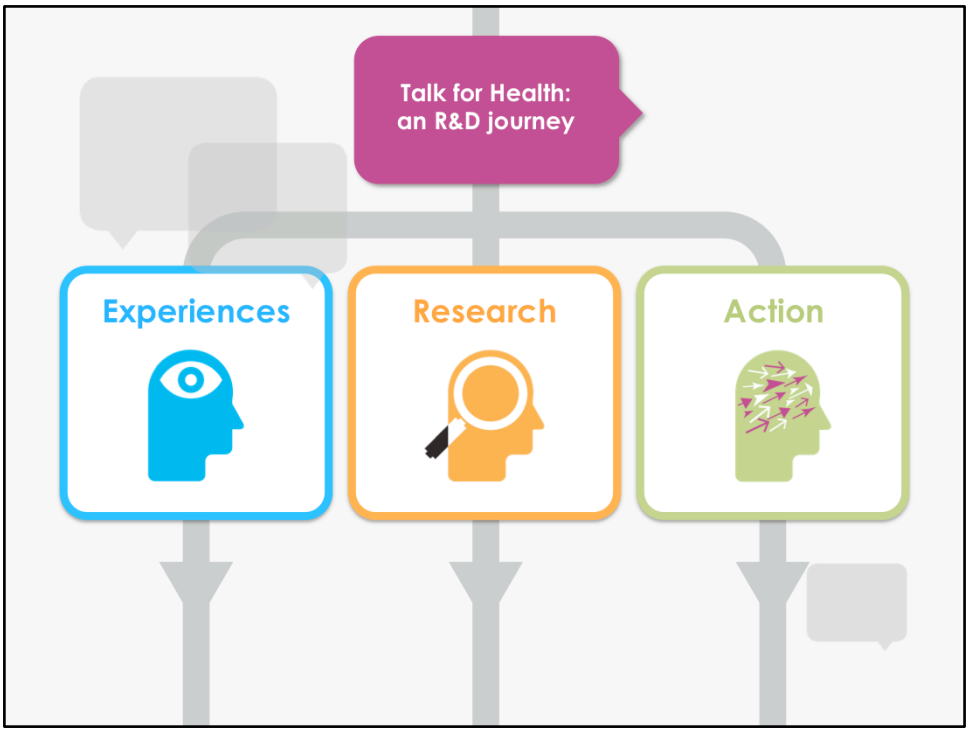
I'm Nicky Forsythe, Founder of Talk for Health. I'm a Psychotherapist and qualitative researcher, and I've come to talk to you today about my project Talk for Health.

The basic premise behind Talk for Health is to teach ordinary people – including people with mental health diagnoses – to do effective therapeutic talk with each other in a group.

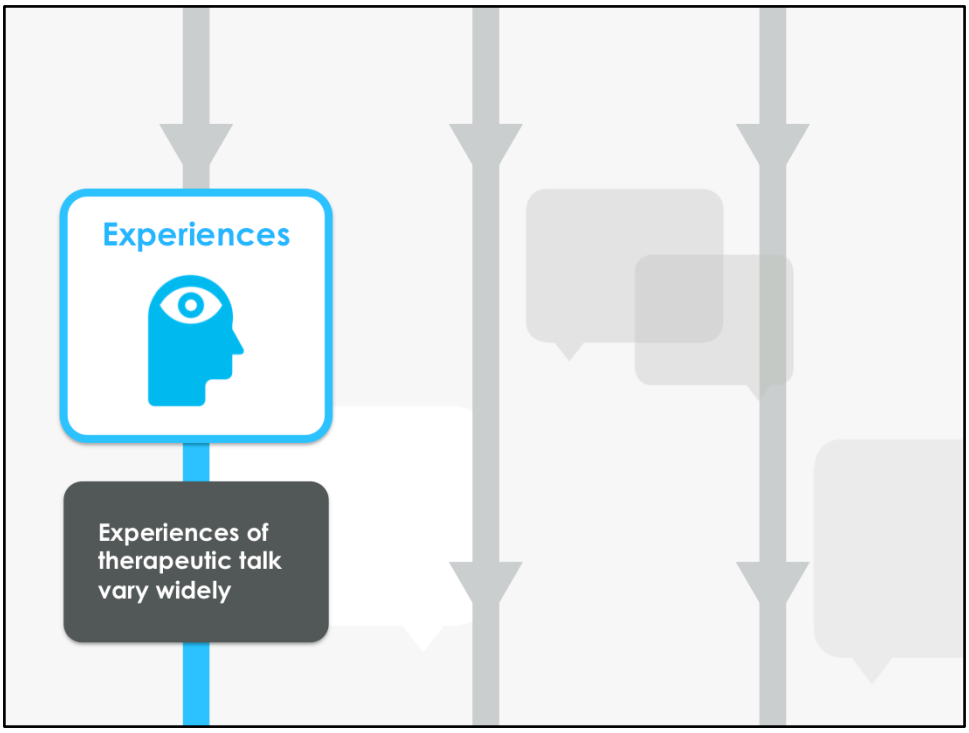


This presentation is in three strands.

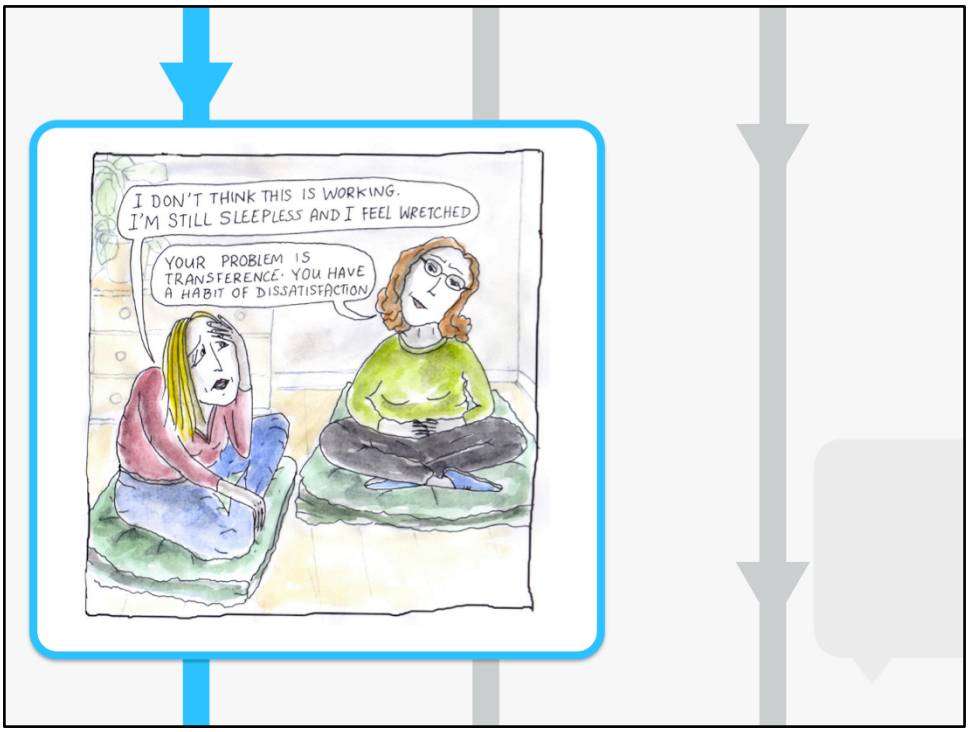
The first is about experiences, including both my own experience of therapy, and qualitative research I have carried out amongst other people.

The second is about academic research, which also fed into the Talk for Health idea.

The third is about moving into action: developing Talk for Health out of strands one and two.



First, then, I'm going to talk about user experiences – both my own and those of the 120 or so people I have interviewed about their experiences of therapy.

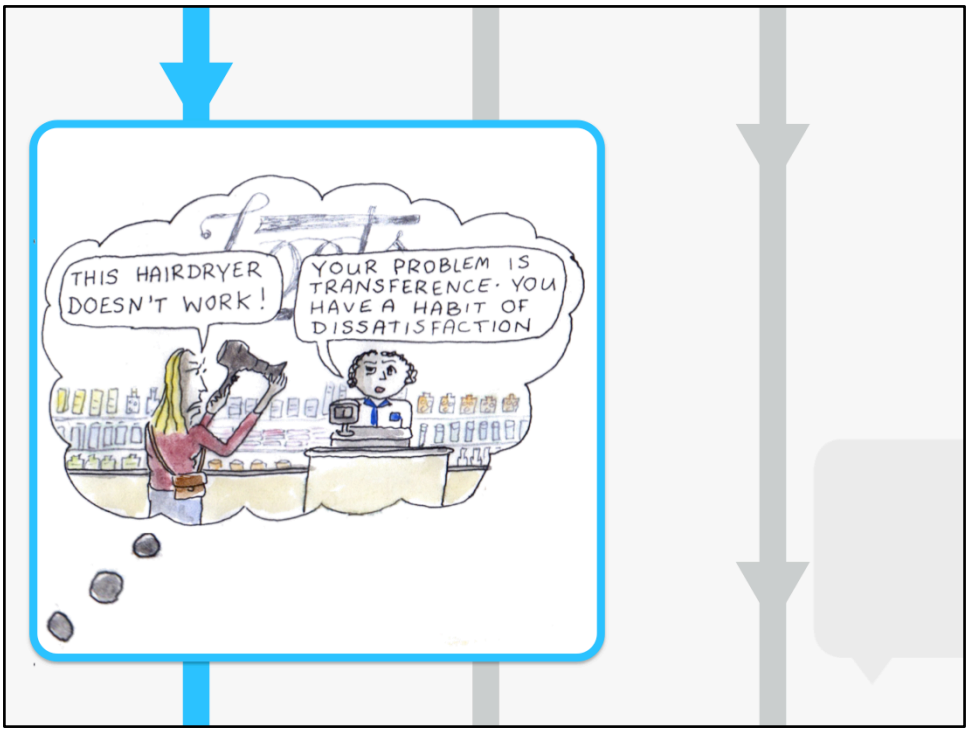


Part and parcel of my own journey of enquiry is my own 20 year experience of therapy. This didn't go particularly well for the first 10 years and it was frustration about that which has fuelled my subsequent research and practice.

I first went into therapy in my late twenties. Two of my close family members had experienced severe mental distress as I was growing up. Their Psychiatric treatment was distressing, humiliating and unhelpful. So when I became wretched and a bit mad in my mid twenties, I sought Psychotherapy not Psychiatry.

It was a less humiliating option certainly, but I was taken aback that after many years, it didn't seem to have worked.

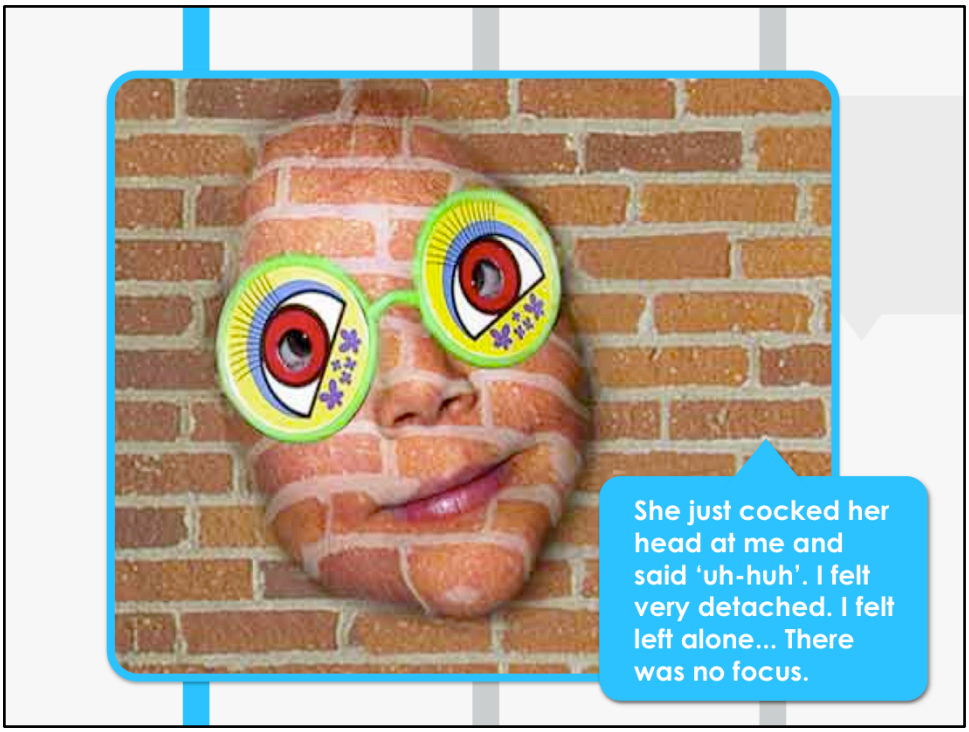
This is a cartoon of me and my therapist. I still felt wretched most of the time and mad some of the time. I was stuck. The therapist told my that problem was transference – that my sense of distance from her as therapist, and my experience of lack of progress, was a microcosm of a remote and dissatisfying relationship with my mother.



It was only after leaving that I realised how provoking I had found this. I wondered what would happen if, say, you walked into Boots with a hairdryer that wasn't working, only to be told that your problem was your transference – that you needed to work on your dissatisfaction and should not expect a hairdryer to work.

In particular the experience provoked me, as a researcher, to ask questions: of myself, of the therapy consumer literature, and of other people.

Was 'feeling better' a reasonable expectation from therapy, or was Freud's 'moving from neurotic suffering to everyday misery' the best people could hope for? *Was* it my 'transference's' fault if I wasn't better and if so what could be done about it? Would another therapy work? Did other people have the same problems and if so how did they resolve them?



These were the kinds of questions I explored in three separate qualitative research projects over a span of some years, where I interviewed, in total, upwards of 120 people.

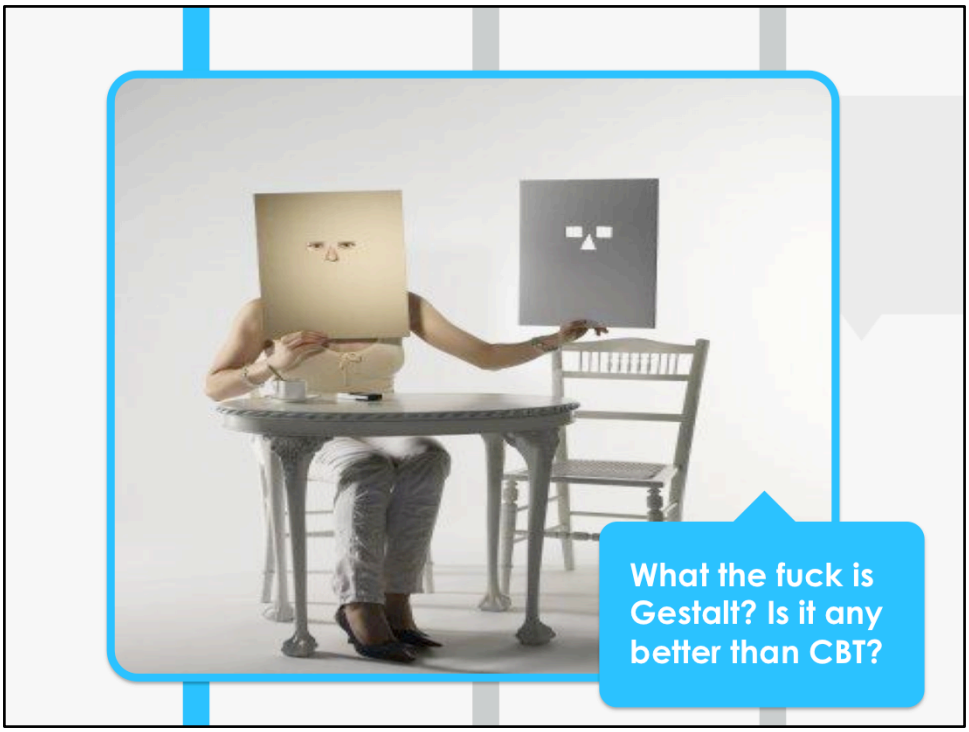
To cut a very long story short, there was an unpredictable mix of good and bad experiences across all different kinds of therapy.

Negative experiences were characterised above all by an experience of disconnect – either a lack of sense of connection with the therapist, or a mismatch of agendas, or both.

One person drew a therapist sitting in a cage, '"tantalisingly out of reach."
Another summarised her eighteen month experiences in the following words: "No relationship developed. Just waiting for something to happen. I could have been speaking to the wall."

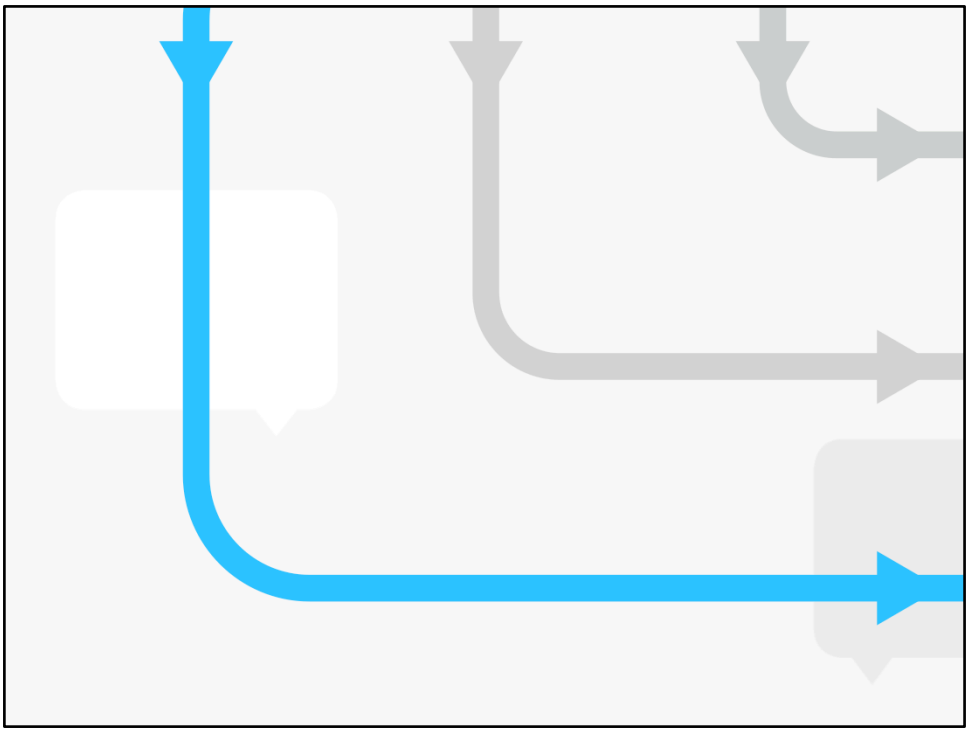
These experiences were across the board and not unique to people who had done psychodynamic psychotherapy.

Disconnect in the context of CBT was expressed in different sorts of statements: "It just felt like someone trying to change me and my negative thoughts rather than accept me and my pain. Like a GP saying 'Take an aspirin'. As if you're bothersome."



There was also the problem of opacity. Therapy seemed like an arcane world with no clear signposting for the consumer and no clear information to be had.

Most service users, unless they do a lot of research, have no idea what products are on the ‘therapy shelf’, so to speak, and don’t know what they are choosing or getting.



In successful therapies, the most important theme was the sense of clicking with one's therapist – as one person put it, 'it's like finding your soulmate'. In this kind of relationship it was possible to open up and confide.

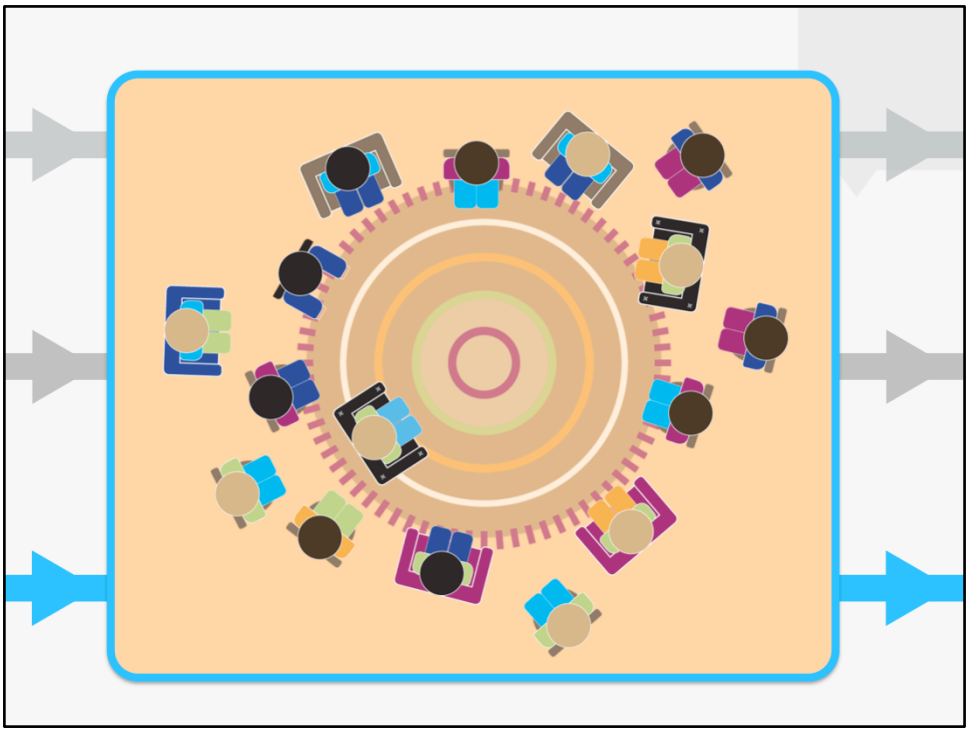
Equally, therapist flexibility to the client's agenda was important.

The main thing seemed to be about *finding the right therapist or method for you*. Indeed a main predictor of good therapy outcome is what's called a 'good therapeutic alliance'. "*The [therapeutic] alliance data suggest that therapy works if clients experience the relationship positively, perceive therapy to be relevant to their concern and goals, and are active participants.* (Duncan et al 2004)

The importance of quality of relationship is also reflected in Howe's qualitative study on the factors at the centre of successful therapy: 'Accept me, understand me, and talk with me'. (Howe 1993)

So the fit between therapist and client is indeed a key factor in therapy outcome. But finding this fit is a very hit and miss process and clients have little assistance in getting it.

In one piece of research I asked people to envision in some detail the ideal future of therapy. Fundamentally people wanted a place to connect and be accepted by others. Those others might be professionals, or they might be just ordinary people. The main thing was that it should be somewhere where "you go there to be yourself and it's okay."



To finish off my own story, having done a lot of research, I was pretty persistent in finding the right fit for me, which turned out to be a Humanistic Psychotherapist and I eventually trained as a Humanistic Psychotherapist myself.

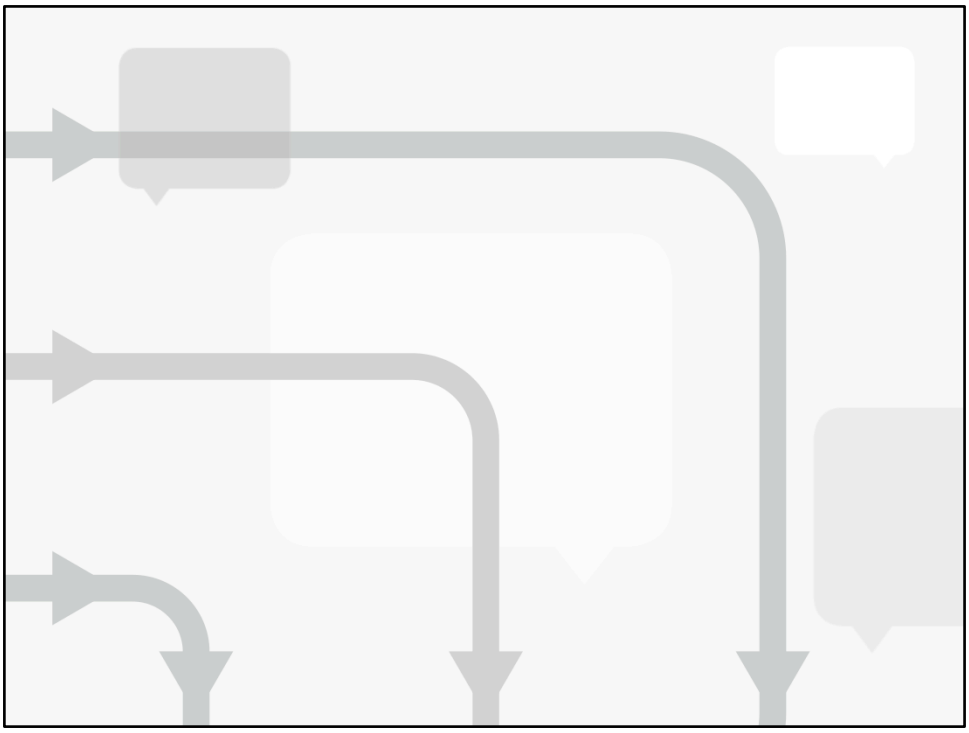
However the interesting thing for me was that actually it was the training, and subsequent practice myself, that had the most profound impact on my wellbeing.

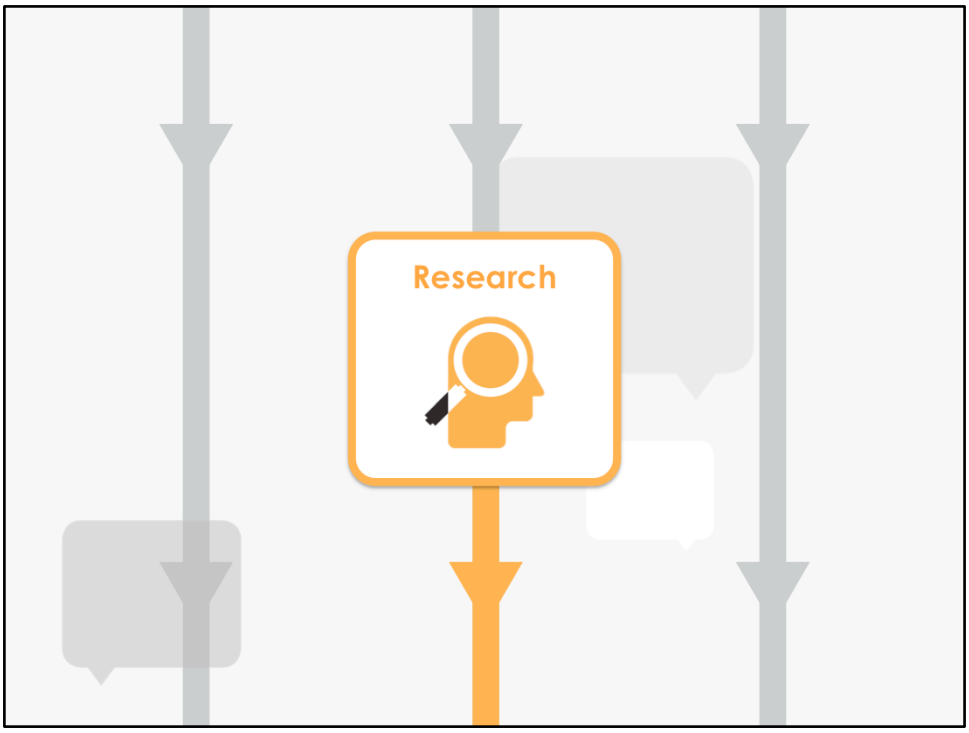
My training group of twenty-four people became my place to confide. Each piece of information that I revealed, and that was accepted non judgmentally in the group, seemed to encourage new pieces to emerge. It was a process of becoming known to and accepted by myself through becoming known to and accepted by others.

Another significant feature of the experience was that twenty-three others were going through the same process at the same time. We had the relief and social bond that is wrought through intimate self disclosure and realising you're not alone.

Also important was the fact that both the training and the practice of therapy were empowering. Each of us was giving as well as receiving – this has been named the 'helper therapy effect' (Riessman 1965, 1990) and is therapeutic in itself.

In my training group we formed small peer support groups, where we would confide in and feed back to each other using structures we had learned in our first month of training. These groups became an ongoing mental wellness practice which I still do 14 years later and is another part of the blueprint for Talk for Health.





I'd now like to summarise some academic research which provides a framework both for understanding the experiences I've described and for underpinning the Talk for Health programme.

Many decades of research have shown that therapy does work on the whole. According to Seligman – former president of the American Psychological Association and widely acknowledged as one of the world's leading researchers on therapy efficacy – relief from say depression occurs in around 65% or 2 in 3 of therapy clients (Seligman 2011). Wampold estimated 69% in 2001. There is a placebo range between 45% and 55% (Seligman 2011).

So therapy works on the whole. But, like the Wizard of Oz, it doesn't work for the reasons it appears to.

For example, despite practitioners' belief in their own particular model of therapy it has been shown that the model doesn't matter much. In fact, only 15% of the effectiveness of therapy is estimated to be down to matters of specific model or technique (Asay & Lambert 1999). In fact when you look at comparative effectiveness, there is much more difference between the performance of *individual therapists* than between *types of therapy* (Miller, Hubble & Duncan 2007).

But apart from whether or not you find a good *therapist,* the effectiveness of therapy boils down to some simple ingredients that *all* therapies share – known as the 'common' or 'non-specific' factors – such as a good quality of relationship (good 'therapeutic alliance') between therapist and client (Wampold 2001, Duncan et al 2004). Importantly, it is the client's rating of the relationship that is the important factor (e.g. Shea et al, 1992)

Also, "while therapy is shown to be more effective than no therapy, it does not appear to matter whether it is delivered by professionals or paraprofessionals" (Yoeli and Morgan 2011). In experiments which compare the effectiveness of professional therapists with untrained but nice people, the latter can get as good or better therapy outcomes (Strupp 1979, Berman and Norton 1985, Jacobsen and Christensen 1994). As Jacobsen and Christensen commented: 'In most professions, it would be ludicrous to compare a trained and untrained person. It is hard to imagine a study comparing trained and untrained surgeons, or trained and untrained electricians for that matter' (Jacobsen and Christensen 1994, p.9).

How is it then that we have such respect for the professional practice of therapeutic talk but not for the 'paraprofessional' practice of simply confiding in an empathic but untrained person?

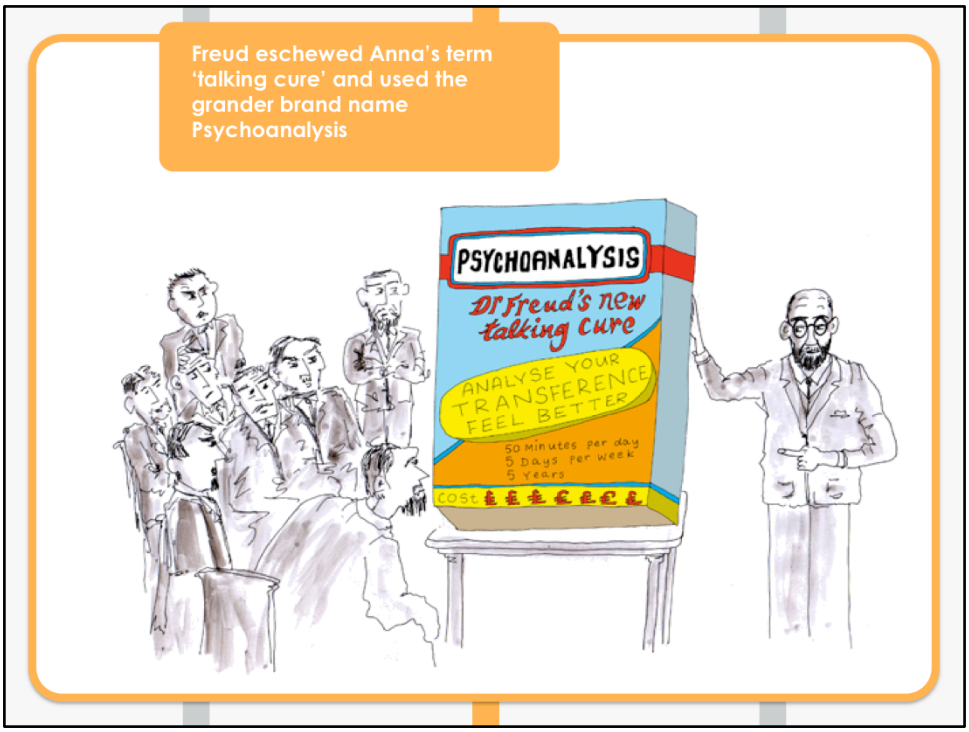
I contend that this has been a bit of a branding exercise whereby the special, branded forms of confiding known as therapies have become much more highly regarded than the generic form.

The following cartoons show the progress of this branding exercise. This one shows Breuer, who had tried all the tricks in his Psychiatric book to help his patient 'Anna O'.

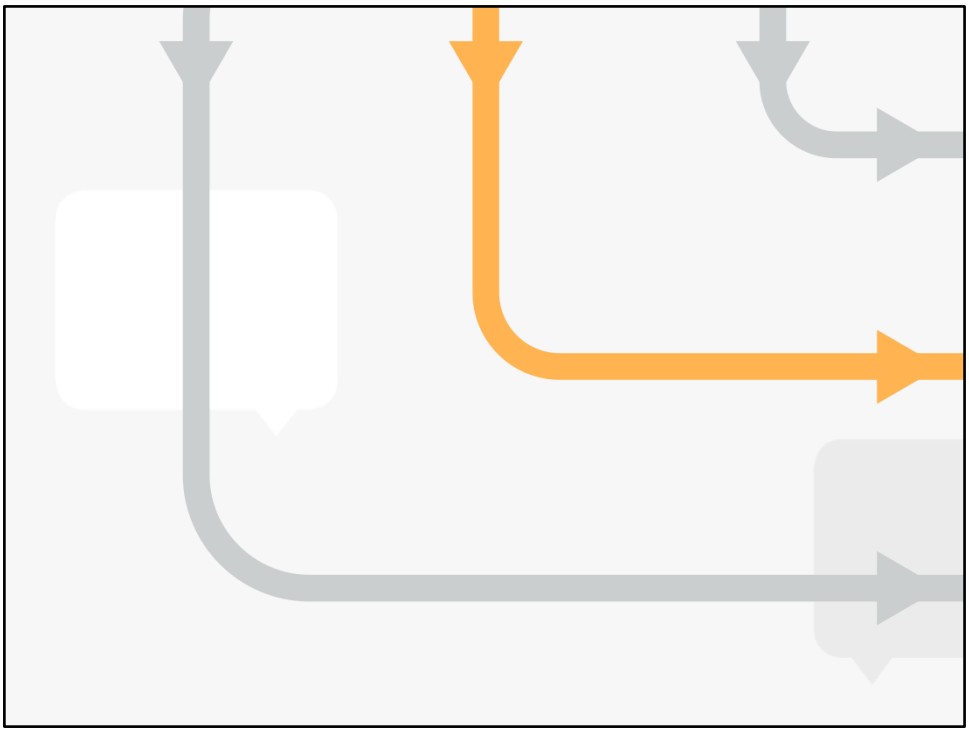
In desperation, he suggested she just talk – which she did – for sessions totalling around 1,000 hours between 1881 and 1882. She found it miraculously helpful and commented that the process has been cathartic – 'like chimney sweeping'. To describe her experience, she coined the term 'the talking cure'.

However, she became worse again after her talking treatment ended, and I suspect this is because as Seligman has said (2011), the effects of talking therapies tend to 'melt' once treatment ends.

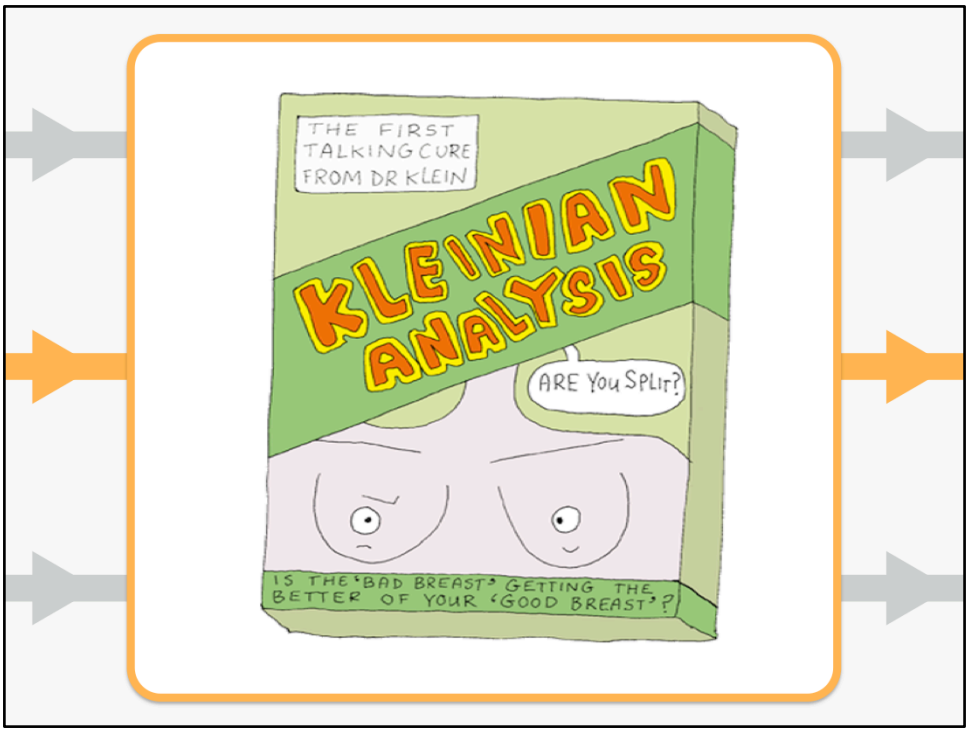
In fact, I believe that therapeutic talk is an ongoing wellness *practice* not a treatment, and this is another part of the rationale underlying Talk for Health.



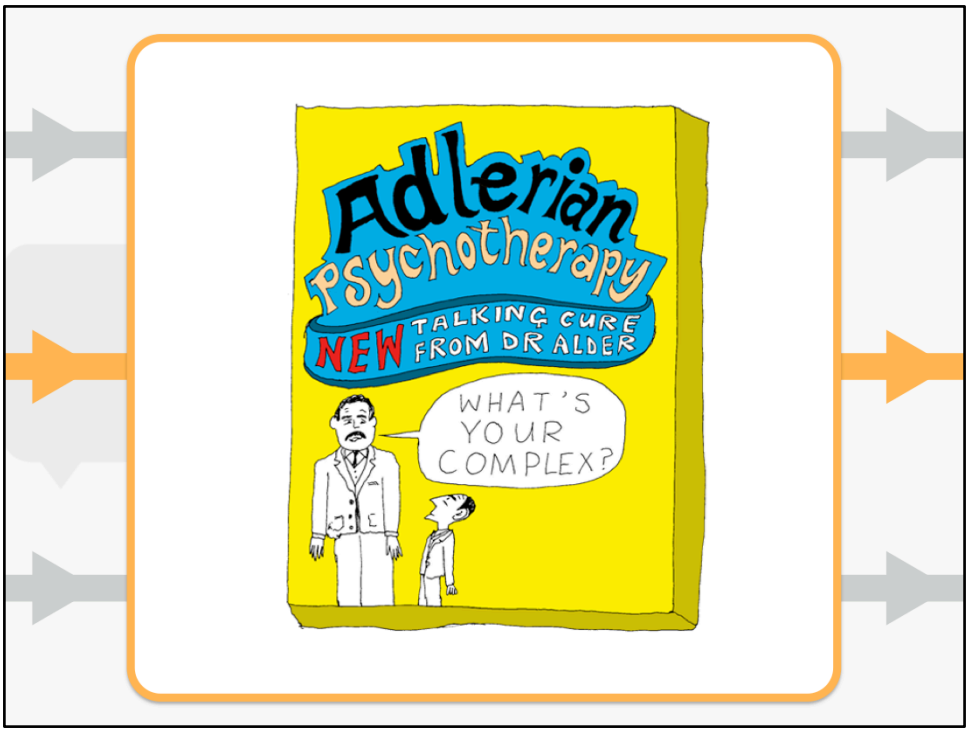
Impressed with Breuer's experiment, Freud was the first to transform the process of confiding in to a branded therapy. He eschewed Anna's term 'talking cure' in favour of the grander brand name Psychoanalysis.



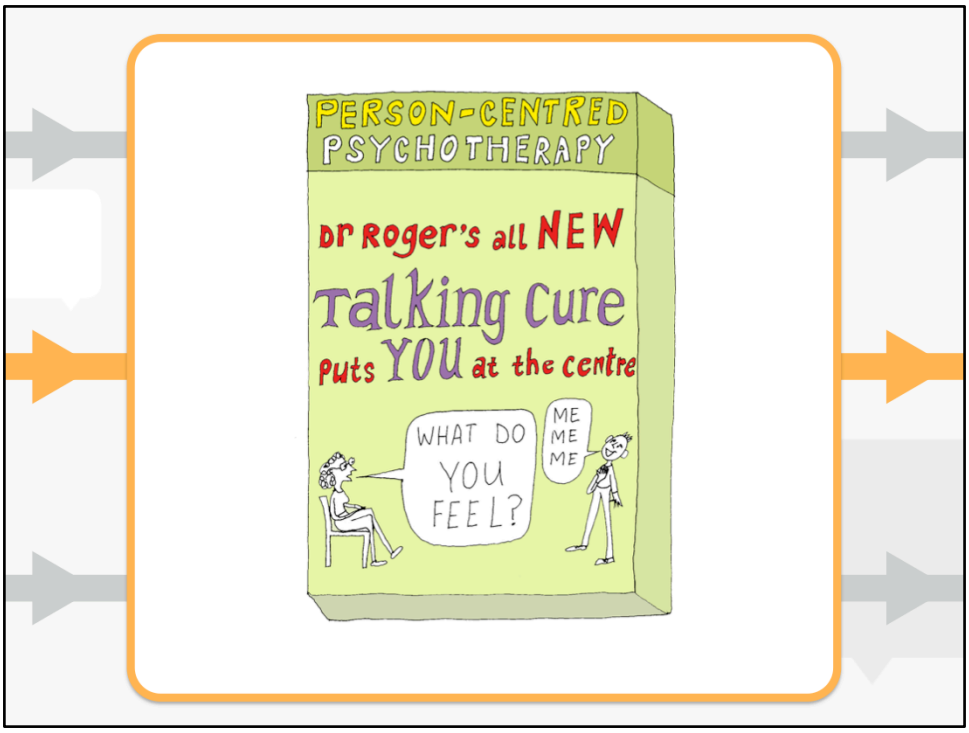
Since then, more than 400 'branded' versions of therapeutic talk have appeared on the scene. Here are some of them.



Kleinian Analysis

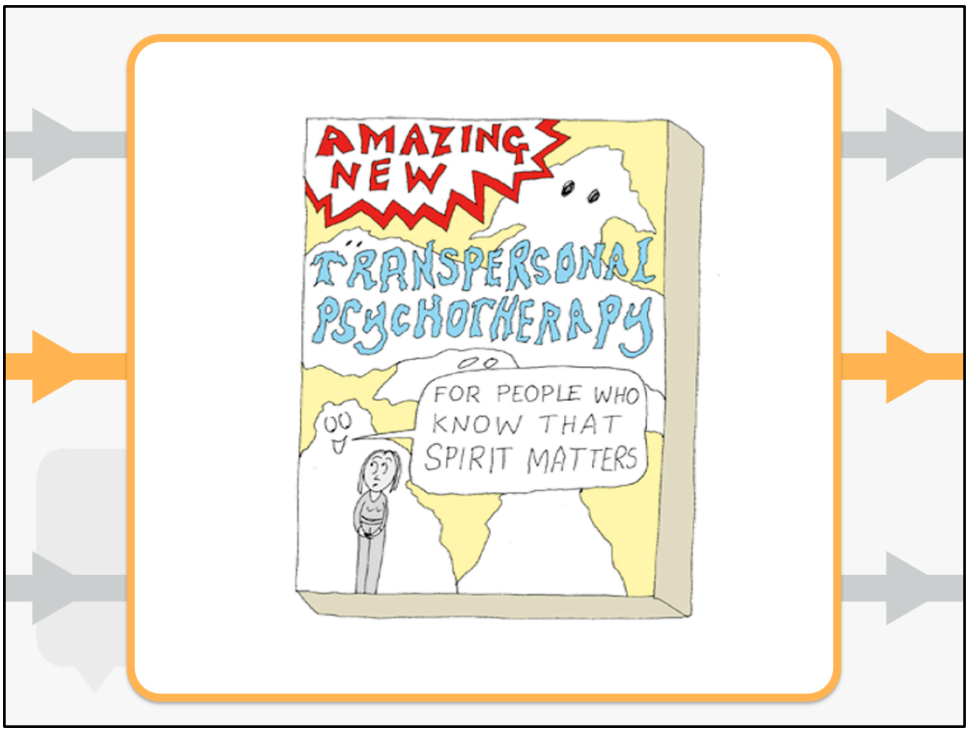


Adlerian Psychotherapy

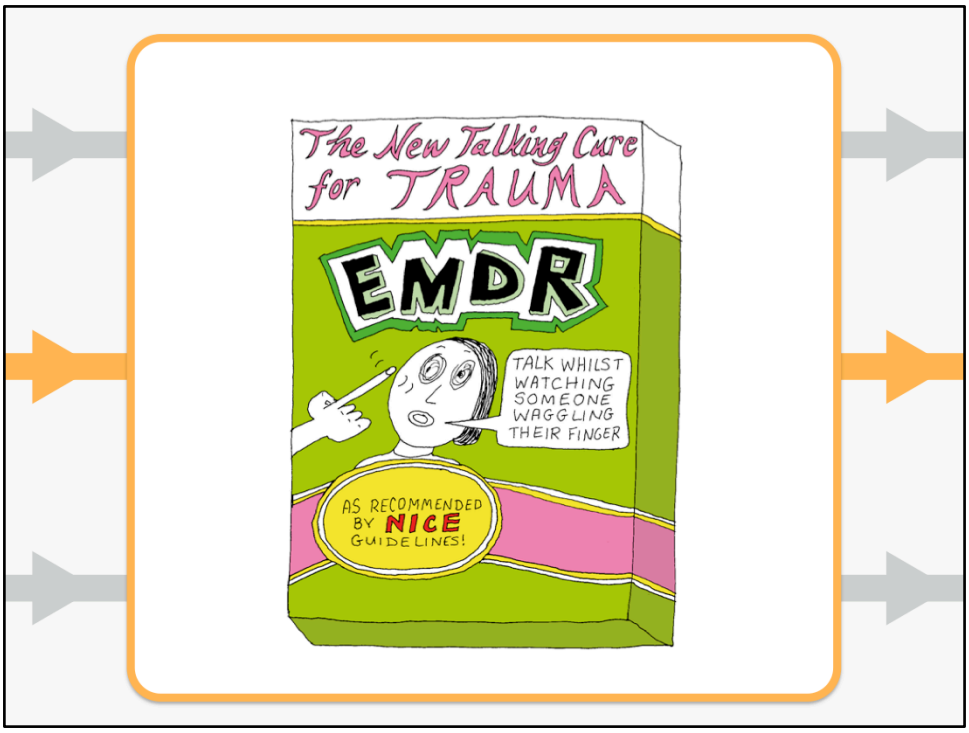


Person-centred and Humanistic Psychotherapies

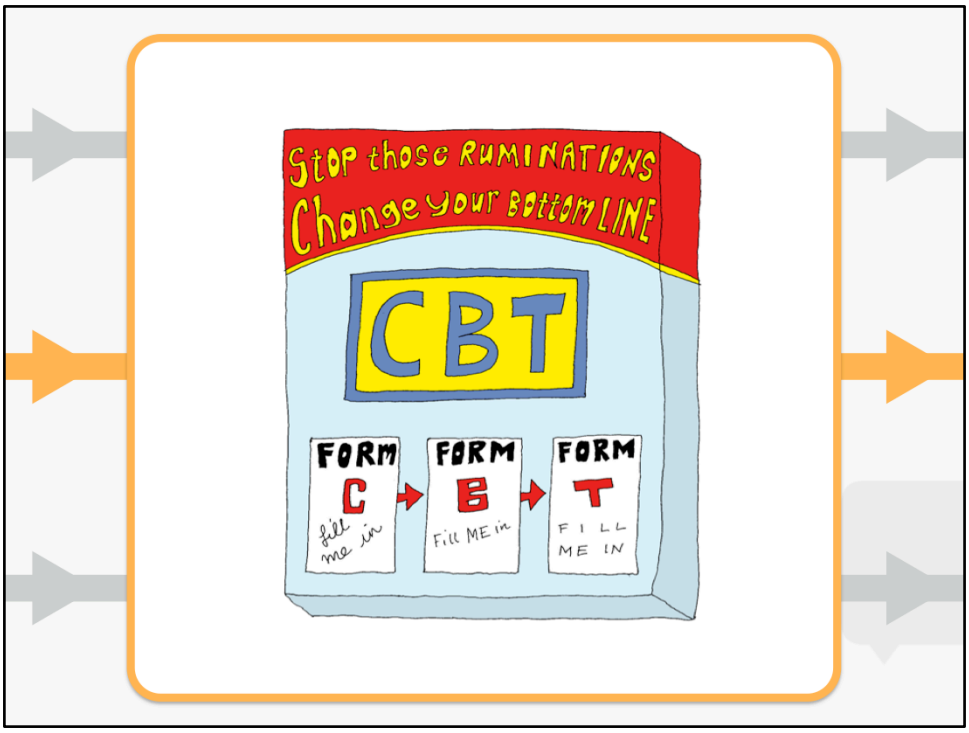
Primal therapy



Transpersonal Psychotherapy


The New Talking Cure for TRAUMA
EMDR
TALK WHILST WATCHING SOMEONE WAGGLING THEIR FINGER
AS RECOMMENDED BY NICE GUIDELINES!

EMDR



CBT

I'll note in passing that this is the main therapy offered on the NHS. In a conference on research and evidence, this if of some interest.

The latest NHS/IAPT recovery figures are 44.4 % with a target of "over 50%" (www.publications.parliament.uk 2012).

This means that a lower than placebo effect is being achieved and the target does not exceed placebo.

The cost of IAPT has been at least £173 million (Department of Health 2010). It seems an expensive way to achieve a placebo effect.

I have heard these problematic figures being explained with the rationale that the total recovery figures combine the rates from both more effective, 'high intensity' therapy with rates from 'low intensity' measures such as bibliotherapy, and the latter are less effective.

The problem with this explanation is the following. If the recovery rates of high intensity measures (let's say 65%) are being averaged with the recovery rates of lower intensity measures and we arrive at 44.4 %, that must mean that lower intensity measures could be very low - say 25%. In this case they are achieving a result substantially lower than placebo. They could be actively making people worse.

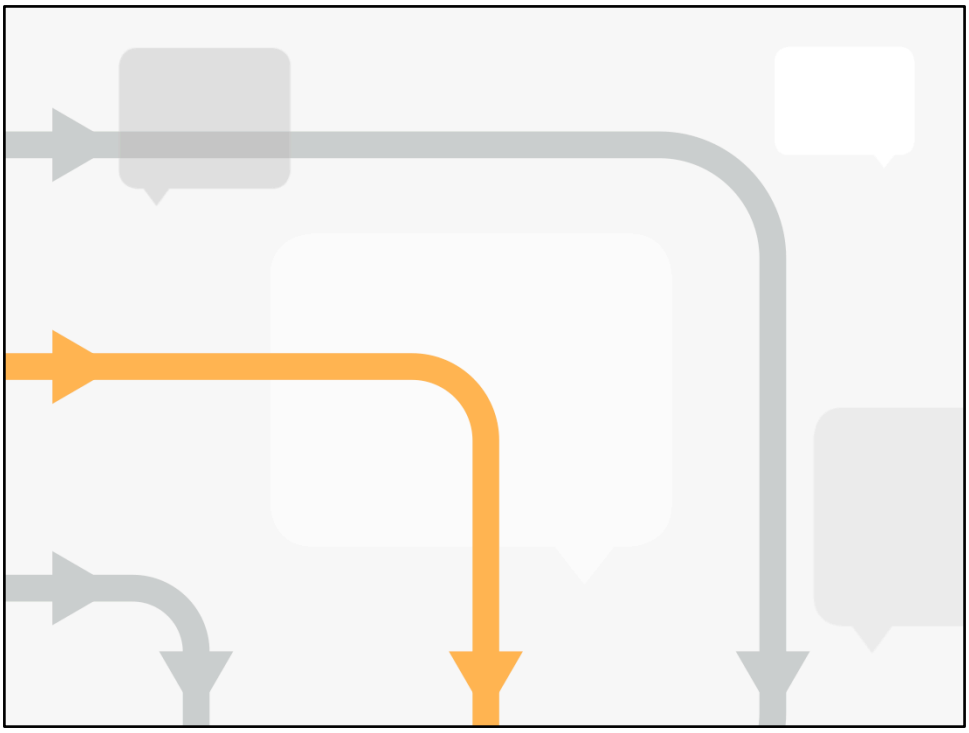
I'm not having a go at the people involved in IAPT here. I have met several of them and they are very good-willed and trying to do a good thing. It is also in my view a very good thing for the NHS to provide talking therapies not just pills.

The problem is, again, our attachment to the idea of the importance of specific technique in therapy.

The reason for the state's focus on CBT is to do with the number of randomised controlled trials demonstrating its effectiveness. However, as I said earlier, the comparative research about therapies shows that CBT works no better or worse than any other.

The disappointing NHS result illustrates to my mind the wrongheadedness of – against decades of evidence – our attachment to the notion that we can identify and apply a 'best' therapy technique. (If you remember, technique only accounts for a small proportion of the impact of successful therapy).

Instead of trying to apply a best technique, we should be creating optimal conditions for people to benefit from the generic benefits of a good therapeutic relationship – which are undoubted. This would mean picking therapists who are good at creating a good therapeutic alliance, and allowing patients to choose a therapist with whom they personally are able to relate well.



But to continue with this story of the evolution of brand-name therapies, what do we get when we turn these, and the 400 other besides, upside down and shake out the contents? We get talk.

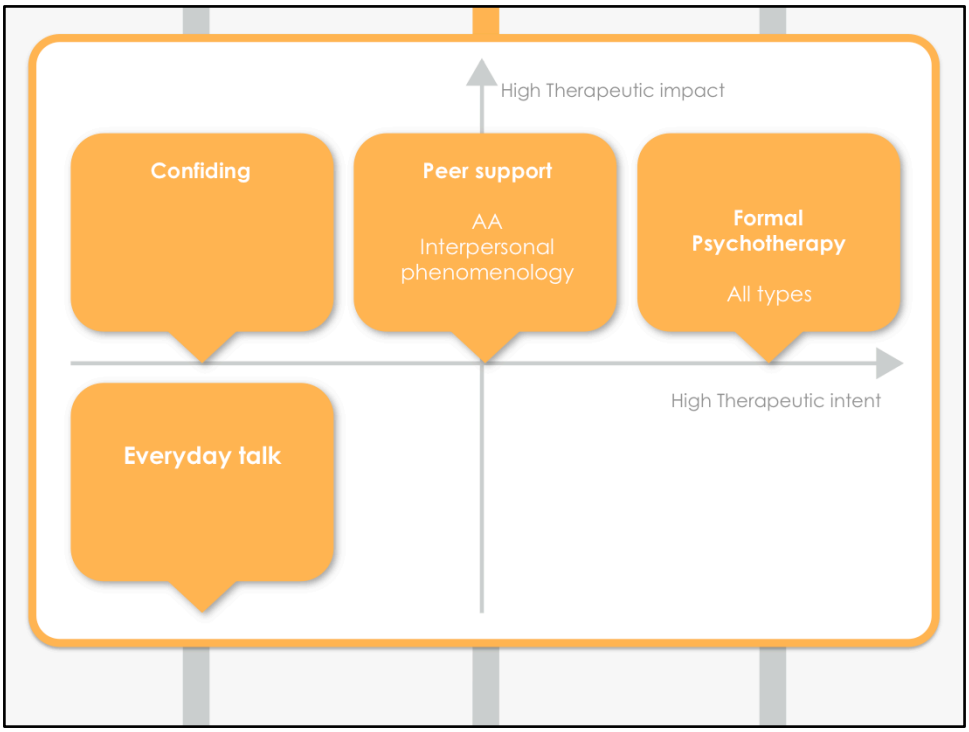
Meta-analyses of empirical research comparing the effectiveness of these therapies repeatedly finds that, despite their protestations of uniqueness, they all work equally well – a finding known as the Dodo Bird Verdict (Cooper, 2008).

So in the end, it is some simple things about talking that work, not the fancy techniques.

As Professor Howe wrote after his Sociological study of Psychotherapy: *"it is talking which cures, and not particular therapeutic schools and their preferred techniques"* (Howe, 1993)

He went further:

"No longer can it be thought that the technique just happens to carry with it a variety of rather common, even mundane human qualities (warmth, a preparedness not to judge or criticize, a wish to understand how the other feels), but the reverse. The common qualities that inform human relationships turn out to be the important elements. It does not matter which technique you use, so long as the 'non-specific' ingredients that characterise successful relationships are present." (Howe, 1993)



Not every kind of talk is therapeutic of course – but it's interesting to think about the boundaries between therapy, therapeutic talk and everyday chat.

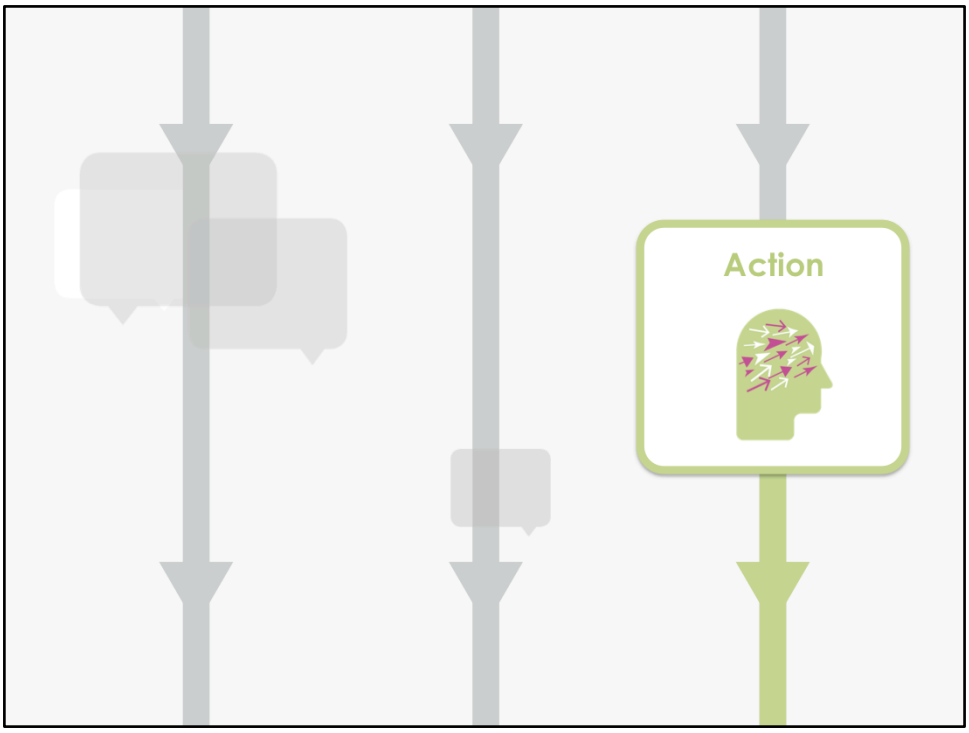
Everything above the horizontal line here works to improve mental wellbeing: confiding, peer support and formal psychotherapy.

It is possible - in the case of confiding - to have a therapeutic effect without intentionally doing psychotherapy, as has been shown by the impact say of AA (Project Match, 1997) or in research showing the impact of confiding relationships on depression (Halpern, 2005).

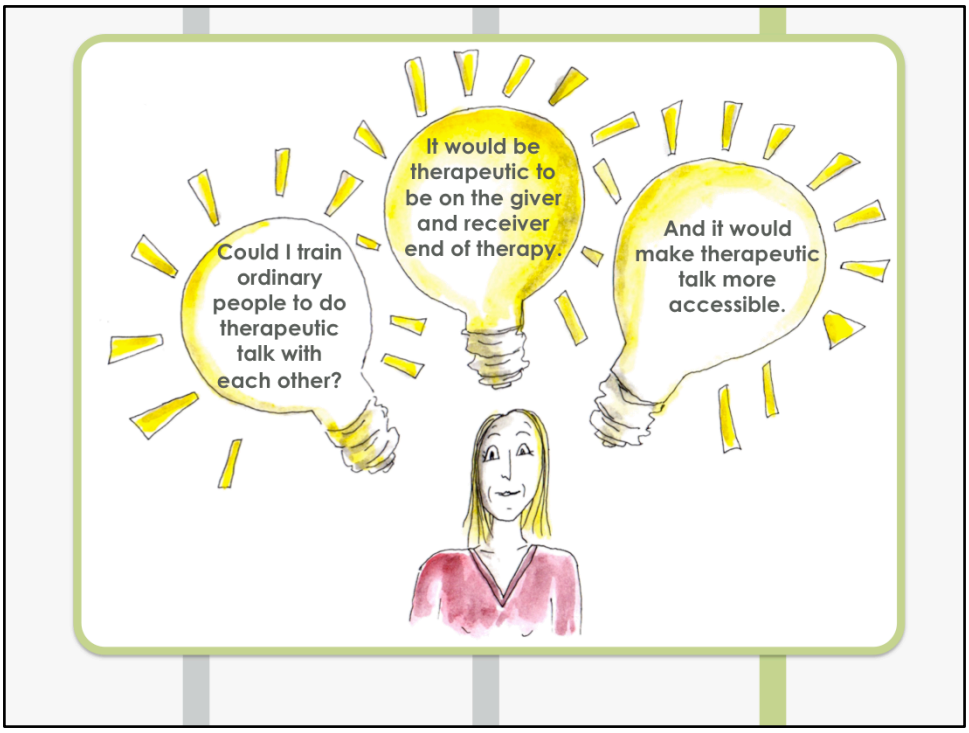
By the same token, a therapeutic intent doesn't guarantee a therapeutic result. Psychotherapy (Lilienfield, 2007) and indeed individual Psychotherapists (Okiiishi et al, 2003) can be harmful.

Everyday talk isn't necessarily therapeutic, though. All of us can think of conversations that 'bring us down' – often the subtly competitive kind.

So while the special techniques of therapy don't seem to be critical to its success, there does seem to be a valid distinction between a type of talk that's therapeutic and a type that isn't.



I'll move now to the question of translating this research into action.



The sum total of these experiences and research left me with a hypothesis

- That therapeutic talk would work if you pared it down to its most basic form – having a regular, reliable opportunity to talk about one's inner experience with an empathic confidant

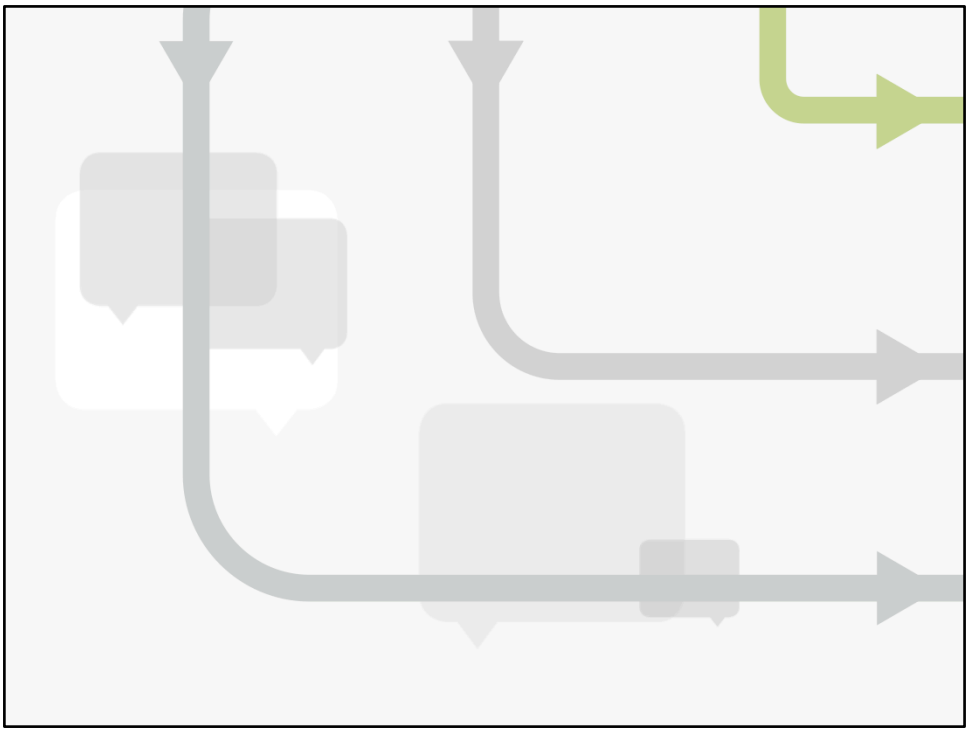
- That it would be possible to deliver effective therapeutic talk with minimal involvement of professionals – in an educational and supervisory role

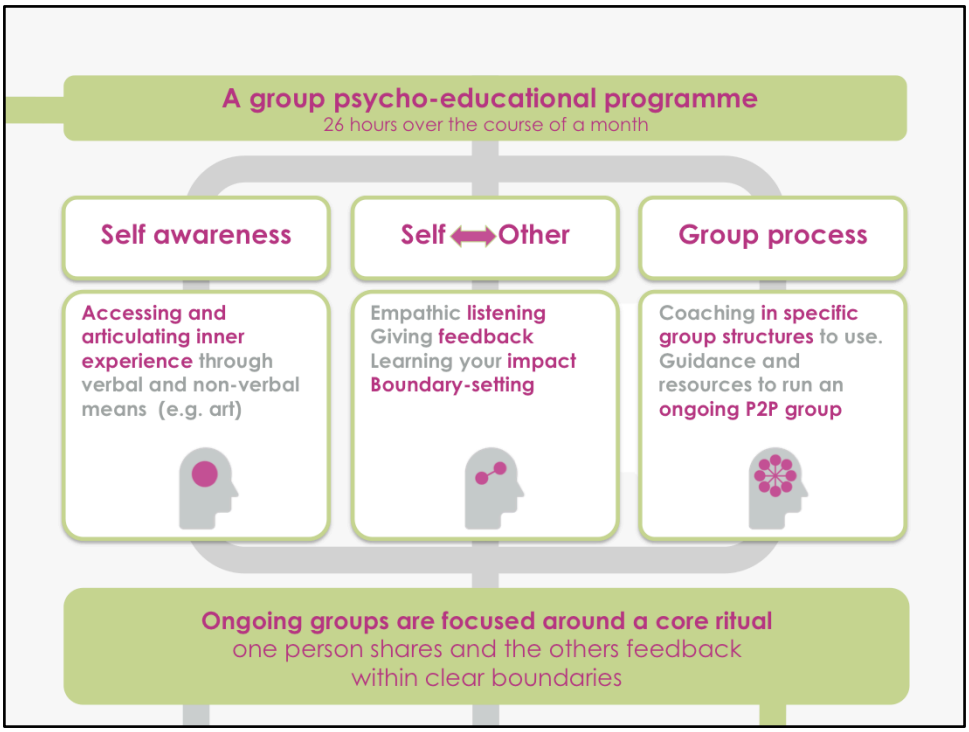
- That such a model would have advantages in terms of conferring the known psychological benefits of helping other people – the 'helper therapy effect' - from which I myself had benefited so much.

- That it would also make therapeutic talk a lot more accessible – both psychologically and financially

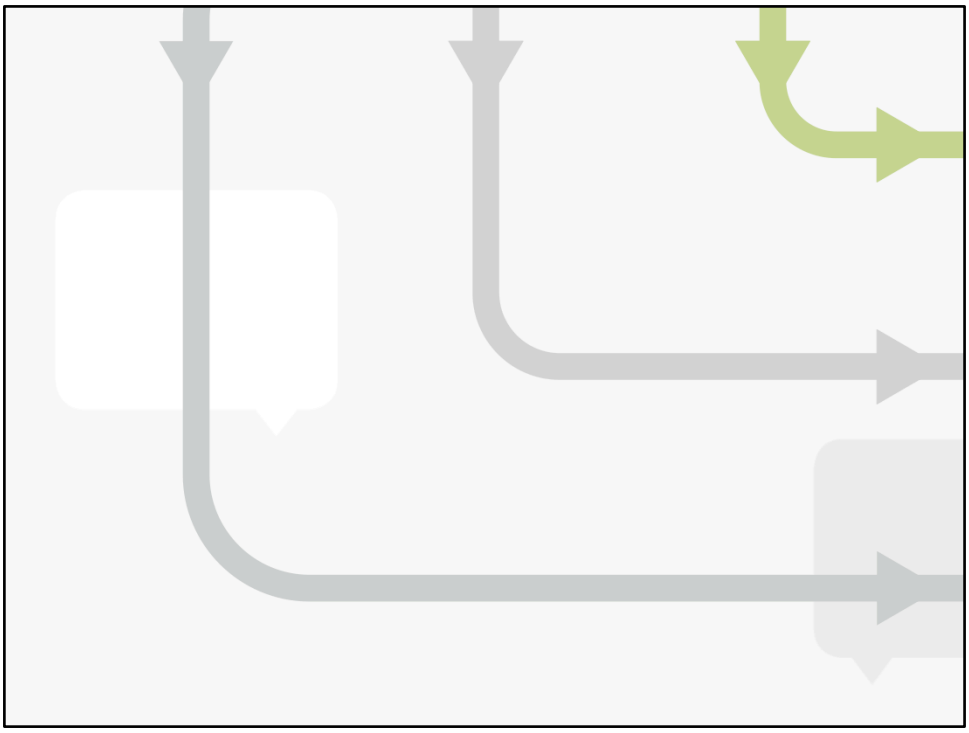
- That it would be advantageous to conceive of therapeutic talk as an ongoing practice rather than a 'treatment' (the problem of 'treatment' thinking is that the effects of talking therapy melt when the treatment ends – Seligman 2011)

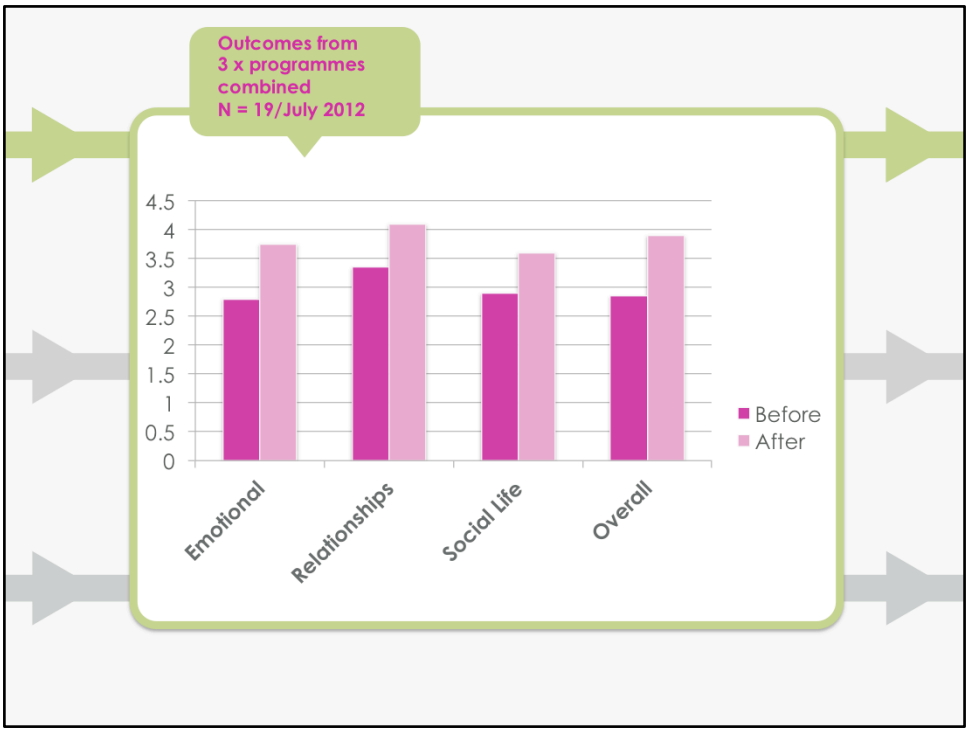
These ideas led to the development of Talk for Health. It is a therapeutic talk approach It sits between formal therapy and peer support, and teaches ordinary people to conduct effective therapeutic talk with each other.





Talk for Health consists of a 26 hour programme, delivered in eight half days or 4 full days across several weeks. It covers the elements in the chart and gives people time to practise their skills in between sessions. The end result is a group trained in therapeutic talk. They continue to meet either as a whole group or in smaller sub-groups to benefit in an ongoing way from 'talking for health'.





Now I'm going to talk about some results from the programme so far. It's not an RCT and it is very small scale but it's encouraging.

So far I have run four groups with the general public and two more amongst groups of people with mental health diagnoses such as Schizophrenia, Bipolar Disorder and Asperger's Syndrome.

I have carried out an anonymous evaluation of pre and post programme mental wellbeing, using a standardised instrument, with three of these six groups – two general public groups and one group of people with mental health diagnoses.

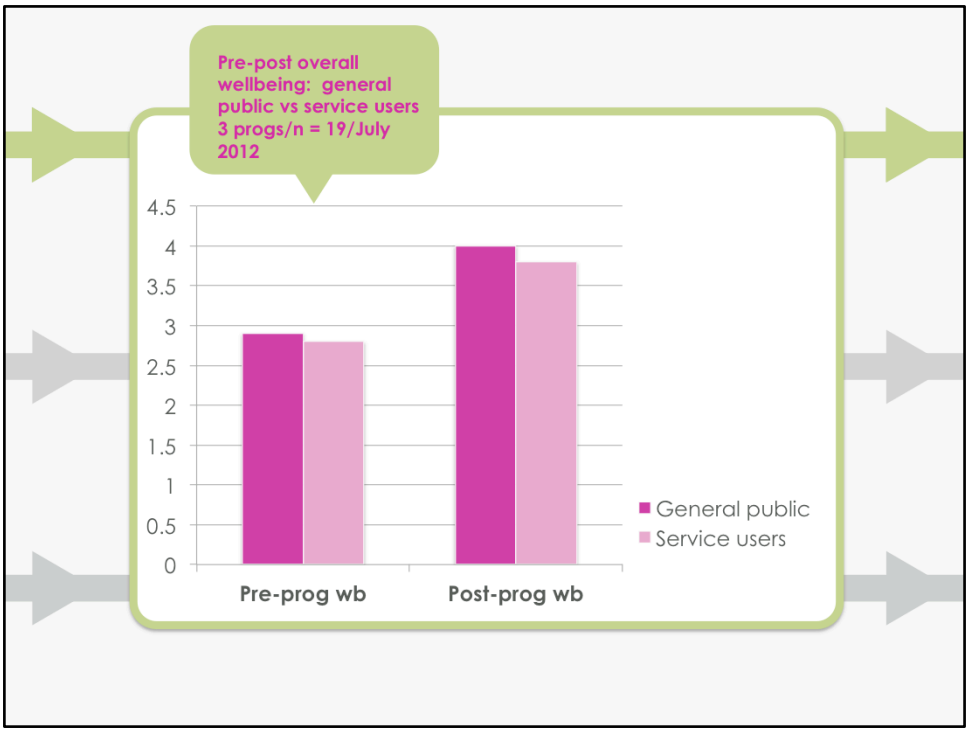
The instrument used was the ORS – 'Outcomes Rating Scale' (Miller 2010), developed for measuring therapy outcomes developed by the Institute for Study of Therapeutic Change.

It asks people to rate their well-being before and after an intervention across four dimensions – emotional, relationships, social life, and overall.

Here are the results on a five point scale where 1 was low well being and 5 was high. As you can see, mean well-being scores increased across all five dimensions.

At an academic conference I should talk about limitations – and the limitations of all these measurements, of course, is the fact that I did the evaluations myself, albeit through anonymised online questionnaires.

A second limitation is that I have not carried out follow up measures at say six months, and critical to the long-term effectiveness of such a programme will be that people continue to meet to 'talk for health' and reap the benefits.

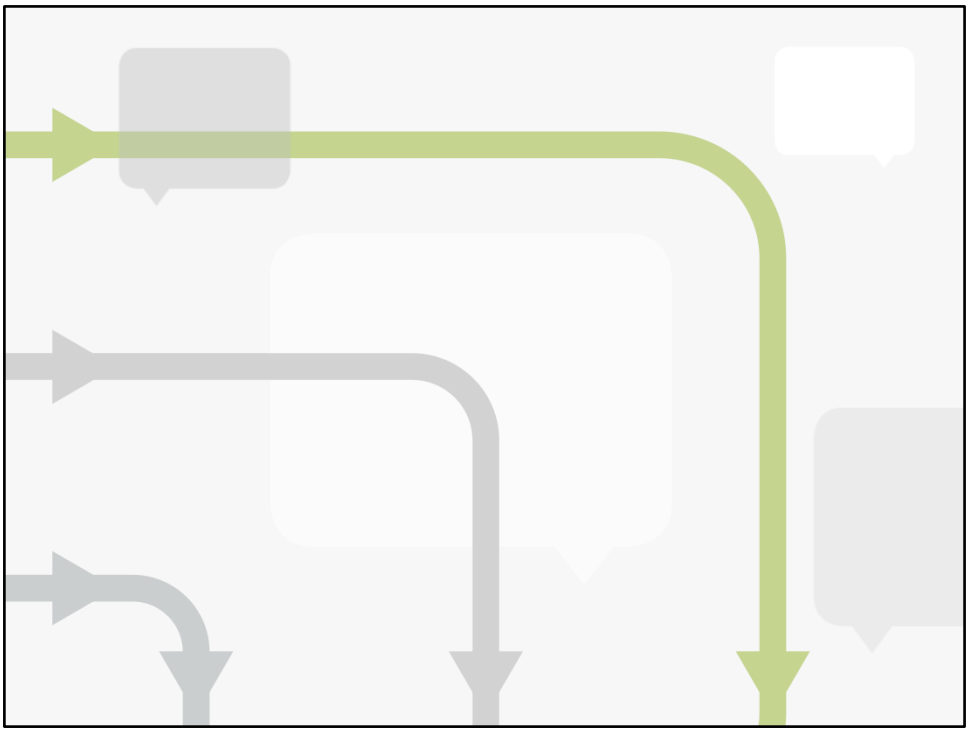


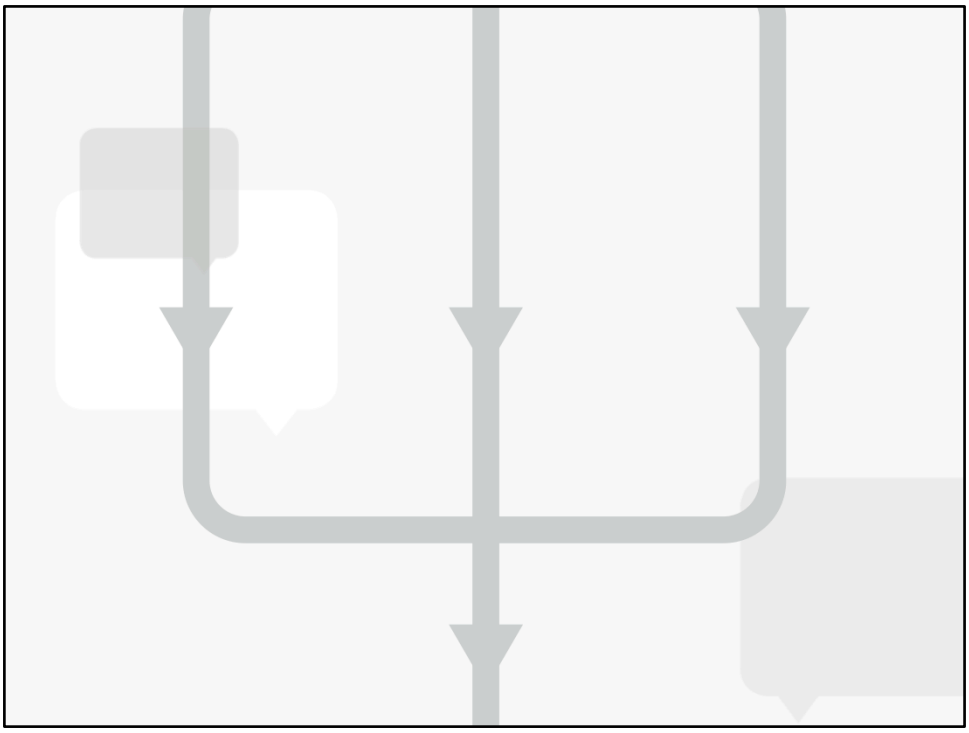
Looking across both groups – the general public and people with diagnoses, their start and end points for the measure 'overall wellbeing' were very similar.

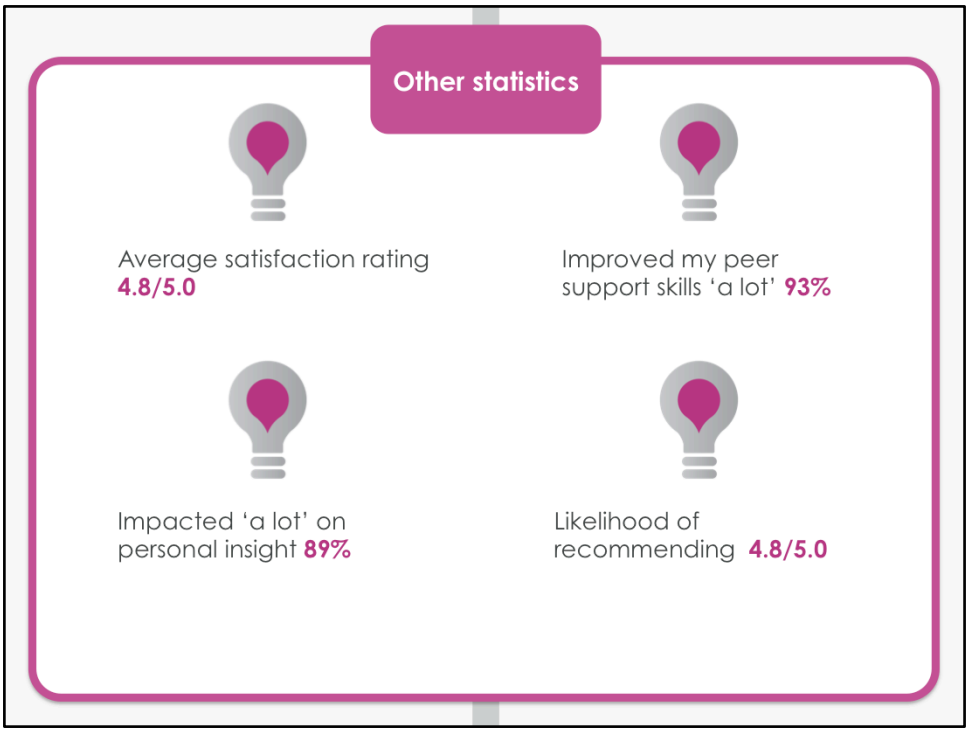
Mean 'overall wellbeing' scores before the programme are on the left. They were 2.9 'before' for the general public (dark pink) compared to 2.8 for people with diagnoses (pale pink).

Mean 'overall wellbeing' scores after the programme – the two bars on the right - were 4.0 for the general public and 3.8 for the service users.

(I should note in passing that the service users were part of the Personalisation Forum Group – an exceptional peer support group set up by Kelly Hicks, who won Social Worker of the Year Award for this week. To see an example of the best that peer support offer, look them up on www.pfgdoncaster.co.uk/)





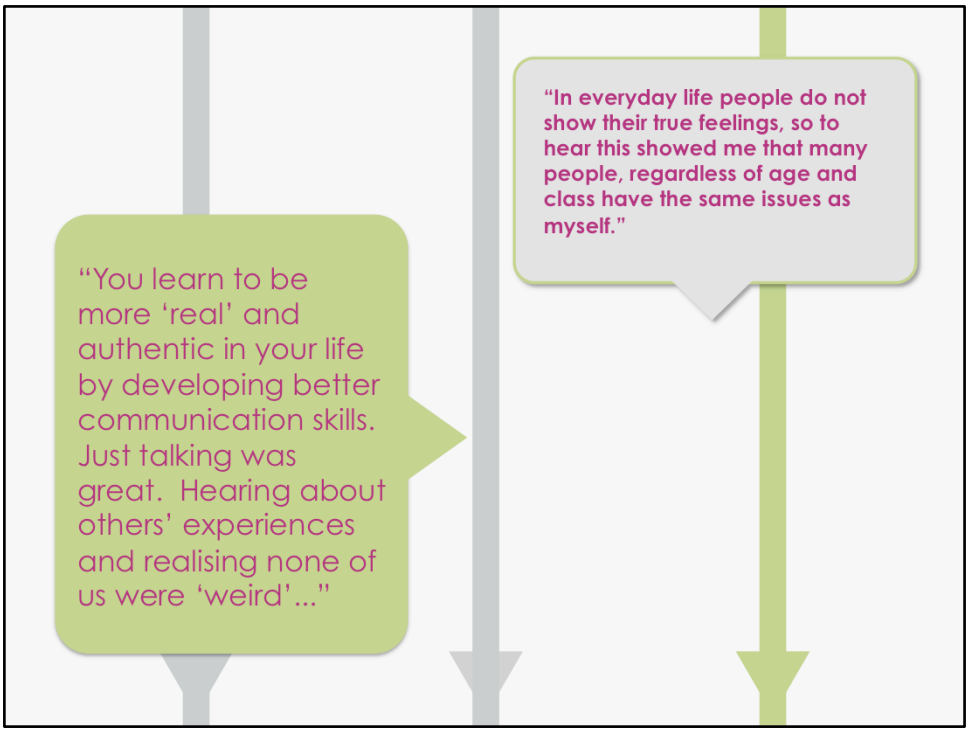


In the end, the key out-takes are:

Therapeutic talk is effective for relieving mental distress.
It does not rest on professional expertise.
It is possible to return therapeutic talk to a more everyday milieu, making it both more empowering – people benefit from the 'helper therapy' effect - and more accessible.

I couldn't sum it up better than Yvonne Bates has (Popescu and Enache, 2005):

"I would see most of therapy as evolving into a social skill that everyone develops, thereby taking much of it out of the professional arena. There will always be a place for some sort of clinical psychological practice for people whose needs are unusual. But for the mainstream, I believe that the consumerist, individualist society that leaves people feeling alone, empty and stressed cannot continue for much longer before there is a backlash. We need to learn to listen to each other again, prioritise friendships, family and concern for others generally, and encourage empathy, genuineness and non-judgemental regard in everyday life"

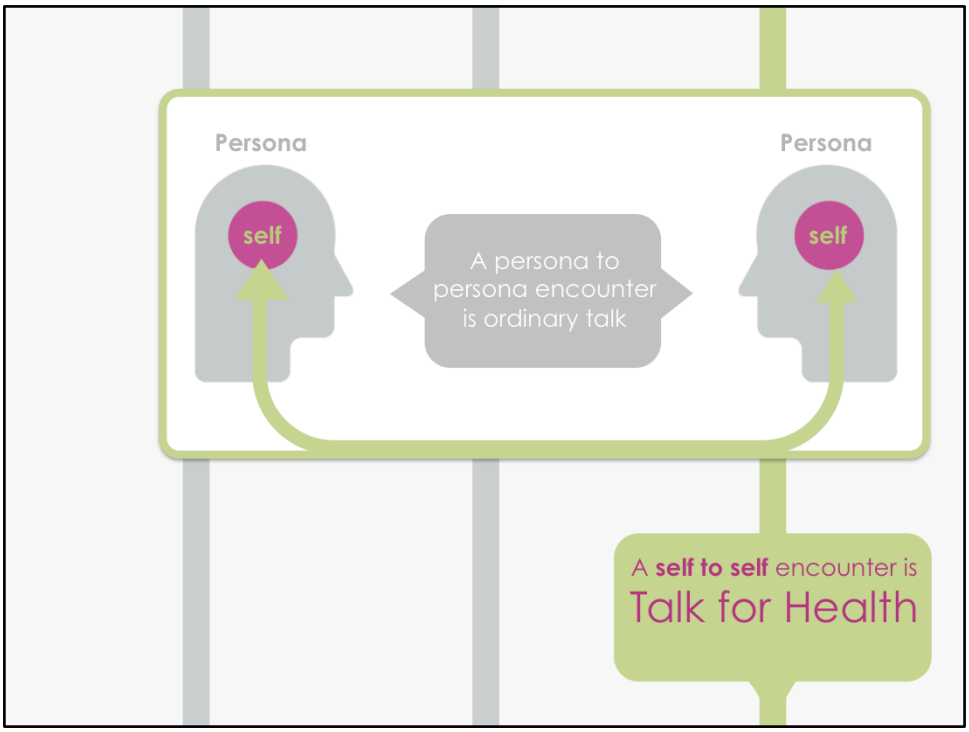


Qualitatively, people report that Talk for Health helps them to express themselves more authentically, talk about difficult subjects, understand others' feelings better and feel accepted themselves.

A striking finding in the first pilot was that participants were presented a range of possible attributes of the programme and asked which they had valued the most. The top rated item - in a list which included things like 'improved wellbeing', and 'improved relationships' was the attribute 'being more in touch with my own truth and better at speaking it'.

There was also an unexpected benefit of Talk for Health for many people. Before the programme, the idea of a group tends to be something that people are doubtful about and don't expect to benefit from. Afterwards, the bond with the group is something they rate highly.

Overall, the benefits seem to be experienced as a combination of being able to be yourself (speak your own truth) yet also have a sense of belonging.

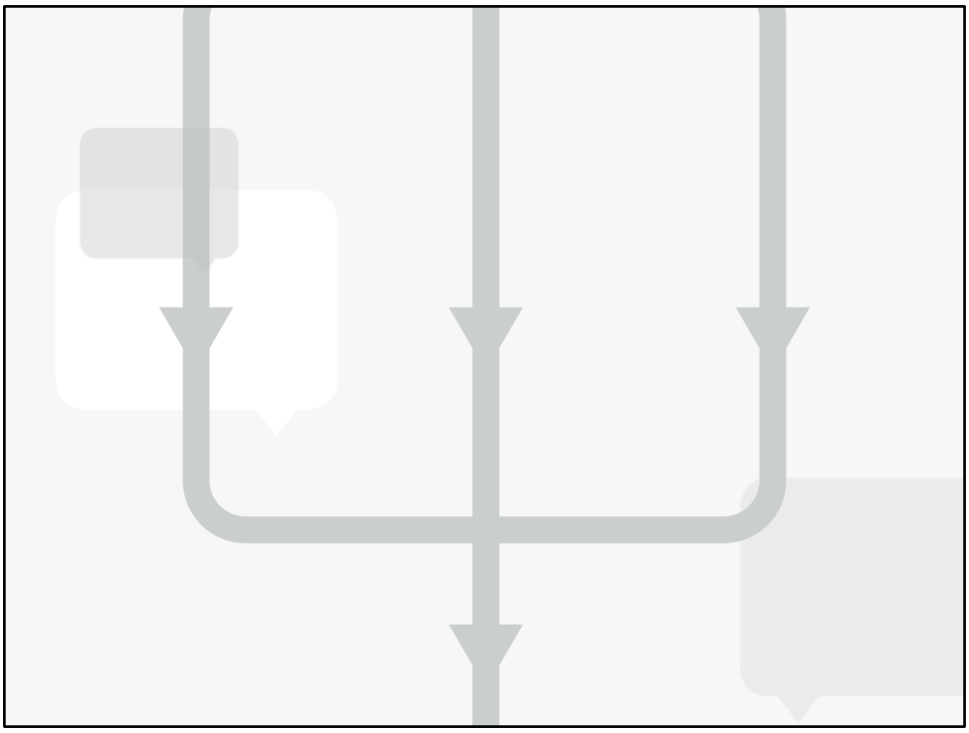


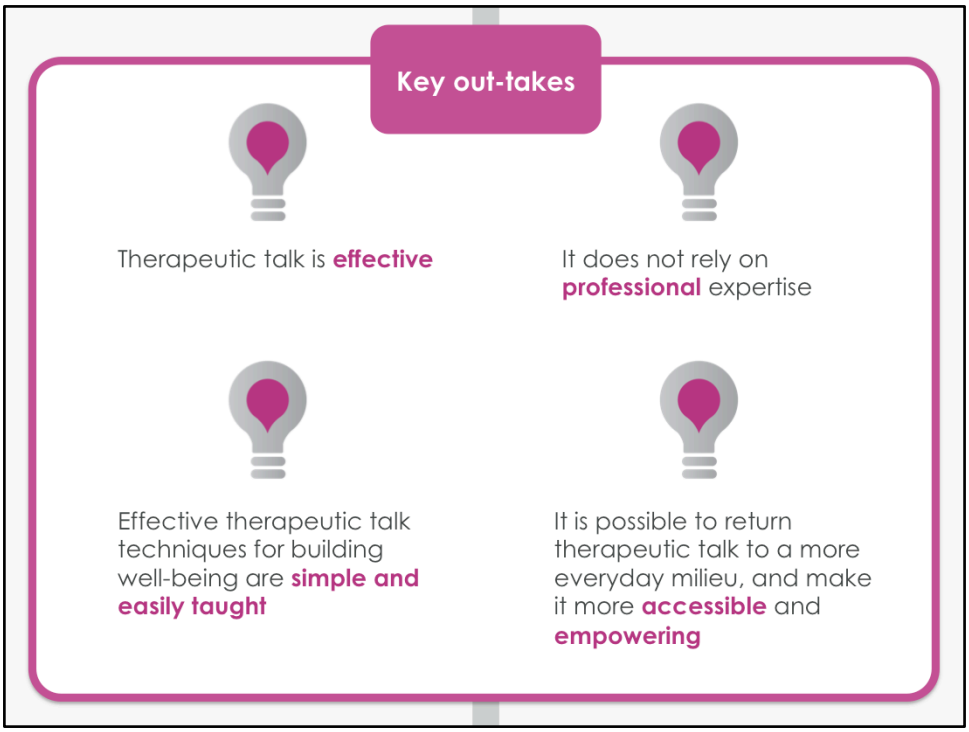
For my money, I think that confiding – the act of disclosing those things we publicly conceal – helps us to manage a kind of tension, described many years ago by psychoanalyst Otto Rank, between on one hand our human need to belong – and therefore to develop a 'persona' that conforms to group norms – and on the other hand our need to be true to our 'self' – our inner feelings and beliefs. Too much conflict between these two needs give rise to psychic pain.

Social researchers such as Asch (1956) and Janis (1982) have famously demonstrated the strength of our need to belong, and the ways in which we distort our selves in order to do so. We will publicly agree with even silly ideas put forward by a group we belong to, even when we don't privately agree with them (indeed we can plainly see they are wrong). We do this because to feel ostracised *hurts* – not just emotionally but physically (Kross et al, 2011).

So the conflict between our need to belong and our personal experience – what we truly feel - gives rise to psychic pain. (In a minor way, we experience this conflict in our daily lives; however, it is experienced in all the more in situations where people are experiencing abuse in their families of origin yet know that public revelations are forbidden by the family conventions).

This pain is relieved when we can confide our inner experience to empathic ears and find that, far from leaving us excluded, our inner experience is accepted and often shared.





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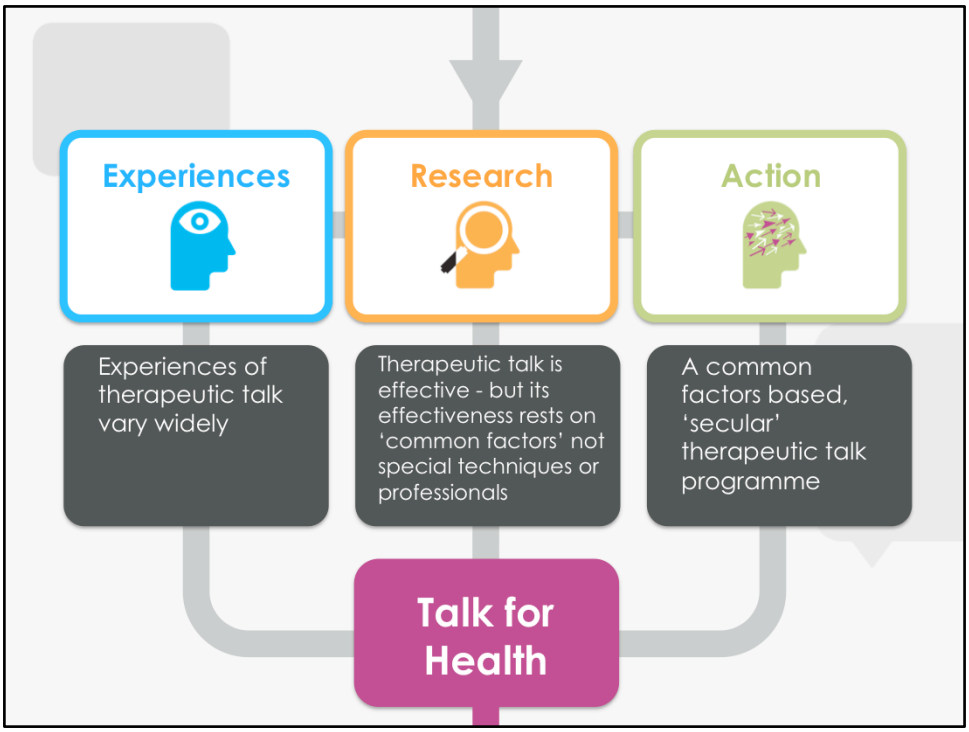

For myself, I'm not entirely sure where I stand with therapy now. It certainly has its uses - and is great with the right 'fit' between client and therapist – but there is a 'mission-creep' there. It has occupied too much of the territory of intimate talk in my view, just as Psychiatric diagnoses have occupied too much of the territory of human malaise.

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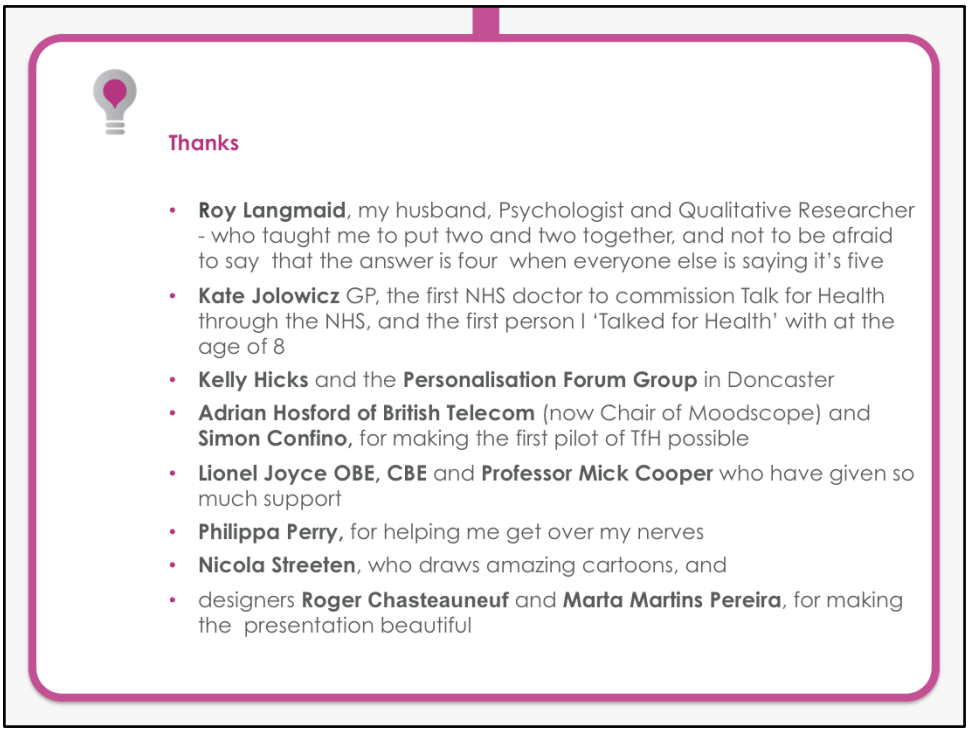

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