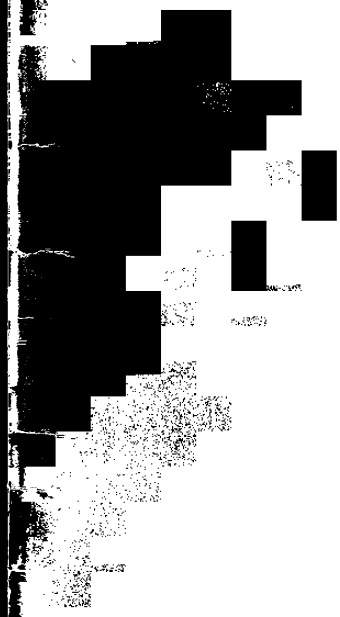
King's Fund

Complementary Therapies in Mental Health Treatment

Sharon Jennings



King's Fund
Publishing
dish Square
0AN

sanctuary
sanctuary
tuary
sanctuary
ry
sanctuary
sanctuary
sanctuary
sanctuary
nctuary
sanctuary
sanctuary

Complementary Therapies in Mental Health Treatment

A commentary on issues arising at a seminar held on 8 February 1995 at the King's Fund Centre, London

Sharon Jennings

King's Fund

Published by
King's Fund Publishing
11–13 Cavendish Square
London W1M 0AN
Tel: 0171 307 2400

First published 1995

ISBN 1 85717 100 4

A CIP catalogue record for this book is available from the British Library

Distributed by Bournemouth English Book Centre (BEBC)
PO Box 1496
Poole
Dorset
BH12 3YD
Tel: 0800 262260
Fax: 0800 262266

CONTENTS

INTRODUCTION

Conventional psychiatric medicine has come under significant criticism of late, particularly with regard to treatment. Mental health professionals within both statutory and voluntary sectors, user-led groups and campaigns have frequently voiced their opposition to what appears to be a professional propensity for drug therapy above any other type of therapy, including talking therapies. For example, two MIND campaigns are currently seeking to raise awareness of the need for a wide range of treatment options to be considered and for users to evaluate the effectiveness and the experience of side-effects of their medication. Research and user feedback have shown that in a significant number of cases, medication is less than effective in eliminating psychotic symptoms and there are significant short and long-term side-effects to be endured.

With regard to Black mental health users, these concerns are even more acute. For nearly two decades, evidence has been mounting to suggest that Black people's experience of the psychiatric system is fraught with inequalities, in comparison to their white counterparts. Various research studies have shown that Black people are several times more likely to be compulsorily admitted to psychiatric hospital that they are more likely to be diagnosed as schizophrenic; and that they are more likely to receive harsher forms of treatment, which include drug therapy and ECT rather than counselling and psycho-therapy.[1,2,3,4,5] The psychiatric system has been charged with being insensitive to the cultural as well as social needs of Black people and for many Black users of the service, it has become synonymous with oppression.

With this surmounting criticism has come the call for viable alternatives. The voices of Black users, carers and professionals alike have continued to demand alternative treatment which is effective as well as culturally appropriate. Many have looked to complementary therapies, suggesting that herein lies the answer. This has coincided with a growing demand for an increase in medical treatment options generally, and a noticeable rise in the popularity of complementary medicine.

It is with this as a backdrop that this seminar was organised. Its purpose was to provide some clarity on the current use of complementary therapy within the field of mental health, with particular emphasis on severe mental illness. A number of mental health practitioners using a wide range of therapies were invited to share, discuss and debate their practice and experiences around the use of complementary therapy. From this, inevitably other issues would emerge regarding the various therapies and their effectiveness in treating severe mental illness, as well as raising wider issues such as research methods, influencing conventional practice and expectations of other professionals.

It was from this forum that I, along with colleagues, hoped to consider the usefulness of these therapies as treatment options for Black mental health service users. More specifically, the information would aid in the development of community-based crisis services for the African-Caribbean community commonly known as 'sanctuaries', where it was envisaged that complementary therapies could play a significant role, alongside more conventional treatment. The 'sanctuary' model – the term conveying both the type of service provided and the atmosphere in which it is provided – represents an alternative to unnecessary hospitalisation, offering a place of safety, professional assessment and support, time out and cultural sensitivity.

Within the field of complementary medicine, generally, the main therapies tend to be homeopathy, acupuncture, hypnosis, manipulation and nutrition/ diet. However, with reference to mental health treatment, therapies which are commonly considered to be 'complementary' tend to fall into the following categories:

- helping people to manage their symptoms largely through some form of talking therapy
- working with families either including or excluding the user
- physical (manipulation) therapies (e.g. massage)
- physical (breathing and movement) therapies (e.g. yoga)
- artistic and creative therapies
- self-help, user-led therapies.

These categories were represented among the invited audience and speakers of the seminar, who worked within a variety of settings. All of the practitioners were practising complementary therapy and many did so while employed as,

for example, psychiatrists or physiotherapists within the health service. These same people were also attempting to develop the use of complementary therapy in their hospital settings as well as operating privately outside. Indeed, a plus for the seminar was that a majority of the participants had more than one professional or theoretical influence guiding their work. Of the therapies represented, a number would be considered unorthodox, such as Hearing Voices Work, while others, such as psychotherapy and occupational therapy, would be considered as primarily mainstream therapies. Many of these therapies come from established traditional bodies of knowledge which may be seen as alternatives to Western (often chemical-based) psychiatric systems while others are more recent and, perhaps, less well developed in terms of theory and practice.

This report attempts to identify key themes within the seminar and highlight questions pertinent to the use of complementary therapies in mental health treatment. It draws selectively from addresses and workshops presented, comments and discussions during the seminar as well as feedback from the evaluation forms. With hindsight, the seminar presentations and workshops seemed to address three key concerns which are:

- What are complementary therapies? are they valid and effective? How do we know this?
- Are complementary therapies an extension of existing conventional methods?
- Are complementary therapies an alternative to (different from) conventional methods?

In addition to considering these questions, the report will discuss certain issues pertaining to the use of complementary therapies with Black people, in particular, exploring the compatibility of the value or culture base of complementary therapies with that of Black people.

Besides being of interest to the seminar participants, this report should be of great interest to those with knowledge and interest in the therapies presented, particularly those who are currently practising as complementary therapists and wish to further explore the issues presented here.

TERMINOLOGY

BLACK

For the purpose of this document, the term 'Black' refers to people of African descent and origin; people who may be commonly referred to as African, African-Caribbean and Black of mixed parentage. It is believed that this group is likely to experience racism and discrimination at individual and institutionalised levels. This usage of the term Black does not, however, imply exclusivity with regard to the experience of racism, generally, or within the mental health system, specifically. It is readily acknowledged that other groups of people, also using the term 'Black', experience varying forms of racism inherent in society.

CARER

A person who gives direct care and takes day-to-day responsibility for a mental health service user, in an unpaid capacity, usually, though not exclusively, within a domestic (home) environment.

USER

A person who currently is or has in the past been in receipt of services of assessment, treatment and support within the mental health system, whether the services were community or hospital-based. For the purpose of this document, the term 'user' replaces terms such as 'patient' and 'client'.

1 COMPLEMENTARY THERAPIES

DEFINITION, VALIDITY AND EFFECTIVENESS

Defining what complementary therapy is and what it entails was the first hurdle encountered. What makes a therapy complementary and does the term 'complementary' itself necessarily mean that it is different and radical and/or working in conjunction with other forms of traditional therapy? Furthermore, who defines a therapy as being complementary. Is it practitioners, users or the medical establishment?

Dr Dinesh Bhugra, in his opening remarks as chair, began by outlining threedifferent definitions of complementary therapies which ranged from it being seen as:

- unscientific, unconventional, not medicine and linked to folklore;
- incorporating a broad range of therapies (some 150 in all) employing various methods but which have in common the promotion of the individual's own healing capacities;
- sharing common principles such as using a broader definition of 'health' which not only represents the absence of symptoms but necessitates a spiritual well being; working holistically with mind, body and spirit.

Professor Ernst, Chair of Complementary Medicine at the University of Exeter, delivered critical analysis of the use of complementary medicine generally, making some reference to its uses in mental health. In particular, he highlighted important issues of effectiveness and how this is substantiated and validated. He also stressed the need to work from clear definitions. Indeed, his opening remarks continued on the theme of finding a valid definition of complementary therapy or medicine; *valid* meaning a definition that could not be disputed. He informed the audience that he and his colleagues (all coming from different backgrounds and schools of complementary and conventional medicine) at the University of Exeter were currently working on an agreed definition, which would encompass the different types of complementary therapies that exist.

Professor Ernst asserted that in measuring the effectiveness of complementary therapies, safety and benefits must be seen as yardsticks, though they must not be viewed in isolation of the risk factors. He felt it was wrong to believe that, because something was natural, it was completely safe. Though anecdotal evidence from therapists and recipients of complementary therapies and current literature would suggest that complementary therapies are safer and more effective than their more orthodox counterparts, Professor Ernst contended this approach may be overlooking potential dangers. He went on to illuminate this point by citing massage therapy, where there is a reported rate of severe/fatal side-effects (e.g. stroke leading to death) of one in 10,000. Taking into consideration the number of people receiving this treatment, the death rate may prove significant enough to warrant further investigation. (A point raised in later discussion highlighted that this rate compared favourably to the reported deaths of mental health users prescribed neuroleptic medication, which is about one death per week.)

Professor Ernst added that the benefits of any therapy must be viewed in relation to the risks involved and some kind of balance reached. With respect to the use of complementary therapies which tends to be for symptom reduction rather than cure or saving lives, the benefits are considered small. Therefore, any form of risk could, technically speaking, easily outweigh the benefits derived from the therapies.

Similarly, in mental health, complementary therapies when used, tend to be used to treat anxiety, depression and stress-related conditions, rather than more severe forms of mental illness. He cited studies in the use of herbal remedies, massage therapy, guided imagery and music therapy, but so far research using randomised control trials has not produced conclusive evidence to support anecdotal claims to the effectiveness of these therapies. Professor Ernst maintained that more rigorous research is needed, which will help to resolve safety and cost issues as well as those regarding effectiveness and validity of the therapies.

The need for further research played an important part in the address of Dr Gillian Haddock who spoke about cognitive behavioural therapy (CBT) and past and current studies being carried out at Manchester University. CBT employs various psychological techniques to enable patients to manage often

quite severe psychotic symptoms such as delusions, hearing voices and hallucinations.

Dr Haddock began by listing why it was important to develop alternatives to conventional treatment of neuroleptic medication for people who are suffering from psychosis. For many people, neuroleptic medication does not eliminate symptoms (some studies have suggested just under 50 per cent of patients still had hallucinations); many people who continue to have symptoms also suffer from anxiety and depression. This leads to a high risk of suicide. There are also side-effects from neuroleptics which are intolerable for some people. Finally, some people want to have a choice of treatment.

The techniques employed in CBT can be loosely summarised in the following way:

- Normalise the symptoms; realising that under bizarre circumstances many of us could experience psychotic symptoms (e.g. sleep deprivation). It is important to understand the symptoms and work with them to reduce the accompanying distress and loss of self-esteem.
- Educate about mental illness; helping the individual to understand the illness and the nature of the symptoms, to inform about medication and the side-effects.
- Distraction and focusing; two techniques used in managing the hearing of voices. Means of distraction are, for example, wearing ear plugs, headphones, playing music. Focusing entails listening to and understanding the content, meaning and context of the voices.
- Coping strategies; using as a starting point the patient's own coping strategies, developing these, making them more effective and useful as treatment.

Until now, studies in the effectiveness of CBT have been in the form of single case studies and the results have been largely positive. CBT has been shown to not only substantially reduce frequency of symptoms, reduce feelings of distress, and increase self-esteem, but also to lessen the disruption that symptoms cause in patients' lives, and to reduce length of hospital stay.

Nonetheless, Dr Haddock felt that there was a need to have larger group samples which would not only assess overall effectiveness but would also help

in the development and delivery of CBT. Current research at Manchester University is looking into whether CBT could be used as an alternative to conventional drug treatment (up to now, it has been used as complementary to neuroleptic medication) as well as considering the viability of training other professionals (e.g. community psychiatric nurses) in CBT techniques.

COMPLEMENTARY THERAPIES AS AN EXTENSION OF CONVENTIONAL THERAPIES

An early criticism of this seminar, the therapies represented and the nature of the audience, was that these therapies were not 'complementary' (in the sense of being unconventional), but actually part of mainstream practices. In particular, psychotherapists, occupational therapists, psychiatrists, etc. were not seen as complementary enough. Aromatherapy was cited as an example of a therapy that was truly complementary. This theme echoed throughout many of the main addresses and picked up further in the afternoon sessions.

Lennox Thomas, Director of Nafsiyat – Intercultural Therapy Centre, addressed the audience on the model of assessment and treatment developed and employed at Nafsiyat, in working with Black and ethnic minority users. The staff come from varying theoretical and cultural backgrounds, but in the main the overriding influence of the work is a psychodynamic model... with some augmentation. This augmentation arose out of the reality of working with this client group. Mr Thomas explained that, though not altogether irrelevant, orthodox assessment procedures which looked at the history of personality development, ability to gain insight and discuss feelings, psychiatric states, etc. did not allow for Black people to 'tell their own stories' in their own way, and that this was important. Similarly, orthodox teaching in psychotherapy did not allow for the therapist to hear the user's story clearly, without making professional or cultural judgements which would then go on to effect the treatment.

The Nafsiyat model has raised the profile of culture, both of the user and the therapist. Culture, as Mr Thomas put it, gives an individual meaning as to how we see the world, our behaviour, identity and emotional state. It provides the rationalisation of a person's actions and thoughts. It is thus important for both user and therapist to look at what effect this has on the circumstances and presentation of the 'illness' but also on the therapy. In this way, therapists are

required to take a more active role within the therapy, not acting as neutral, but, in Mr Thomas's words 'doing more and being more to the person'. The therapist will ask questions, invite the user to explore an issue, and provide information/education on the therapy process when it is felt appropriate. In short, the therapist is more 'real' and this, according to Mr Thomas, is important for users who have hitherto been told that their experiences are unreal.

Other aspects of this model include:

- **The role of the user's family**. As most of the users operate within an extended family system, the family are seen as partners within the therapeutic process.
- **Language**. It is important that users are able to tell their own stories and communicate in a language that is most comfortable for them especially when communicating emotional/cultural meanings which may not be transferable in another (English) context. Many users are able to have a therapist who speaks their first language and interpreters are used if necessary.
- **Empowerment.** The model works to demystify notions of 'illness' and 'health' and instead focus on a user's reality. The importance is placed on behaviour and justification of that behaviour and often the answer lies in the cultural meanings attached.

Occupational therapy could also fall into the category of conventional treatment. Commonly seen as a practically focused profession, and often mistakenly viewed as recreational (basket-weaving, etc.), occupational therapy generally helps people with mental illness learn or relearn everyday tasks in order to lead a fulfilling life.

However, the workshop facilitated by Carmen O'Leary, Maxine Slapper and Dolman Domikles, illustrated how it is essential for the occupational therapist to have as a starting point an understanding of the needs of the user, as defined by the user. Taking the workshop through an exercise using Maslow's hierarchy of need, the facilitators demonstrated how our needs are directly linked to our life activities and in turn how these have a great effect on our self-esteem. For each of our needs to be met requires us to possess particular

skills and abilities. How successful we are at accomplishing this will determine how positively we view ourselves.

In this way, the work of the occupational therapist is to enhance an individual's life and self-esteem by assisting them in identifying their needs and learning the skills necessary to satisfy them. The occupational therapist needs to employ effective counselling and empathic skills in order to gain an overall understanding of the user, within the context of their life, and from there a programme of activities is planned. It is often the case that the occupational therapist will need to negotiate a compromise between the user's needs and desires, and between what the user wishes to do and what the user has the capacity to do.

COMPLEMENTARY THERAPIES AS AN ALTERNATIVE TO CONVENTIONAL THERAPIES

This theme was expressed either explicitly or implicitly in many of the formal addresses and workshops of the seminar. Featured here are two examples of complementary therapies where their alternative nature is reflected not only in the practice but also in the underlying 'theoretical' base.

The basis of the Hearing Voices workshop, facilitated by Phil Thomas and Ron Coleman, lies in the underlying belief system that supports the voice-hearer to be proactive in developing strategies for coping, developing self-help networks and empowerment. This model rejects the medical and biological models, which make hearing voices a symptom of an illness and then attempt to 'cure' it through medication. Instead, Hearing Voices Work starts with the standpoint of normalising voice-hearing and understanding what it is like to hear voices and the type of experiences this may cause for the hearer. To further illustrate this, the facilitators began the workshop with an exercise which required people to work in groups of three. Two of the people would be involved in a discussion while the third person played the part of a 'voice', which talked non-stop to the 'voice-hearer'.

The large group discussion which followed this exercise focused on the responses and feelings generated for the voice-hearer, which ranged from exhaustion, paranoia, confusion, to temporary disorientation, splintering and withdrawal. It was pointed out by the facilitators that many of these responses

are considered to be secondary symptoms of schizophrenia according to conventional assessment procedures. Apparently, presentation of two or more of these symptoms would be considered a justification for medication and possible containment. Further awareness was gained in the experience of voice hearers as many of the participants in the exercise felt that some of what the voices were saying sounded plausible, which would lead to their allowing what the voices told them to effect their behaviour.

Hearing Voices Work stresses the importance of focusing on the content of the voices and expression of underlying feelings instead of pathologising and suppressing them.

Therapeutic Body Work, as presented by Ann Childs, has as its starting point the interrelationship between the physical, mental and emotional states of the body and the balance of energy between these states, an imbalance of which represents 'ill health'. Energy and the balance of energy are believed to be very subtle and making physical interventions, through various forms of massage, can have a holistic therapeutic effect. The physical treatment works to correct the energy balance of the individual and this in turn can lead to unlocking long-standing memory and suppression of feelings. The therapist can then support the individual in opening up and expressing and understanding these feelings.

In this way the work of the therapist is not only seen in terms of its 'hands-on nature', but also in terms of forming and developing a relationship with the user. It can be seen less as a set of physical techniques and more about gaining and using awareness of self and the user. Building on the relationship and developing trust is important; yet, certainly in the early stages, this is done largely non verbally, through the body work. At the heart of this therapy is an ability to tap into deeper levels of communication thus leading to a change in the user's own mental, spiritual and psychological well-being.

2 DEFINITIONS, VALIDITY AND EFFECTIVENESS REVISITED

During the seminar, it became clear that many complementary therapies faced a similar dilemma: that of not being accepted as part of the mainstream by more conventional colleagues. Many of the therapists at the seminar work in hospital settings where they are attempting to use complementary therapy and are consistently coming up against blocks to furthering this. Others were grappling with how to initiate complementary therapy services, both within and outside of conventional settings. Is this, in part, to do with a lack of convincing, conclusive, research-based evidence to support their anecdotal claims? Is there a need for clearer, better-defined definitions and expected outcomes of treatment and rigorous research, as suggested by Professor Ernst?

The importance of having clear definitions, and establishing validity and effectiveness, especially through conventional research methodology, seemed less of a priority for much of the audience. Generally speaking, this was borne out in the comments on the seminar evaluation sheets, as well as comments and questions raised during discussions. Indeed, a member of the audience suggested that the process of forming a distinct category and definition for complementary therapy was largely about furthering professional self-interest and creating boundaries for people accessing the care they needed. It was recognised that some complementary therapies were easier to package than others (e.g. acupuncture) and were, therefore, being accepted within more conventional settings (e.g. GP practices). It was also acknowledged that, perhaps, it would be inappropriate to expect that complementary therapies should be incorporated into conventional settings, but that a more responsive attitude to them be developed by conventional practitioners. Similarly, it may be more productive to 'win over' an amenable individual rather than envisaging converting an entire medical system.

On the whole, it felt that the audience, who were largely practitioners of some form of complementary therapy, did not need reference to scientific research evidence in order to accept or challenge the validity and effectiveness of the therapies presented. Their judgements seemed to be based on a combination of

factors: case studies, their own practice and experience, anecdotal evidence. If this is a reasonable concept, could this be applied to more conventional institutions, for example, to purchasers of mental health services, who at present seem to require clear outcome studies and are reluctant to accept the validity of many complementary therapies? Indeed, some of the seminar audience were asking that alternative measures be used to ascertain validity. User/consumer views, use of case studies and, in some way, going on faith, were suggested as reasonable alternatives to scientific research using extensive samples. With regard to the last point, it was surmised that we all in some way accept the validity of a form of treatment (e.g. aspirin) without knowing exactly how and why it works, when it does.

All in all, it appeared that many of the participants were suggesting a more accepting attitude towards methods of research that could encompass a more subjective perspective, rather than a rejection for exploring the effectiveness of complementary therapies. This would entail the use of methods that were in keeping with the basic principles of complementary therapy, which were expressed at the beginning of the seminar and reflected in most of the presentations that followed. These principles include:

- an holistic view of health which incorporates, the mind, body emotions and spirit;
- promoting self-healing; self help; self-management;
- involving the therapist as a 'real' person; breaking down professional barriers of objectivity;
- working in ways that validate the individual and their experiences.

Further discussions brought forth notions of 'individual experience', 'wellness' and 'personal growth', which all seemed important within a complementary therapy context. Evidently, it was difficult to discuss complementary therapy using orthodox, medical or scientific terminology. Terms like 'holistic' and 'healing' are difficult to define accurately, in any case, but the need to use scientifically based language, as well as research methodology further adds to the difficulty. The question remains, do we need to prove something works in order to believe in its effectiveness, and if so, can conventional psychiatric medicine accept methods that are less 'scientific' than the norm in proving this, and if not, what are the implications for the validity of such therapies in the field of conventional psychiatric medicine?

3 COMPLEMENTARY THERAPIES: VALUES AND PRINCIPLES

Throughout the seminar, terms such as 'holism', 'healing', 'empowerment', 'individual', 'experience', 'wellness' and 'therapy' were used and, except for the a few occasions, went unexplored as to their actual meaning. It seemed that therapists worked holistically and the outcome was healing, wellness and personal growth. There appeared to be a universal, though unspoken, acceptance of what this process was, without consideration of its deeper significance. In the light of the aforementioned struggle to work from clear definitions, it would seem prudent to examine some of the underlying values of complementary therapies and, within that, clarify what these terms actually mean.

For example, Art Therapy, as defined by Sheila Grandison, was seen as 'encouraging the development of symbolic discourse/language, a language which is developed through images and materials'. The Art Therapy presentation featured the drawings of a selectively mute Nigerian young woman of 19. In her work with this young woman, Sheila explored the uses she had made of the art materials (in this case paper, pencil, felt tips) and the relationship she has formed with the object. The object created is seen as an expression of the young woman, and its meaning is viewed within the context of the relationship between the young woman and the therapist. In this instance, what do notions of wellness, holism and healing mean for this young woman and who would judge this? At the beginning of her Art Therapy, lasting six months, the young woman was selectively mute, socially withdrawn and detained in mental hospital. She regained her speech, left hospital to live in a hostel, and has now moved to another hospital of her own choosing and had a baby.

With regard to a user of CBT, what is wellness? Is it the gaining of insight into one's symptoms, the management of those symptoms in a way that does not call adverse attention to oneself, or the ability to live with one's symptoms? One conflictual aspect of this therapy with many of the others seemed to be the emphasis on 'symptoms', either frequency or content as opposed to notions of holism.

Using the model of assessment employed by Nafsiyat, what would be considered a successful outcome within this context? It was unclear from the presentation, but would it be fair to say that under this model, notions of wellness would be viewed within the cultural perspective of the user and family?

It was suggested that the user/consumer of complementary therapies defines the outcome of the therapy, i.e. using their own definition of 'wellness' or 'personal growth', etc. Viewed within a context of mental health, this would pose a societal as well as professional dilemma. If mental health services as perceived by society are about control and containment, the notion of allowing users to define what they want and presumably how they want it, would be an anathema. Similarly, many professionals hold these views. Would this right be extended to all users or those who were perceived, perhaps assessed, as being able to manage such a responsibility? What assessment tool would be used to ascertain who was able and who was not? And what of the therapist's role in defining outcomes?

One member of the seminar audience raised an important challenge, not only to the terminology used but also to the concepts behind them. Namely, we continued to speak of 'therapies', both conventional and complementary and in doing so we accepted a model which implies conventional notions of illness, of the therapy doing something to someone, and getting better, cured etc. Further points were raised about our 'intentions' to help others and who helps us to help others. Another point was made on how we need to acknowledge that, particularly in mental health, our desire to help people is, in part, due to the distress we feel in relation to the presenting symptoms. These comments point to a much wider issue of the therapist being part and parcel of the therapy process, being personally affected by the process, and the implications this has for practice as well as effectiveness studies. While this 'intimate' stance was, in some respects, postulated as being positive, the true implications and, in particular, the impact on working with (cultural) difference, was not concluded. This will be explored further in the next section with regard to Black mental health users. Suffice it to say, concepts of being ill, getting better, and the role of the user and the therapist in defining these, need further discussion and examination.

4 COMPLEMENTARY THERAPIES: THEIR APPROPRIATENESS FOR BLACK PEOPLE

As to the question of the appropriateness of complementary therapy to the needs of Black users, it would seem reasonable to ask 'does complementary therapy offer anything different to what is found in conventional medicine for Black people, and if so, what?' In order to answer this question, one must, again, look to some of the culturally defined values of complementary therapy and assess whether this is in congruence with the cultural values of Black people.

For instance, many complementary therapies come out of well-established traditional cultures and societies which stress a more holistic view of the world and life. One lives in harmony with the total environment. However, within the practice of these therapies, generally, there seems to be a strong emphasis on the individual, (e.g. aspects of personal growth), which is more in keeping with conventional, Western therapies, rather than Eastern and African philosophies. Again, generally speaking, Black cultures stress the importance of communalism, the group and family; that the effectiveness of an individual is judged by their interrelationship with their community and the roles they have within that. Practising complementary therapies without an awareness of the match or mis-match of cultural values between the therapist and the user could lead to misunderstanding and insensitivity.

Moreover, Black people living in Britain often find themselves existing between two cultures, and the manner in which these cultures interplay can cause great confusion and insecurity. Add to this the fact that Black people live within a context that is influenced by the experience of racism, on varying levels from individual to institutional. In what way does the value base of complementary therapy assist (mainly white) therapists to understand Black users?

A similar examination could be made with respect to notions of wellness, empowerment, and most certainly, holism. In order to fully operate within these concepts, the therapist needs to clarify in what areas their understanding is similar and different from the user. If one is working with someone of a

different culture, it is imperative that this clarity is sought, or at least actively and continually worked towards.

In terms of the seminar, it seemed to be the Black practitioners and those working with a significant number of Black users who considered the importance of these cultural perspectives and made efforts to incorporate them into their work. This raises concerns which centre around the inequalities faced by many Black users of mental health services owing, in part, to the assumed cultural superiority inherent in the models and practice of psychiatry. Certainly, many Black mental health users and professionals are looking to complementary therapies to offer a valid alternative to orthodox treatment. We need to ask what alternative is offered if the cultural and practice base of complementary therapies remains the same as that of traditional medicine.

What is of no doubt is that the experience of many of the complementary therapies are benign and often sensorily pleasurable and emotionally uplifting. The user often gets attended to and regarded in a positive way. It was suggested that when one goes to a complementary therapist, one is taken seriously as a person, but does not have to be in the 'sick' role (with the corresponding assumption that the therapist is 'well') in order to get positive attention. This may feel new for the user and initially empowering in itself. However, have practitioners in complementary therapy examined their underlying beliefs about what wellness or empowerment or holism actually looks like in the reality of Black people?

It is a common experience for many Black people to have their feelings of empowerment and assertiveness be perceived and acted upon by others as aggressive and unacceptable. There are a plethora of examples on an international scale to illustrate this and many within the mental health system. Indeed, the Race Equality Unit's report on the Christopher Clunis Inquiry[6] reported that there were several examples of clinical notes written on Christopher Clunis which remarked on his size and attitude, rather than his behaviour or content of his message and these seemed to have a strong influence on how he was, subsequently, medicated. Indeed, Clunis's protest and subsequent refusal to take medication that he believed, and was later proven to be 'an extremely large dose',[7] was viewed only as a 'threat' and not as his right to protest.

non-western cultures with large bodies of systematic knowledge. There is growing evidence of the effectiveness of TM, particularly in the fields of addiction and physical medicine.

Therapeutic Body Work

Ann Childs, Physiotherapist, Bassettlaw Hospital and Community Services Trust, Rampton Special Hospital

A workshop which will examine therapeutic ways to explore the relationship between mind and body; how physical interventions which tap into subtle vibrational energy can lead to increased emotional expression on a deeper level and facilitate change in the user's outlook and mental well-being. The workshop will also consider priority factors for being effective as a therapist; one's own personal qualities, having an overall understanding of the user, and possessing skills for dealing with subtle energy. Participants will also sample the techniques of massage, reflex therapy, touch, posture and movement.

Appendix 2 Details of seminar presenters

Dr Dinesh Bhugra (Chair). Senior Lecturer in Psychiatry at the Institute of Psychiatry. Honorary Consultant, Community Psychiatric Services, Maudesley Hospital. He has written extensively on cross-cultural issues and is the author/editor of several books. He feels he is 'struggling hard to introduce Complementary therapies...on my ward'.

Professor Edzard Ernst. Director of the Centre of Complementary Health Studies at University of Exeter.

Dr Gillian Haddock. Dr Haddock has trained as a Clinical Psychologist and is currently Tutor in Clinical Psychology at Manchester University and Honorary Consultant Clinical Psychologist with the South Manchester University Hospitals NHS Trust. She is involved with research and teaching programmes with Community Psychiatric Nurses and in the research of Cognitive-Behaviour Therapy in managing psychoses.

Sheila Grandison. Ms Grandison is presently Head of the Art Therapy Service in the Lewisham and Guy's Mental Health NHS Trust and is Vice Chair of the British Association of Art Therapists.

Lennox Thomas. Clinical Director of Nafsiyat – Inter-Cultural Therapy Centre.

Dr Hagen Rampes. Dr Rampes is a medically qualified homeopath with a background in Psychiatry. He has a keen interest in the use of Acupuncture and has completed a review article on the role of Acupuncture in alcohol dependence and abuse. He was the principal investigator and fund holder for a randomised trial on the use of Electroacupuncture and the results of the study have been submitted and accepted for publication.

Pat Gray. Ms Gray has worked in Mental Health for the past 19 years. An ex Community Psychiatric Nurse, she has recently left the African-Caribbean mental health Association (Manchester), where she was one of the founder workers and agitated for appropriate, sensitive and accessible mental health services for the Black community. As a trained Family Therapist, she now works in Liverpool for Barnardo's Family Therapy Services.

Ron Coleman. Training and Development Worker, Hearing Voices Network, Newcastle.

Dr Phil Thomas. At present, Dr Thomas is a Senior Lecturer in Psychological Medicine at the University of Wales College of Medicine. He

Using the model suggested by Nafsiyat, there are cultural reasons for Black people's behaviour. In this way, the culture (seen as incorporating gender, class, religion, etc.) defines whether a certain type of behaviour is normal and acceptable or not. For example, in some Asian and Middle-Eastern cultures, it is acceptable and even expected that upon meeting someone for the first time, they will enquire about the type of work you do, your income, how well-off you are, etc. Equally, it would acceptable for you to offer this information without being asked. In English culture, however, this would be seen as unacceptable and offensive. In assessing and working with Black people, within a complementary therapy framework, these inter-cultural meanings should be understood and validated.

This is not to say that the external or majority culture's perception goes unstated. On the contrary, the reality of Black people's existence is that there is a majority culture, in some ways similar to but in other ways different from their own. One way of viewing wellness for Black people is that they are able to cope successfully with living across these cultures. In this way, Black people need to have an awareness of the realities of both cultures, in order to cope successfully.

5 Conclusion

It was hoped that the seminar would go some way to clarifying current uses of complementary therapies in mental health. It provided that and much more. During the day, we were presented with a number of therapies currently being used with people with varying forms of mental distress. We were informed not only of models of good practice but also of the values and principles behind such work. We were given access to practitioners' skills, knowledge, thoughts and an opportunity to share our own.

There are questions that remain unanswered and require further discussion and examination. The role of research and outcome studies, the theoretical models and terminology we use to inform our 'complementary' work, the need to acknowledge and evaluate the cultural bias to this work and to extend and enhance both the underlying values and our own skills and outlook. Further exploration of these issues can only strengthen the already commendable work that is being done.

This seminar represented the first step in a much longer journey. As a group, we have neither identified the end of the journey nor our next step. New initiatives within the King's Fund are currently being planned which will focus on mental health in primary care and, here, the role of complementary therapies could be explored further. There is a need for more ongoing opportunities, formal as well as informal, to share examples of good practice, debate issues and raise awareness. The focus on race and culture should not get lost in the endeavour to show effectiveness and validity of complementary therapies, but be seen as essential in the development of therapies that will be sensitively used with all sections of the population.

There is a growing need for therapists to have an appreciation of working intra-culturally (between or across cultures). This is significantly different from taking a position where one culture – the majority's culture – is seen as 'right' or 'correct' and therefore comparing other (different) cultures to it in a negative way.

During the seminar there was much discussion on what appeared to be a similar cultural dominance within orthodox medicine. There was general appreciation and agreement of the hindrance this has placed on the progress of the practice and development of complementary therapies. Though there are more questions than answers as to how to change this, growing user and professional dissatisfaction with the status quo cannot be overlooked.

REFERENCES

1. Cochrane R. Psychological and Behavioral Disturbance in West Indians, Indians and Pakistanis: A Comparison of Rates Among Children and Adults. *British Journal of Psychiatry* 1979; 1344:201–10.

2. Francis E. Black People and Psychiatry in the UK. *Psychiatric Bulletin* 1989; 2(13):482–5.

3. Crowley J, Simmons S. Mental Health, Race and Ethnicity: A retrospective study of the care of ethnic minorities and whites in a psychiatric unit. *Journal of Advanced Nursing*. 1992; 17:1078–87.

4. Littlewood R, Lipsedge M.*Alien and Alienists: Ethnic Minorities and Psychiatry*. London: Unwin Hyman, 1989.

5. Burke A. Racism, Prejudice and Mental Illness. In Cox J. (ed.) *Transcultural Psychiatry*. London: Croom Helm.

6. Harris V. *Review of The Report of the Inquiry into the Care of Treament of Christopher Clunis: A Black Perspective*. London: Race Equality Unit1994.

7. See 6, p.19.

FURTHER READING

Alexander B. *The Place of Complementary Therapies in Mental Health (Part A: Aromatherapy and/or Reflexology; Part B: Talking Treatments)* available from:

Nottingham Patients' Council Support Group,
Nottingham Advocacy Group
9a Forest Road East,
Nottingham NG1 4HJ (Tel: 01602 484111)

Callaghan K. Movement Psychotherapy with Adult Survivors of Political Torture and Organised Violence. *The Arts In Psychotherapy* 1993; 20:411–21.

Kareem J, Littlewood R. (eds.) *Intercultural Therapy: Themes, Interpretations and Practice.* Oxford: Blackwell Scientific Publications, 1992.

Morrison A P. Cognitive Behaviour Therapy for Auditory Hallucinations without Concurrent Medication: A Single Case. *Behavioural and Cognitive Psychotherapy* 1994; 22:259–64.

Rampes H, Pereira S. Role of Acupuncture in Alcohol Dependence and Abuse. *Acupuncture In Medicine.* 1993; 11(2):80–4.

Sellwood W, Haddock G, Tarrier N, Yusupoff L. Advances in the Psychological Management of Positive Symptoms of Schizophrenia. *International Review Of Psychiatry* 1994; 6:201–15.

Tarrier N *et al.* A Trial of Two Cognitive-Behavioural Methods of Treating Drug-Resistant Residual Psychotic Symptoms in Schizophrenic Patients: I. Outcome. *British Journal of Psychiatry* 1993; 162:524–32.

Appendix 1: Format of the seminar

The seminar entailed formal presentations of work in the field followed by questions and comments from the audience. Afternoon workshops provided informal presentations in smaller group settings in order to facilitate involvement and discussion of the issues arising.

The programme and abstracts of each presentation are given below.

MORNING ADDRESSES

Welcoming Address
Sharon Jennings, Development Consultant Race and Mental Health and Seminar Organiser, King's Fund Centre

Welcoming audience and stating the aims of the seminar:

- to bring together mental health practitioners who practised and shared interests in a wide range of complementary therapies
- to provide further clarity on the current use of complementary therapy within the field of mental health, with particular emphasis on severe mental illness
- to share, discuss and debate their practice and experiences around the use of complementary therapy
- to aid in the development of mental health services for Black people where complementary therapies could play an important role

Opening Remarks
Dr Dinesh Bhugra Honourary Lecturer at the Institute of Psychiatry and Chair of the Seminar

Introduction of the format of the day. Outlining common definitions of complementary therapies.

Complementary Medicine: A critical overview of its use in mental health
Professor Edzard Ernst, Director of the Centre for Complementary Health Studies, University of Exeter.

Highlighting the need for rigorous research on effectiveness, safety and cost of complementary therapies.

Psychological Approaches with People Experiencing Psychotic Symptoms
Dr Gillian Haddock, Tutor in Clinical Psychology, Manchester University.

Outlining current work at Manchester University on helping people with severe psychotic symptoms, manage them by the use of various techniques which can be learned and used independently.

Engaging with Materials: Art Therapy and the Therapeutic Process
Sheila Grandison, Head of Art Therapy, Lewisham and Guy's Mental Health NHS Trust

A presentation to show art therapy in practice using slides of work produced in art therapy sessions in both acute psychiatric and community health settings. The focus of art therapy is on communication through pictures and images. Art therapy encourages the development of symbolic discourse whereby access to unacknowledged feelings and a means of integrating them into the personality is created and therapeutic change able to take place.

Alternative Models of Assessment and Treatment
Lennox Thomas, Clinical Director, Nafsiyat Inter-Cultural Therapy Centre

Outlining the model of assessment used at Nafsiyat, which incorporates an awareness of culture, language, religion, etc and the effects on behaviour. The client as well as the therapist are seen as coming from cultural perspectives which will interact within the therapy and an awareness of this is essential for positively and sensitively working with Black clients

AFTERNOON WORKSHOPS

The Role of Acupuncture in Addiction
Dr Hagen Rampes, Royal London Homeopathic Hospital

A workshop which explores the effectiveness of acupuncture in eliminating addictions of all kinds. The workshop focused on recent research conducted by Dr Rampes where acupuncture was found to be highly successful.

Working with Black Families
Pat Gray, Barnardo's Family Therapy Services

A workshop exploring working with Black families. It is important to know something of their reality before being able to effectively intervene. The family's narratives of their reality quite often will not 'fit' with the expectation of traditional psychiatry. Powerful, culturally determined realities are often assessed and defined as 'illness'. Family therapy offers the opportunity to discuss and understand the impact of history, culture, racism, etc. and can be a means of finding new solutions that are more appropriate for the Black family.

Hearing Voices Work
Ron Coleman, Training and Development Worker, Hearing Voices Network
Dr Phil Thomas, Senior Lecturer in Psychological Medicine, University of Wales

A workshop which will help participants to experience some of the issues which relate to hearing voices. The facilitator's starting point is a framework which rejects medical and biological models which view voice hearing as a symptom' of an illness. Their stance is one of normalising voice hearing, gaining awareness of what it is like for the voice hearing and developing, through self-help networks, effective coping strategies.

The Role of the Occupational Therapist
Carmen O'Leary, Maxine Slapper and Dolman Domikles
Community Psychiatric Occupational Therapy Department, Hackney Hospital

Starting from a belief that people engage in activities in order to satisfy needs, and using Maslow's hierarchy of needs, this workshop through experiential learning, will establish that satisfying needs is a complex task, particularly so for individuals with mental health problems. Occupational therapists work with individuals to identify the skill they require to satisfy their needs. By using a graded programme of activities the user is helped to develop the relevant skills and to transfer them to their individual environment.

Transcendental Meditation and Ayur-Vedic Medicine: Developing Self-Knowledge
Dr Nick Argyle, Consultant Psychiatrist, Northwick Park Hospital

A workshop that explores the basic principles of Transcendental Meditation and Ayur-Vedic Medicine, both derived from well-established traditional,

has a wide research interest in cognitive science, having spent the last 12 to 13 years researching language and communication in psychiatric disorders. He is also committed to the notion of community care and in this recognises the importance of a critical approach to the role of psychiatrists and other professionals in understanding the social and political contexts in which community care takes place.

Carmen O'Leary. Ms O'Leary heads the Community Psychiatric Occupational Therapy Department. She carries a diverse case load, mostly of clients with long-term mental health needs. She is a group Analyst and uses her psychodynamic understanding to inform her practice as an Occupational Therapist.

Dr Nick Argyle. Dr Argyle is a Consultant Psychiatrist at Northwick Park Hospital in Harrow. He has many years experience in teaching Transcendental medication and has worked in England, America and the Soviet Union.

Ann Childs. Ms Childs has worked for 20 years within a broad field of complementary therapies in a natural therapy clinic setting. She has taught and facilitated many courses on a simple 'hands-on' approach to complementary therapies to both general public and health workers. In addition to her work at Rampton Special Hospital, she is currently employed as a physiotherapist by Bassettlaw Hospital and Community Services Trust, working with children and adults with learning difficulties.

Sharon Jennings (Seminar Organiser). Ms Jennings is a Development Consultant in Race and Mental Health at the King's Fund Development Centre. She assists in the development of 2 crisis support projects aimed at the Black community. It is envisaged that the projects, on completion, will offer a range of therapies as part of its service.

Appendix 3 List of seminar participants

Dr Nick Argyle
Harrow & Hillingdon Healthcare NHS Trust
Northwick Park Hospital
Watford Road
HARROW
Middx HA1 3UJ

Richard Ashrowan
The Stress Project
Shelburne House
2 Shelburne Road
LONDON
N7 6DL

Sharon Bennett
Public Health Research & Resource Centre
4 Acton Square
off The Crescent
SALFORD
Manchester M5 4NY

Dr Dinesh Bhugra
Institute of psychiatry
De Crespigny Park
off Denmark Hill
LONDON
SE5 8AF

Alison Brear
Physiotherapy Department
Springfield Hospital
Glenburnie Road
LONDON
SW17

Faith Burrows
97 Knatchbull Road
LONDON
SE5

Ann Childs
Natural health Therapist
Rampton Special Hospital
167 Big Barn Lane
MANSFIELD
Notts
NG18 3LH

Yvonne Christie
Aveleon Associates
110 Perry Hill
LONDON
SE6 4EY

Tracey-Anne Clarke
69 Landor Road
LONDON
SW9 9RT

Ron Coleman
Hearing Voices Network
67 Abbot's Court
Gateshead
Tyne & Wear
NE8 3JY

Rick Cresswell
Ivydale Mental Health Day Centre
300 Ivydale Road
LONDON
SE15

Marcia Day
The Stress Project
Shelburne House
2 Shelburne Road
LONDON
N7 6DL

Maxine Dennis
West Battersea Community Mental Health Team
Garratt Court
Furmage Street
LONDON
SW18

Dolman Domikles
City & Hackney Occupational Therapy Service
Community Psychiatric Occupational Therapy
Hackney Hospital
Homerton High Street
LONDON
E9 6BE

Professor Edzard Ernst
Centre for Complementary Healthcare
University of Exeter
25 Victoria Park Road
EXETER
EX2 4NT

Dr Kylza Estrella
10 Powis Gardens
LONDON
W11 1JG

Dr Suman Fernando
20 Burghley Road
LONDON
NW5 1VE

Robert Grandison
MIND in Haringay
Station House
73c Stapleton Hall Road
LONDON N4 3QF

Sheila Grandison
Lewisham & Guy's Mental Health Trust
The Speedwell Centre
Speedwell Street
LONDON
SE8 4AT

Pat Gray
Dr Barnardo's Family Therapy Service
Mornington Terrace
29 Upper Duke Street
LIVERPOOL
L1 9DY

Dr Gillian Haddock
University of Manchester Withington Hospital
West Didsbury
MANCHESTER
M20 8LR

Audrey Harrison
Bradford Community Health
Lynfield Mount Hospital
Heights Lane
BRADFORD
BD9 6DP

Sue Holland
North Wycombe Community Mental Health Trust
1 Cedar Avenue
Haslemere
HIGH WYCOMBE
HP15 7DW

Sharon Jennings
King's Fund
111-13 Cavendish Square
LONDON
W1M 0AN

Merle Joseph
Bridge Project
129 Bloemfontein Road
LONDON
W12 7DA

Dr David Langton
Rampton Special Hospital
RETFORD
DN22 OPD

Professor James Lindesay
University of Leicester
Leicester General Hospital
Gwendolen Road
LEICESTER
LE5 4PW

Conchita Manau
Mental Health Services
National Temperance Hospital
Vesey Strong Wing
112 Hampstead Road
LONDON
NW1

Shirley McNicholas
Mental Health Services
National Temperance Hospital
Vesey Strong Wing
112 Hampstead Road
LONDON
NW1

Paula Morrison
King's Fund
11-13 Cavendish Square
LONDON
W1M 0AN

Zenobia Nadirshaw
West Herts Community NHS Trust
Harperbury Hospital
Harper Lane
RADLETT
Herts
WD7 9HQ

Amanda O'Brien
North Kent Healthcare NHS Trust
Admin Corridor,
A Block
Medway Hospital
Windmill Road
GILLIGHAM
Kent
ME7 5NY

Carmen O'Leary
City & Hackney Occupational Therapy Service
Community Psychiatric Occupational Therapy
Hackney Hospital
Homerton High Street
LONDON
E9 6BE

Ameachi Odiatu
22 Nash Court
Pembroke Street
LONDON
N1

Steve Onyett
A Block
Medway Hospital
Windmill Road
GILLINGHAM
Kent
ME7 5NY

Charlie Osborne
Physiotherapy Department
Springfield Hospital
Glenburnie Road
LONDON
SW17

Sherron Parris
Community Psychiatry Research Unit
50-52 Clifden Road
LONDON
E5 OLJ

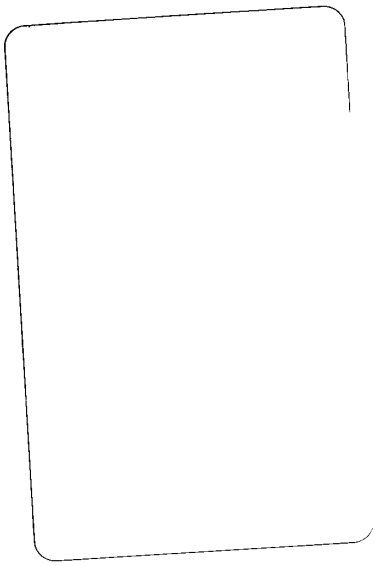
Herby Pillay
Department of Psychology
University College
Phillips House
Gower Street
LONDON
WC1 6BT

Dr Hagen Rampes
Royal London Homeopathic Hospital and NHS Trust
Great Ormond Street
LONDON
WC1

Maxine Slapper
City & Hackney Occupational Therapy Service
Community Psychiatric Occupational Therapy
Hackney Hospital
Homerton High Street
LONDON
E9 6BE

Lennox Thomas
Nafsiyat – Intercultural Therapy Centre
278 Seven Sisters Road
LONDON
N4 2HY

Jenny Willmot
MIND
Granta House
15-19 Broadway
LONDON
E15 4BQ



According to a 1995 report, the health service is now spending £1 million on complementary therapies. In particular, many professionals both within and outside conventional medicine suggest that complementary therapies offer a more effective way of treating mental illness, including the more severe forms, and do not have side-effects.

This report is a commentary on the proceedings of a seminar held at the King's Fund Development Centre which explored the use of complementary therapies in mental health treatment.

A section of the report deals specifically with issues arising for Black mental health service users. It gives an account of the 'sanctuary model' which is a crisis service based in the community. The sanctuary offers a culturally appropriate alternative to unnecessary hospitalisation: a place of safety, professional assessment and support.

ISBN 1-85717-100-4

9 781857 171006 >