed the participants in a position of control, and was compared positively to pharmaceutical treatment. The emphasis on self-help not only privileges such agency but presupposes a patient who is capable of it. The patient is positioned as an agentive, rational being, independently responsible both for their ill health and their recovery (Rizq, 2012b).

Treatment was not something that was done to the patient, but something that they enacted on, in and through their own bodies, thoughts and behaviours. Self-help in IAPT could be exerted first of all on the body of the patient as Cami notes:

> I just thought it [IAPT treatment] might be another way of controlling my brain. There was clearly some sort of imbalance going on in my brain.

IAPT also enabled the patients to regulate their thoughts with the responsibility for changing mental states placed firmly in themselves. Michelle tells us:

> I was expecting her [the therapist] to say, 'You've fallen into a way of thinking that is not helpful to you'. And she never said that. I worked that out for myself based on what she gave me to do.

By promoting discourses of self-help, IAPT risks participating in a cultural pathologisation of dependency and perhaps eroding clinical responsibility to hold people when ill health prevents them from holding themselves (Manning, 2009). IAPT thus sits at the centre of an increasing tension between the traditional role of care giving structures and the expectations of a neo-liberalist discourse, that is to say a discourse which emphasises individual over collective responsibility, a reduction in public services and the primacy of the market (Ballatt and Camping, 2011). Viewed alongside IAPT's emphasis on supporting people back into employment, 'self-help' may be seen as having a distinctly market focused agenda, where productivity is paramount, with worrying implications for patient wellbeing and the very ontology of the NHS as a system of care.

Treatment as self-regulation

Whilst self-help may usefully support patients to master the symptoms of their ill health this becomes more complex when we think of treatment as a form of self-regulation. Participants understood treatment as regulating their thoughts and their behaviours, in a linear fashion from the negative to the positive. Thoughts could be easily classified and daily anxieties made simpler. As Nadia explains:

> She [the therapist] helped me a bit to understand, when the symptoms come try to think how to fight the symptoms and try to think in a more positive way, constructive way.

Crucially, such positive thinking ensures chaotic anxiousness is replaced by productive behaviours, as Calum discussed:

> Sometimes I slip back at the beginning of the month when it's changed from February to March. You then have to think: "Let's not keep worrying about something that's not worth worrying about. Let's get the garden sorted. Let's go wash the car".

Regulating behaviour (be that thoughts or action) was positioned as necessary in order to function effectively in the everyday social world. The responsibility for adhering to a particular way of being is again positioned firmly at the level of the individual. And again something they enact *on*, *in* and *through* their thoughts and behaviours.

Self-regulation required self- awareness. This was facilitated by the role of the therapist as the patient's mirror, a technique that the patient could then model in re-conceptualising the self. Michelle is succinct:

> I think the trouble is that when you're depressed the mirror that you've got is cracked. [The therapist] had a good clear mirror and she could say, 'Look here's the reflection, here's what's going on'.

The participant constructs mental ill health as impacting upon her capacity to be conscious of, and so monitor her behaviour. The therapist however is able to show the patient herself 'as she truly is' with the therapist's *objective* insight, privileged above that of the patient. This exemplifies the shift towards methods of disciplinarity in psychiatric treatment where individuals come to recognise the abnormality of their own behaviour in comparison to internalised social norms (Foucault, 1967). Through the recognition of abnormality, individuals can then regulate their own ways of being.

In line with theories of disciplinarity, social constructions of the normal and the abnormal are clearly re-produced at the IAPT site. Katie comments:

> The other interesting thing that CBT taught me was to stand back and look at yourself. Look at the way I'm reacting is not necessarily normal. It's not the way other people [react]. I used to think that they were all abnormal. I was the normal one.

The IAPT lens redefines the participant's behaviour as problematic. This can be seen as exemplifying normalizing processes meaning processes which function specifically to sustain systems of power by promoting certain ways of being over others (Burr, 1995; Henriques et al., 1984; Parker, 2007). Here, self-regulation ensures that the patient judges previous ways of being as deficient compared to those sanctioned by IAPT.

Important questions are raised as to the purpose of this regulation: who and what does it serve? We are reminded of the neoliberal ideals of personal responsibility and Layard's key principles, including the economic imperative for adults to work. IAPT appears to promote constructions of treatment in which these ideals are internalised, reproduced and enacted by the participants on their own beings. It may be seen then as a form of "biopolitics" by which mechanisms of state control are

operationalised internally, on and within the body of the individual (Foucault, 1988; Rose, 2006). The extent to which treatment of ill health thus becomes political tool is troubling.

Conclusion

As a paradigm shift in treatment model, it is crucial to understand the impact IAPT is having on its 'consumers'. By prioritising a specific account of mental health, and systematically disseminating this account at a national level, IAPT reinforced constructions of mental ill health which focussed on individual pathologies, insisted upon numerical representation of personal distress and privileged productivity using a market agenda. Nonetheless, participants constructed a service that had helped, that was preferable to pharmaceutical intervention and one in which the therapists were thoughtful and sensitive.

The reality is that with further investment and the expansion of target patient groups, IAPT, for now, is likely to stay. It is then pragmatic to consider how IAPT can be supported to be a service, not constrained by unrealistic fantasies of cure, but a service that is 'good enough', a service that is sensitive to the needs of its patients and makes use of its available resources to meet these needs as best as it can for most of the time.

Just as IAPT promotes particular ways of being a patient so too may it promote particular ways of being a therapist. The stepped care model, manualised treatment and outcome measures all frame what the therapist can bring, and how they can relate to the patient. As such IAPT's function may be better understood and so improved, by investigating the ways in which professionals understand the service, and their role within it. We would suggest that further consideration be given to the psycho-

education provided to patients thereby clarifying the therapeutic modality of IAPT, and the range of longer term therapeutic interventions available. We would also suggest that further consideration be given to the value and validity of current outcome tools and a possible need for more holistic exploration of recovery. Finally, we make a call to policy makers to consider the extent to which care services, including mental health services can and should resist promoting a political agenda and in doing so, pathologise dependency for an already stigmatised group of people.

Limitations

The sample is small and homogeneous. Whilst relatively representative of the metropolitan borough from which the sample was drawn, it does not adequately reflect the diversity of people living in the UK seeking treatment for mental ill health. Further research with a larger, more diverse sample is required in order to understand the extent to which IAPT can make space for the multiplicity of subjectivities it aims to contain.

Appendix

Analytic Steps for the Foucauldian Discourse Analysis

Step 1: Interviews were transcribed verbatim, according to the conventions outlined in by Parker (2005).

Step 2: Transcripts were read and constructions of treatment and constructions of mental health were marked on the transcript. The transcripts were read three times, first from Participant 1 to Participant 6, then from Participant 6 to Participant 1 and then in a random order in order to limit priming effects.

Step 3: A table was drawn up for each primary research aim and constructions from each transcript listed in one column.

Step 4: In a second column notes were made on how these constructions relate to existing literature on IAPT.

Step 5: In a third column notes were made on how these constructions relate to Foucauldian theory.

Step 6: Constructions which were repeated between transcripts were grouped together.

Step 7: Constructions which indicated a contradiction within or between transcripts were marked.

Step 8: Constructions for discussion were selected based on their prevalence within and between transcripts.

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