

**Representations of Cognitive Behavioural Therapy in Newspaper  
Articles post Layard: A Critical Discourse Analysis**

Thesis submitted in partial fulfilment of the Doctorate in Clinical Psychology for the  
University of Leicester

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This thesis constitutes original work by the named author. It has not been submitted for any other qualification, or to any other institution.

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## Thesis Abstract

### **Representations of Cognitive Behavioural Therapy in Newspaper Articles post Layard: A Critical Discourse Analysis**

Submitted by Laura Hickman BA (Hons.)

#### Paper 1: Self-contained literature review

This systematic review considered the literature exploring associations between socio-economic status and depression. Fourteen quantitative studies deemed to show quality and relevance were selected for inclusion. Results focussed on the areas of income, education, neighbourhood factors, social support and resilience and cognitive appraisal. Findings suggested that individual socio-economic status was significantly associated with depression, with income and education being a mediating factor. Neighbourhood socio-economic status appeared to compound this effect. Negative appraisal of personal and social status was also suggested to increase vulnerability to depression. The research considering the effectiveness of social support in promoting resilience was contradictory and required further exploration.

#### Paper 2: Main research report

Following the release of the Depression Report in 2006, Professor Layard recommended increased funding be given to psychological services within the NHS, prompting the development of the Improving Access to Psychological Therapies agenda. This agenda paid particular focus to cognitive behaviour therapy (CBT). This study considered the way in which CBT was represented in eleven newspaper articles, post Layard, using critical discourse analysis. Findings suggested the presence of gendered accounts of mental illness. Individuals considered suitable for receiving CBT were often constructed as passive. CBT was not only suggested to be potent and fashionable, but also showed characteristics that were paralleled with concepts of masculinity. The text was seen to polarise in several ways, often marginalising other therapeutic approaches. Emerging discourses were found to frequently mirror wider socio-historical practices. Clinical implications of the findings and suggestions for future research were discussed and a critical appraisal of the research process included.

**Socio-Economic Inequality and its Impact on the Development of Depression: A  
Review of Existing Literature**

## 1. Abstract

### *Purpose*

A systematic review of the current literature on socio-economic status and depression was carried out. This attempted to synthesise findings, critique methodologies and identify gaps.

### *Method*

A quantitative data extraction form was used to identify articles deemed to have quality and relevance. Fourteen articles were found to be suitable and included in the review.

### *Results*

Results focussed on the areas of income, education, neighbourhood factors, social support and resilience and cognitive appraisal factors. All articles were of a medium to high methodological quality, with the main difficulties involving poor response rates and lack of variable definitions.

### *Conclusions*

Findings suggested that individual socio-economic status was significantly associated with depression, with income and education being of relevance. Neighbourhood socio-economic status appeared to compound this effect. Negative appraisal of personal and social status was also suggested to increase vulnerability to depression. The research considering the effectiveness of social support in promoting resilience was contradictory and required further exploration. Future research might also consider how self-understanding and social comparison feature in the association between socio-economic status and depression, alongside identifying barriers to support for those of low socio-economic status.

## 2. Introduction

One hundred and twenty one million individuals worldwide are thought to experience depression. This figure is seen to be increasing, making depression the second most likely mental health problem to effect quality of life by 2020 (World Health Organisation, 2010). Perhaps surprisingly, in countries that are considered developed, levels of emotional distress are increasing more so than in those countries considered to be still developing. James (2007) noted that rates of distress are at least twice as high in English-speaking nations such as the UK and the USA, than in some places within Western Europe.

Beck (1975) described depression via a 'negative cognitive triad', whereby the individual has a distorted view of themselves, their future and their surrounding world. His theory led to the development of cognitive behavioural therapy, currently recommended as the most effective therapeutic treatment for depression in healthcare services in the UK (NICE, 2009). This therapy aims to alleviate emotional difficulties by changing dysfunctional thoughts and behaviour and therefore requires the individual to make changes to themselves. However, what it is less suited to addressing is the difficulties that an individual might face at a societal level, which they may have less power over. These problems include poor education, low income, limited social support and residence in dangerous or neglected communities.

In recent years, there has been an increased focus on attempting to understand the causes of depression at a community level. Orford (2008) suggested that the social contexts of individuals' lives have been neglected and that by refocusing on things such as social class, employment status, and community involvement, inequalities can be addressed. This approach appeared quite different to those such as cognitive behavioural therapy, which have been recommended through health policy. In

attempting to prevent the rise in depression, it seemed useful to consider how much social factors might play a role in the development of emotional distress and to consequently question whether therapeutic approaches might need to be adjusted in accordance with this.

Brown and Harris (1978) suggested there to be an association between social class and depression, stating that working class women in South London were two to three times more likely to develop depression than those from other classes. In particular, they referred to several vulnerability factors which they believed would make the individual at greater risk. These were unemployment, lack of a confiding relationship, the presence of greater than three children at home (under the age of 14 years) and early maternal loss. Later studies of a similar nature have given support to these findings (Campbell, Cope & Teasdale, 1983; Patten, 1991).

Kessler (1982) considered a range of socio-economic factors, suggesting that low income was the biggest predictor of mental health difficulties for men, whilst for women, it was low education. These findings sparked an interest into how social class and socio-economic status influence the onset of depression, with research growing in recent years.

Argyle (1994) described the variation in social positions within different countries, claiming that egalitarianism was virtually unknown in today's society. Following this, Wilkinson and Pickett (2007) concluded that inequality was central to understanding the differences in prevalence of mental health between nations, finding that the greater the inequality in a country, the more emotional distress was present. This study was supported by a more recent commentary (Marmot & Bell, 2009) which discussed the USA's plan to improve health by focussing on social disparity. It gave an example of there being a 28-year gap in life expectancy between those in the richest and

poorest areas of Glasgow, Scotland, with some of the poorer areas having a life expectancy for males that is eight years below India's average.

With many of the aforementioned studies suggesting that an individual's position in the social hierarchy is likely to affect their levels of emotional distress, there have been suggestions that government initiatives should focus on prevention of depression through attempts to change the economy and develop stronger societal values (e.g., James 2007; Marmot, 2005; Wilkinson, 2005).

With social inequalities rapidly becoming more pronounced in countries such as the UK and USA, it seemed of use to review the research evidence that considered the association between socio-economic status and depression. Within the current review, whilst the term 'socio-economic status' was chosen over 'social class' (due to the fact that this seemed to incorporate a wide range of social and economic factors, rather than just income as a measurement) there was an acknowledgement that definitions vary depending on sources and that the two terms are often used in the literature interchangeably. For this reason, articles considering 'social class' were also included if relevant.

### 3. Review Aims

The aims of the current review were to use a systematic approach to provide a synthesis of relevant research considering socio-economic status and depression and to evaluate this literature, including a critique of the methodology. The review also attempts to identify the gaps in the current literature, suggesting future research directions. The study was conducted in a manner that complied with the guidelines given by the targeted journal 'Social Science and Medicine' (see Appendix A for guidelines).

#### 4. Method

To ensure that no previous systematic reviews considering associations between socio-economic status and depression had been done, a search was conducted using the Cochrane Library. This yielded no evidence of previous work and so it was presumed that this was the first review regarding this topic. Relevant databases were then selected and search terms entered (often adapted to fit with pre-existing topic headings in each database) in order to identify relevant articles (see Appendix B). Only articles after the year 1995 were retained as it was felt that recent research might be more applicable when considering today's society.

Abstracts obtained from each search were then checked for relevance to the current review topic and those that were explicitly unrelated were excluded. Books of appropriate subject matter were also obtained and all reference lists then checked for further literature. This produced 107 articles to be inspected and the details of these were stored using reference database software (Refworks).

Abstracts were then studied with greater depth and full texts obtained where necessary in order to exclude those articles that were:

- book excerpts or chapters
- discussions or theoretical pieces only
- dissertation abstracts only
- not available in English

Articles were also discarded if they did not include the following:

- Consideration of the effects of socio-economic status or social class.  
(Articles which used more subjective terms such as 'poverty', 'disadvantage' and 'deprivation', were not included as it was felt that strict inclusion criteria was needed in order for articles to be comparable)



- A measure of depressive symptoms or a clear, comparable alternative such as ‘neurosis’.

This application of inclusion and exclusion criteria left 53 articles remaining. A ‘literature web’ (based on that by Creswell (2003) - see Appendix C) was then used to cluster articles into areas, with those most frequently researched and most related to the topic being reviewed to the right of the map. The studies produced findings most commonly focussing on the following key areas: Income and financial difficulties; Education; Neighbourhood; Social support and resilience; and Cognitive appraisal factors.

The full text of the 31 articles (covering the above areas) was then examined using a quantitative data extraction tool (Centre for Reviews and Dissemination, 2001) to assess quality and relevance to the current review (see Appendix D). No qualitative studies were found for review. Fourteen of the quantitative articles were considered suitable for inclusion, based on being of medium to high quality and relevance.

## 5. Results

### *5.1 Overview of Findings*

The articles included were all of a medium to high quality with some being methodologically rigorous. Of the fourteen included, twelve were cross sectional studies and two longitudinal cohort studies. All of them considered the relationship between socio-economic status/social class variables and levels of emotional distress, using a variety of measures. Some included further variables in the studies, such as social support, cognitive factors, neighbourhood environment and so on.

Most studies lacked a clear definition of 'socio-economic status' or 'social class' and as a consequence, variables included under these terms differed vastly. However most took measures of income, education, and employment status. Factors such as gender, age, ethnic background and marital status were also included in most studies. Populations reported varied from around the world, including the USA, Australia, Brazil, UK and Finland. The total number of participants across studies was 72,937, although it was possible that some samples were taken from the same areas, so individuals may have participated in more than one study. Excluding studies with missing data, 42.6% of all participants were male and most studies used samples representative of the population they were measuring. Participants' ages ranged from 15-92 (although again, there was some missing data), however the longitudinal study used retrospective accounts from when individuals were children (under 14 years). The main characteristics of each study are presented in Appendix E.

As stated previously, the results could be grouped into several key areas of research: 'Income and financial difficulties'; 'Education'; 'Neighbourhood'; 'Social support and resilience'; and 'Cognitive appraisal factors'. This felt important as socio-economic status by itself seemed to be an expression that could be viewed in terms of

several sub-categories and if used as a singular term, might yield limited information. The results from each area are discussed below. Socio-economic status is written as 'SES' from this point onwards.

## *5.2 Income and Financial Difficulties*

Five of the studies made reference to results that were specifically related to income within SES (Fone & Dunstan, 2006; Fone, Dunstan, Williams, Lloyd & Palmer, 2007; Frojd, Marttunen, Pelkonen, von der Pahlen & Kaltiala-Heine, 2006; Ross, 2000; Skapinakis, Weich, Lewis, Singleton & Araya, 2006). In general, these studies were of a good quality with large sample sizes (shown through small confidence intervals) and standardized measures that were considered to be reliable. Four used random sampling methods, though one study lacked clear information as to how they had picked an individual from each household to complete the measures (Skapinakis et al., 2006), possibly suggesting some bias. The remaining study chose children from two Finnish schools to participate, reducing the generalisability that could be claimed. There may also have been difficulties with the exclusion criteria used to screen completed measures, with 'facetiousness' being a reason to exclude responses without further details being given (Frojd et al., 2006). For all studies, response rates were low, and three of the studies reported a slight overrepresentation of those with high SES (Fone & Dunstan, 2006; Fone et al., 2007; Skapinakis et al., 2006)

Skapinakis et al., (2006) compared two cohorts in the UK (one with and one without depression) at baseline and after eighteen months, finding that SES was not associated with an episode of depression at follow-up. However, perceived financial difficulties were associated with an increased risk of depression for both groups, even when adjustments had been made for baseline psychiatric symptoms. This highlighted

the importance of viewing SES as a group of variables rather than just as a single measure.

In a study of 15-16 year-old Finish children, it was found that traditional SES indicators, including income and occupational level, were significantly associated with the development of depression. Furthermore, perceived parental financial difficulties were significantly associated with depressive symptoms, even after controlling for other SES factors (Frojd et al., 2006). This suggested that subjective measures of financial status might be as important as objective measures. If this were the case, then narratives used to describe the self and to carry out social comparisons may be of particular relevance.

In a study comparing neighbourhoods, Ross (2000) found that poverty and single-parent family structure were the most detrimental factors to well-being. Interestingly, women had higher levels of depressive symptoms than men, with low household income being a significant predictor. This may be explained through some samples being taken from mother-only neighbourhoods, where in this case the female role would be to provide for the children, meaning low levels of income had an even greater impact.

Two studies found that mental health difficulties were significantly associated with SES factors including low household income and residing in rented accommodation. Furthermore, a significant relationship was observed between mental health status and economic inactivity. In both studies, the affect of these variables on mental health was greater for females (Fone & Dunstan, 2006; Fone et al., 2007).

### *5.3 Education*

Four studies were identified that made specific references to education in the results (Frojd et al., 2006; Miech & Shanahan, 2000; Ross, 2000; Turner & Turner, 1999). Despite these studies using clear random sampling methods and attempting to adjust for potential bias, there were some apparent limitations. The ways in which SES information was collected was not defined clearly in one of the articles (Miech & Shanahan, 2000). Another used a scale to measure emotional reliance that was deemed to have only moderate reliability (Turner & Turner, 1999). Again, high response rates were not observed across studies. Although this may have been hard to overcome in studies of this scale, this has obvious implications when claiming generalisability.

All of the studies found that depressive symptoms were reported significantly more amongst those with the lowest education levels. Miech and Shanahan (2000) also found that the differences in depressive symptoms amongst educational groups increased with age, with the differences being relatively small in early adulthood. This divergence was explained by the increased prevalence of physical health problems in those older adults with poorer education, suggesting that increased levels of education help to promote healthy lifestyles more generally.

Ross (2000) found that in neighbourhoods where there was an increased prevalence of reported depression, residents were also more likely to have poor levels of education. He discussed the difficulty for disadvantaged mothers who, without an education, cannot gain employment and consequently struggle to support their families. In single parent families, the role of caring for children may have restricted the likelihood of returning to education, creating a vicious circle.

In the previously reported study by Frojd et al. (2006), analysis showed that low parental education was related to teenage participants reporting perceived financial

difficulties. These perceptions were significantly associated with depression. This suggested that those variables that constitute SES might interact in a complex manner, with this interaction influencing the likelihood of depression.

The association between SES, emotional reliance and depression was investigated by Turner and Turner (1999). They described a significant association between ratings of emotional reliance (dependence on others for emotional stability) and depression, though this differed between genders and was moderated by SES. In particular, education was found to reduce emotional reliance ratings in women. This study will be referred to in further detail later.

#### *5.4 Neighbourhood*

Six articles considered neighbourhood factors in the link between SES and depression (Fone & Dunstan, 2006; Fone et al., 2007; Gilman, Kawachi, Fitzmaurice & Buka, 2003; Phongsavan, Chey Bauman, Brooks & Silvoe, 2006; Wen, Hawley & Cacioppo, 2006). Some of these studies had clear methodological limitations. Some had missing data on ethnicity and age (Fone & Dunstan, 2006; Fone et al., 2007; Phongsavan, et al., 2006) making it hard to judge how well they represented the populations considered. One had a much smaller number of participants than comparable studies (Wen, et al., 2006) and the longitudinal cohort study used very simplistic measures of SES including splitting parental occupation into just two categories ('non manual' and 'manual/not employed') (Gilman et al., 2003). However, despite these limitations, all the cross-sectional studies used thorough random sampling methods and used measures with good reliability and validity.

Results showed that depression was not only related to individual SES factors, but was compounded by living in a more deprived electoral division (Fone & Dunstan,

2006). Furthermore, cross-level interactions were observed between ward-level and individual economic inactivity from permanent sickness or disability. This implied that the impact of sickness or disability on mental health was significantly greater for those living in economically inactive communities (Fone et al., 2007). This suggested that in considering SES, the status of individuals in the immediate neighbourhood might also need to be considered.

Wen et al., (2006) did this, finding that neighbourhood SES had a significant effect on self-rated health, after controlling for gender, age and ethnicity. However, after accounting for individual SES, the effect of neighbourhood SES was reduced by 45% and considered not to be significant. Interestingly, *perceived* neighbourhood quality was found to have an association with self-rated health and this result was significant even after controlling for individual and neighbourhood SES, perceived social support and marital status. As previously suggested, emotional well-being may be affected through a number of mediating variables. In this case, neighbourhood SES may have an impact on mental health via individual SES and perceived neighbourhood quality.

A longitudinal study by Gilman et al., (2003) considered whether low SES, family disruption and residential instability experienced in childhood were associated with depression across the lifespan. They found that this was the case, with those from low SES backgrounds who had experienced family disruption and residential instability by the age of seven being more likely to experience depressive symptoms recurrently and with less chance of remission. The greatest impact of these factors was seen by age fourteen. It should be noted that retrospective accounts of depression were used in this study and it relied on self reporting of symptoms, which may have led to reduced accuracy. Due to participants being recruited from a previous perinatal project, there were obvious difficulties surrounding claims of generalisability. Despite this, the idea of

family and residential stability being important to well-being was interesting and suggested that beliefs about, familiarity with, and control of surroundings might be important. This theme was explored further in the following two studies.

Ross (2000) found that disadvantaged neighbourhoods had higher levels of depression than non-disadvantaged ones. Whilst individual SES accounted for over half of the effect size, there was still a significant neighbourhood effect after controlling for this. Furthermore, the study found that individuals who reported a high level of neighbourhood disorder (any condition or activity which is seen to be a sign of social order breaking down) were significantly more likely to suffer from depression than others. There was a correlation between disadvantaged neighbourhoods and disorder.

In comparison, Phongsavan et al., (2006) considered social capital, measuring constructs of community participation and neighbourhood connections, reciprocity and feelings of trust and safety. Their findings suggested that having trust and feeling safe within the community were associated with reduced rates of depression. However, individual SES significantly attenuated this relationship. This suggested that whilst neighbourhoods with lower perceived risk factors might increase resilience to depression, individual status might work against this. This again supported the complex nature through which SES might moderate an individual's perceptions of the world around them. An individual's SES may well determine the neighbourhood in which they live. Neighbourhood factors may then have an effect on emotional well being through the way in which that individual experiences and makes sense of their environment.

### *5.5 Social Support and Resilience*

The four articles referring specifically to social support and resilience were of a medium to high quality (Almeida-Filho et al., 2004; Mirowsky, Ross & Willigen, 1996;



Phongsaven et al., 2006; Wen et al., 2006). They all used random sampling procedures and despite there being some missing data, were considered representative of the populations they were measuring. One study had a small sample size compared to the other studies (Wen et al., 2006) as mentioned previously and one did not give detailed information on the reliability and validity of the measures created (Mirowsky et al., 1996). One study used lay interviewers to conduct interviews, though several reliability tests were used to ensure that their approaches were considered accurate (Almeida-Filho et al., 2004)

As discussed previously, social capital was explored by Phongsavan et al., (2006). Findings showed that there was a moderate association between neighbourhood connections and reciprocity and emotional distress. Though a slightly weaker association, community participation was also thought to reduce the likelihood of distress. This suggested that not only might familiarity of neighbourhood be important, but that familiarity of residents may also be beneficial in developing resilience from depression.

In comparison, Wen et al., (2006) suggested that the association between perceived neighbourhood environment and well-being was partially explained by factors such as loneliness and hostility. This might suggest that social connections are a protective factor for individuals at risk of developing depression. Despite this, somewhat surprisingly, perceived social support and social networks were *not* found to contribute to this association. This in itself did not show that social relationships do not have a role in promoting emotional well-being, but rather suggested that the way in which the physical environment is perceived has an effect on our mental health, despite our social support. This is an area which needs further research.

A study in Brazil found that those placed in groups who were considered to have less power socially were more likely to develop depressive symptoms (Almeida-Filho et al., 2004). Highest rates of depression were found in females and Mulattos. Overall, non-White females were found to be 1.65 times more likely to develop depression than White females, though this ethnic divide was not seen in males. A highly significant gender effect was seen amongst poor participants. Also of interest was that women and Mulattos had an increased resilience to depression when placed in local dominant SES groups. This appeared to suggest that SES might lead to community hierarchies and that having a high status in itself could aid resilience to depression, even when other factors lead to vulnerability. The authors also noted the importance of considering social meanings: that social factors may be valued differently within different communities. For example, in a population where there were gender inequalities, being female might have more of an impact on social status than in a population where equal rights were promoted.

Mirowsky et al., (1996) studied instrumentalism in the USA, finding that individual instrumentalism, or, when this was lacking, a firm belief in American instrumentalism, was associated with protection against depressive symptoms. They stated that high SES was significantly associated with high levels of both individual and national instrumentalism. The findings suggested that emotional well-being might be associated with personal resources such as self-belief. When these resources were not available, resilience might come from the status of the direct community, when that is of a high level.

### *5.6 Cognitive Appraisal Factors*

Four studies took specific measures of what could be termed cognitive appraisal factors (Lever, Pinol & Uralde, 2005; Mirowsky et al., 1996; Turner, Lloyd & Roszell, 1999; Turner & Turner, 1999). These were factors through which the individual was seen to mediate their response to their social world. The methodological limitations of two of these studies have been discussed previously (Mirowsky et al., 1996; Turner & Turner, 1999). The remaining two articles were of a high quality, using random sampling procedures, defining variables, using what were seen to be reliable and valid measures and analysing results thoroughly, addressing and attempting to account for potential bias.

As described previously, Mirowsky et al., (1996) considered the role of instrumentalism in protecting against depression. Exploring the role that SES plays in this association, findings suggested that although the majority of individuals with low SES endorsed an instrumental view of their own and others' circumstances, over half of those who were non-White, poorly educated and had a low income believed that most people's problems were caused by others who were selfish, greedy and mean. Furthermore, recent economic hardship, whilst having no direct effect on instrumentalism, caused resentment.

Constructs of self-esteem and mastery were found to be significantly and independently associated with depressive symptoms, with SES being a mediating factor, such that when an individual has a low SES, they have less personal resources such as mastery and self-esteem available and so are more likely to develop depression (Turner et al., 1999). A gender difference was observed in the findings and it was suggested that women were more vulnerable to loss of personal resources than men. One unexpected result was that although depression was found to be lowest amongst married

individuals, the highest mastery scores were found in the group who had never married. Perhaps the increased levels of self-esteem found in married individuals had a role to play in developing resilience to depression.

Lever et al., (2005) considered the mediating effects of a number of psychological variables in the association between low SES and well-being. Results suggested that those with low SES coped with stress in the least direct way, often using strategies such as avoidance and attribution of behaviours to external factors. They also had significantly lower self-esteem and competitiveness, though no association was found with mastery. Interestingly, social support seeking (for coping with stress) was higher in those who were moderately poor than in those who were extremely poor and it is suggested that whilst seeking social support is beneficial, it is often initiated more by those with an internal locus of control. Of further interest was the finding that SES was not found to be significantly associated directly with depressive symptoms (measured separately to 'well-being'). Instead, it was suggested that SES had an influence on several factors (including mastery), which in turn affected the development of depression. These findings were illustrated by a structural model, which suggests how poverty, as defined through SES factors, affects well-being through three trajectories (see Appendix F).

Returning briefly to a previously discussed article, Turner and Turner (1999) suggested that emotional reliance was linked to depression and was moderated by SES, with both education and occupational prestige reducing reliance (being noted as particularly beneficial for women), and marriage increasing reliance in men. Women reported significantly more reliance on others in their social networks overall and the authors suggested that women may be more affected by social hardship and other individuals' negative life events.

It feels useful to note, prior to discussing these results, that in many of the articles cited, a main limitation was the assumptions made about causal pathways. For example, whilst articles discussed the impact of SES on depression, few questioned fully whether depression might influence SES. This is particularly important to consider in areas such as social support, as whilst social isolation may lead to depression, being depressed might also reduce the likelihood of an individual seeking social contact and so on. In the discussed studies, there was limited reflection on the weaknesses of correlation as a methodology in inferring such causal relationships and rarely consideration of additional variables, unidentifiable to the researcher, in mediating results.

## 6. Discussion

The findings of the current review suggest how SES affects emotional well-being, giving factors which might contribute to the development of depression. The articles discussed were of a medium to high quality, often seeming to have few methodological problems. Definitions of SES and social class were an area of difficulty. Definitions varied and these two terms were sometimes used interchangeably. Also, the studies often relied on self-reporting of both SES factors and depressive symptoms. As personal status and mental health can be sensitive issues for some to discuss, it may be that some individuals tried to present what could be considered a more favourable view of themselves, underreporting some of the negative aspects of their lives.

The other major difficulty appeared to be poor response rates and this might affect views of generalisability. However, with large sample sizes and demographic data showing that samples did match trends in the wider community, it may be that concerns about response rate should not be overstated.

Despite limitations, it seems apparent that there may be ways in which SES influences the development of depression and reviewing the evidence, it has been suggested that complex sets of pathways exist through which many variables mediate the association between the two (Lever et al., 2005, etc). With findings suggesting that after adjusting for individual SES factors, the contextual effect of neighbourhood SES was reduced considerably (Ross, 2000), it seems that individual variables, particularly education and income, have a part to play in vulnerability to depression and that neighbourhood SES is significant in compounding these effects.

It seems likely that higher levels of education lead to greater career opportunities. The knowledge gained and the potential for increased finances consequently leads to a broader choice in lifestyle. It is thought that those with higher

education levels and incomes are better prepared to overcome stressful experiences, having more access to health resources and social support (Miech & Shanahan, 2000). Furthermore, it is believed that disadvantaged individuals experience more threatening and uncontrollable life events than the rest of the population (Ross, 2000), suggesting that not only is stress difficult to overcome, but there is more of it for those of a low SES. Ongoing stress has been thought to lead to the development of depressive symptoms (Kawachi & Berkman, 2001).

One confusing aspect of this argument is that if being disadvantaged leads to depression, one would assume that the highest rates of emotional distress would be found in the poorest countries. However, contrary to this, some research suggests that distress relates to inequality rather than poverty alone (Wilkinson & Pickett, 2007). This suggests that whilst being poor alone might be a struggle, being of a low SES in a country where there is a massive SE divide between rich and poor may be even more likely to lead to the development of depression. High SES appears to relate to high levels of power, with those normally regarded as powerless in certain societies through, for example, their gender, ethnicity, and so on, being situated higher up the social hierarchy (Almeida-Filho et al., 2004). It might be considered understandable why those who are experiencing economic hardship feel resentful (Mirowsky et al., 1996) when comparing themselves to those with status and wealth.

The findings in the current review suggested that neighbourhood SES compounds the effects of individual disadvantage. Economic inactivity at a community level was associated with increased risks of depression (Fone et al., 2007) and it seems likely that whilst social comparison of individual SES can be detrimental in unequal societies, local community comparisons might have an even more pronounced impact.

Communities perceived as disadvantaged, having large amounts of disorder and being unsafe were significantly related to the development of depression (Phongsavan et al., 2006; Ross, 2000; Wen et al., 2002). Therefore, an individual of low SES who does not have the financial means to relocate to a more desirable environment may feel helpless and disempowered. However, any proposed causal pathways between these factors and depression might be two-way. For example, whilst perceiving an environment as disadvantaged may contribute to depression, being depressed may affect interactions with the social world. This process may be circular, maintaining problems.

In working professionally with those with depression, it might be beneficial to consider the individual's community environment. Interventions such as CBT, whilst having less effect in changing a person's living environment, may be able to help them challenge negative narratives about their social world as a short-term measure.

Neighbourhood connections, reciprocity and community participation were found to be associated with protection against depression (Phongsavan et al., 2006). This may be due to the empowerment that comes from being part of a group who might share similar life stressors, providing a support network (Cohen, Underwood & Gottlieb, 2000). In low SES neighbourhoods where there is likely to be more disorder (Ross, 2000), it may be harder to develop these social connections.

It is important to note that Wen et al., (2006) found that social support and social networks did not mediate the association between perceived neighbourhood quality and well-being, contradicting the findings of Phongsavan et al., (2006) discussed above. This was a surprising finding and could suggest that 'social support' as a term might be broad, needing further unpacking. Future research might ask if individual variables within this 'umbrella' term are meaningful to those with low SES. One hypothesis would be that community support as a physical act is of no use if an individual does not



feel that they have a sense of community identity and belonging. This would be a useful area to consider further as it is suggested by Turner and Turner (1999) that women make more social comparisons, looking to their relationships with others to evaluate their own identity. If such relationships are impoverished in low SES neighbourhoods, this may contribute to an understanding of why more females than males present with depression. It might also be of use to question how the decline of nuclear and extended family structures is associated with mental health.

Factors such as instrumentalism, self-esteem, mastery and emotional reliance were all found to be significantly associated with well-being, with SES being a mediating factor (Lever et al., 2005; Mirowsky et al., 1996; Turner & Turner, 1999; Turner et al., 1999). It is suggested that those with a low SES tend to avoid problems, believing that there is little that they can do to change them. With less SE resources available to problem-solve, it is possible to see why this might be the case. These findings have implications for professionals who promote self-help techniques. Perhaps the first step in facilitating change might be empowering the individual.

Lever et al., (2005) provided a structural model as to how SES might impact on cognitive appraisal and this suggests the complex nature by which our social worlds shape our feelings of well-being. As perceptual factors feature strongly in the findings, it might be necessary to reflect on the subjectivity of experience, with each individual seeming to make sense of their worlds differently. This may be another area which needs further research.

To summarise, individual SES factors such as income and education often play a part in determining the neighbourhood that an individual is placed in. Neighbourhood SES appears to compound individual SES and might shape evaluations of the surrounding community. These evaluations are seen to be linked to cognitive attribution

styles viewed as maladaptive to emotional well-being. There is a sense that the negative aspects of an individual's community are in some way 'internalised', shaping their sense of self.

Further research might focus on how we come to understand the self and subsequently make social comparisons and whether these processes mediate the SES-depression association. It might be interesting to consider the impact of the increased role of the media in shaping such meaning. In considering resilience, it seems that the role of social support needs to be considered further and it may also be useful to question what barriers those of low SES face in accessing this support. Qualitative studies may also help to enrich our knowledge in this field, particularly when contemplating personal experiences and how sense is made of these. Research aside, the current review concludes by suggesting that in tackling the increase in depression at a national level, there might need to be a shift in focus from the individual to more widespread social and community issues. In saying this, whilst being of use in some situations, intrapsychically directed therapies might need to be recognised as having limitations.

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**Representations of Cognitive Behavioural Therapy in Newspaper Articles post**

**Layard: A Critical Discourse Analysis**



## 1. Introduction

### *1.1 Improving Access to Psychological Therapies*

In June 2006 The London School of Economics, led by Lord Layard, released ‘The Depression Report’ (The London School of Economics, 2006), which recognised the growing number of individuals with depression and anxiety unable to access psychological support due to limited numbers of therapists within the NHS. This report recommended increased government funding, claiming that at least half of those individuals could be treated for no more than £750 sterling. Subsequent parliamentary discussions contributed to the development of a profile of psychology, communicated to the public via the media.

As a consequence of this report, the Department of Health’s *Improving Access to Psychological Therapies* (IAPT) (2008) initiative saw investment being made into developing services that offer cognitive behavioural therapy (CBT). IAPT documentation presented CBT as a short-term, cost-effective 1:1 therapy aimed at helping clients to recognise how dysfunctional thoughts and behaviour relate to negative feelings. This was CBT described in its simplest form however, and many CBT therapists argued that they work in a more sophisticated manner. UK services within Doncaster and Newham piloted the IAPT scheme and considered it effective, with 52% of individuals who had experienced symptoms for over 6 months being classed as ‘recovered’ following treatment (Clark, Layard and Smithies, 2008). Furthermore, the study claimed that around 5% more individuals entered employment after receiving CBT.

Despite promising results, further inspection suggested that there were methodological flaws within the UK pilot study. At both the Doncaster and Newham sites, attrition was high. For example, Doncaster had 4,451 individuals referred for

CBT, but only 1,270 attended at least two sessions and completed the relevant measures. There is no further information to explain why so many individuals terminated treatment, however patient characteristics were suggested as a possible reason. Furthermore, of those whose data was used in the final analysis at the Doncaster site, only 833 had been “ill” for over sixth months. A study by Kendrick et al. (2006) stated that when individuals had had depression and/or anxiety for under six months, there was no significant difference between treatment as usual by GPs and therapeutic intervention by mental health teams. This suggests that even without CBT, many of the individuals would have shown improvements.

Other concerns with the IAPT pilot study were the limited contact individuals received from services (in Doncaster this was an average of 2.6 hours, which included an introductory meeting) and the high proportion of individuals who used self-help rather than completing one-to-one therapy (in Doncaster only 2.7% received step 3 treatment). In addition, at the Newham site follow-up, although there was an increase of 1.8% in employment rates and a decrease of 1.8% in benefit receipt, there was also an increase of 3.5% in numbers receiving Statutory Sick Pay. This may have a big impact on how cost-effective the therapy is in the long term.

These methodological difficulties sparked unease in some clinicians, especially as CBT as an intervention was being suggested as a first-line treatment option, often in manualised form. Clinicians frequently view formulation of emotional difficulties as a professional strength, with each individual being treated as unique. Therefore it seemed to cause concern that person-centred approaches should be suspended, with, instead, a manualised approach being favoured that treated all individuals as alike. Furthermore, with CBT being presented as the initial treatment option, those seeking therapy were limited in treatment choice.

Within the British Psychological Society's magazine, 'The Psychologist', there was publication of an influx of letters that expressed concern about IAPT, with headings such as 'Layard's Folly' (Japp, 2007, December). One letter (Marzillier, 2006, June) referred to 'Orwellian psychotherapy', suggesting that the government was using CBT to keep employees happy and working, rather than showing consideration for human emotions and viewing difficulties as social problems that occur between the individual and their context. What was interesting about this letter was the reference to the use of such terms as 'illness', 'curing' and 'normal', suggesting that the IAPT agenda was not only pathologising emotional difficulties, but also defining, through language use, how an individual should 'be'. A further article (Jarrett, 2006, May) reported on how Lord Layard had referred to happiness being 'bottled'. This type of language might be seen to imply that emotions can be given to individuals by professionals, without them needing to engage in any active process of change.

Besides coverage in 'The Psychologist', published papers had also previously discussed the use of CBT. One questioned the use of individually-focussed approaches such as CBT to address issues that can be thought to involve social factors (Hagan & Donnison, 1999). Interestingly, Bragesjo, Clinton and Sandell (2004) found that whilst members of the public deemed CBT as more credible than psychodynamic approaches, those who had previously received therapy rated the latter as most credible, suggesting public perceptions may vary from experience. Newnes (2007) suggested that whilst those who define mental health problems and offer treatment express an aim of eradicating difficulties, they have a personal investment in there still existing a need for psychological intervention. This leads to research being marred by self-interest which is unavoidable. Newnes also suggested that the meaning of psychological difficulties is constructed between individuals and their social environment, rather than within the

individual alone. For this reason, he suggested systemic and community approaches were more suited to addressing such difficulties.

The interest in IAPT at a national level grew and newspapers began to report increasingly on psychological provision within the NHS, noting the tensions that the agenda was causing. Newspaper articles containing references to CBT soared, from seven in 1998, to 63 in 2003, and 206 in 2007. Wild (2006, August) noted how a representative of IAPT described the coverage as generally positive, though had expressed concern that CBT was being portrayed in some instances as simplistic. The effects of negative representations of psychological therapy within the press were considered of interest within the current study.

### *1.2 Health in the Media*

Howard & Bauer (2001) explored genres used in newspapers when referring to psychology. Articles were frequently polarised, depicting psychological approaches as either scientific, or mystical and superstitious. Furthermore, they found a growing number of articles featuring psychology-related celebrity ‘gossip’, illustrating the interest in popular psychology.

Roy (2008) found an emphasis in English-Canadian women’s magazines on the negative consequences of not seeking help for health difficulties. These articles featured a discourse of personal responsibility for the individual. Responsibility was suggested as a moral imperative for women, not only for themselves, but also for their families, through the construction of them as caregivers. Furthermore, analysis suggested that responsibility was equated with an entrepreneurial stance, with the female viewed as an informed consumer, through the choices they make.

Cranshaw (2007), exploring masculinity and health in men's health magazines, suggested that discourses of medicalisation and of individualisation of risk are interlinked within the articles. Again, there was a discourse of personal responsibility for managing health and this was interwoven with a discourse relating to male dominance and competence in demonstrating personal agency.

Chananie (2005) explored television advertisements for psychopharmaceutical medication, suggesting four gendered advertising strategies were used towards females: establishing medical legitimacy, suggesting individual blame, offering empowerment and using feminist rhetoric. It was felt that these strategies reinforced constructions of female inferiority. Similarly, Bilic and Georgaca (2007) proposed that articles on mental illness in Serbian newspapers featured discourse of bio-medicalisation of emotional distress, with individuals as passive sufferers, dependent on psychiatrists. This suggested dependency is a contrast to the findings mentioned above, which suggest that the media often place health maintenance as the responsibility of the individual.

Some studies found that language within the media used diagnosis and behaviour to construct personal identity. Coyle and MacWhannell (2002), exploring the social construction of morality in newspapers, suggested that accounts of suicide explained such behaviour through dysfunction, deviancy and moral weakness. This not only constructs distress as something internally arising, but also implies that those who are suicidal are inadequate, constructing 'normal' individuals as emotionally stable.

Paterson (2007) examined newspaper representations of mental illness and found that parallels were drawn between mental illness and societal threat, positioning mental health as a social problem. Moreover, the public could be seen to be depicted as innocent victims, with the government failing to protect. Byrne's (2003) review of psychiatry in the media referred to negative representations of those with a psychiatric

diagnosis. This was supported by Lawrie (2000) who suggested that those with diagnoses were viewed as ‘bad patients’. Another study found depersonalisation to be common, with individuals being referenced through their diagnosis, e.g. ‘a schizophrenic’ (Penn & Nowlin-Drummond, 2001) which might reduce public empathy. Bilic and Georgaca (2007), in the previously referred to study, found a discourse of dangerousness surrounding individuals with mental health difficulties.

Finally, one study explored media coverage of NHS ‘rationing’, finding that articles diverged thematically, either being centred on patient help-seeking perspectives or presenting tensions between patient needs and funding objectives (Burgoyne, 1997). To summarise, previous research revealed a contrasting of individual responsibility with dependence on medical professionals. It identified discourse relating to gender construction and related emotional stability to moral worth. Research differs on whether mental illness is constructed as an individual or societal problem, however individuals experiencing it have, on occasions, been depersonalised and considered dangerous to the public. Some articles have considered how individual need can be met within funding restraints.

### *1.3 The Use of Language to Construct Meaning*

The above studies are useful in considering how the media shapes meaning through language use, influencing how the public understands health and illness. Foucault’s (1967; 1973; 1977; 1980) influential work suggested that throughout history dominant discourses have evolved, particularly within institutional settings. Through these discourses power is distributed, with some becoming subjugated. Foucault also discussed the notion of truth, relating this to claims made by those who specialise in ‘scientific’ approaches. He suggested that proposed ‘knowledge’ (through truth claims)

was equated with power, and that consequently all disciplines operated through self-legitimising channels. For example, not only does the medical profession define mental illness, but they also then offer treatments which supposedly remove symptoms, therefore reinforcing the existence of mental illness.

Foucault's belief that language shapes meaning suggests that discourses surrounding mental illness are important in defining social understandings of 'normality' and 'wellness' and also play a role in constructing power within society. Therefore it seems not only interesting to consider discourses relating to psychological difficulties and their treatment within the media, but also to question which may be subjugated or absent.

#### *1.4 Study Aims*

With IAPT being so prevalent in newspapers over recent years, the current study used critical discourse analysis to explore some of these articles discussing CBT. The aim of the study was to attempt to develop an understanding of the current preoccupation with IAPT and specifically CBT, considering the faith invested in it by some, the unease expressed towards it by others, and opening up possibilities for responding to it in alternative ways. For this reason, the main research question was: How do newspaper articles, post Layard, represent CBT?

## 2. Method

### *2.1 Critical Discourse Analysis*

Van Dijk (1997) noted that discourse analysis, rather than being a fixed method, covered a range of approaches that can be applied when studying the use of language. Previous approaches have considered both the structure of language, including how forms vary within and between texts (Fairclough, 2003), and the function of language, viewing its use as a form of social action (Brown and Yule, 1983).

Critical discourse analysis (CDA), whilst often giving consideration to structure, predominantly focuses on the function of language, aiming to relate the study of this to the study of society more generally. There is frequently a focus on the relationship between discourse and power (Wodak, in Wodak & Meyer, 2001) and analyses often consider how discourse produces and maintains social inequalities (Mayr, 2008). In this respect, those using it may aim to emancipate and consequently, the researcher is advised to make their stance explicit, promoting transparency in approach (Van Dijk, 1993).

### *2.2 Suitability of Methodological Choice*

Considering the above description of CDA, it seemed an appropriate methodology to use in the current study. Language *use* in descriptions of CBT was of interest - it was not merely what the text says, but *how* it is said and what this *does* that was of concern. The study also questioned whether arising discourse might parallel that found in wider social practices. There was acknowledgement that the topic of the study involved a political agenda and a government body (the NHS). As Foucault (1967; 1973) suggested, much institutional language shapes power and therefore this further suggested CDA, with its aim to reveal marginalised discourses through analysis, as



being an effective method. Finally, the current study adopted a social constructionist epistemology (see Appendix G for further explanation of epistemological position). Given CDA's perspective of language as the site at which meaning is constructed, this methodology again appeared to be an appropriate choice.

### *2.3 Ethical Considerations*

As the study did not involve the recruitment of participants, ethical concerns were minimal. However, as the articles used were in the public domain, ethical approval was obtained from the University of Leicester (see Appendix H).

### *2.4 Overview of Research Design*

The approach to CDA adopted within the current study was based on the work of Richardson (2007), who drew upon Fairclough's (1995) approach and used it specifically to analyse newspaper articles. Titscher, Meyer, Wodak and Vetter (2000) discussed the three-dimensional nature that Fairclough attributed to discursive events. Richardson, using this three-dimensional approach, recommended that analysis begins at a textual (linguistic) level, proceeds to consider discursive practices and then finally focuses on consideration of the relationship that discourse might have with wider social practices.

### *2.5 Sample*

Eleven newspaper articles (see Appendix I) were drawn from UK national newspapers between 1<sup>st</sup> June 2006 (when Layard's 'Depression Report' was released) and 31<sup>st</sup> May 2008 (two years later and around the time that funding for IAPT workers

was being commissioned to NHS trusts). This period of time saw the NHS remodelling psychological provision as a result of the IAPT agenda.

Careful consideration was given to analysis of a sample of newspaper articles. The researcher did not speculate as to the meaning for the reader and so for this reason, there was less concern that the sample needed to be in some way ‘representative’ of public readership. However, it did make sense that the sample was located as centrally within the public eye as possible, so that the findings, if only suggested interpretations, could be considered transferable when thinking about health-related public messages. Newspapers are read by individuals from a range of backgrounds and it seems likely that even those who were not interested in psychological therapy might have viewed articles on CBT within newspapers, due to the variety of content.

This choice was supported by research literature. Bilic and Georgaca (2007) stated that the media was the primary source of information for the public on mental health issues. Howard and Bauer’s (2001) study suggested that the coverage of psychological issues within newspapers was growing in intensity over time. A search of UK national newspapers for the inclusion of references to CBT in the time span mentioned above revealed 619 articles – at least one every two days on average.

The articles were acquired through the internet search engine ‘Nexis UK’ which held articles from all UK national newspapers. An initial scoping search found that, despite the large number of articles available relating to CBT, few contained the phrase ‘Improving Access To Psychological Therapies’ or ‘IAPT’, despite that being what many of the articles related to. Therefore, in order to find articles relevant for analysis, the keywords ‘Cognitive behavioural therapy’ OR ‘Cognitive behaviour therapy’ OR ‘CBT’ were used as search criteria. The option to find only articles with the keywords ‘at the start of the article’ was selected, ensuring CBT was the main focus of the article.

The keyword 'NHS' was added to ensure that articles were related to public service provision and therefore were likely to discuss the IAPT agenda. This felt particularly relevant as 'IAPT' as a search term had been omitted. Using these criteria, eleven articles remained for analysis, once book reviews and duplicate articles were removed.

## *2.6 Analysis*

Analysis used Richardson's (2007) three-stage model, explained above, as a guide. Stages are detailed below, with tables included to give examples. Although Richardson described these levels of analysis in a systematic way, the present researcher moved between them in a flexible, circular fashion.

### *2.6.1 Textual analysis.*

Textual analysis involved exploration of linguistic structuring, combination and sequencing. Each article was read through initially and then studied word by word. Initial points of interest were highlighted in the margins and then full analysis documented in a research log book. The selection and meaning of each word was considered, with attention being paid to nouns, verbs and adjectives that appeared to be unusual, spark interest or convey particular meaning. These words were considered in relation to those words in the rest of the article, with contrasts being noted.

Next, the way in which the actors were referred to and described was explored. Following this, the manner in which sentences were structured to convey meaning was considered. In particular, consideration was given to the relationships between actors, and the roles they assumed in the processes detailed. Modality (whether suggestions of belief or truth were attached) was considered throughout. The final stages of textual analysis involved identifying presuppositions, metaphor and narrative.

Examples of textual analysis	Excerpt from newspaper article
<p><b><u>Selection and combining of words:</u></b>  Words relating to CBT: 'mass scale', 'cultural revolution', 'taught', 'deny', 'symptoms' - <i>Hard-hitting, shocking.</i></p> <p>Words relating to individuals: 'separated', 'loved ones', 'witnessed', 'murder', 'legitimacy' - <i>Emotive, passive.</i></p> <p>Words relating to depression: 'just', 'outcome', 'false beliefs' - <i>factual, ordinary.</i></p>	<p>CBT-style therapies were last used on a mass scale in China in the cultural revolution. Separated from loved ones - having perhaps witnessed their murder - people were taught to deny the legitimacy of their symptoms: depression was just the outcome of false beliefs.</p>
<p><b><u>Sentence structuring:</u></b>  'CBT' is 'used on': suggests CBT as something tangible which can act on something else.</p> <p>'China' 'cultural revolution' - this is often viewed as an inhumane period. This is then aligned with CBT.</p> <p>'deny' 'legitimacy' 'false' - this implies experiences are authentic/normal, but that CBT refutes this.</p> <p>'depression' 'just' - this denies the importance of beliefs in relation to 'witnessed' 'murder'.</p>	
<p><b><u>Modality:</u></b>  'were' 'was' – these are statements of 'fact'.</p>	
<p><b><u>Presupposition:</u></b>  Presumes there <i>was</i> a 'cultural revolution' and that this involved people being separation from loved ones. Also presumes that it <i>was</i> these people who received CBT-style therapy and that they <i>could</i> be taught to deny their symptoms.</p>	

Table 1: Example of textual analysis

### 2.6.2 The analysis of discursive practices.

The second level of analysis is concerned less with the linguistic elements of the text, but questions what its construction as a whole *does*. In order to complete this stage,

arising discourses were noted throughout the text and described. 'Discourse' is understood to be the way in which language is used to construct meaning through its production. As an illustrative example, in constructing mental health problems as a medical condition, medication options are opened up, whilst social care options are closed down. Medicalised discourse marginalises psychosocial approach-related discourse, privileging medical actions whilst reducing treatment choice.

During this stage of analysis, consideration was given to where there were shifts in language use both within and between articles. For example, if scientific, diagnostic terminology was used when discussing CBT therapists and then language became more informal and common-place when CBT-users were mentioned, this was noted. Particular attention was also paid to shifts in agent and recipient. For instance, analysis considered whether CBT-users were described as actively doing something in one section, then passively receiving something in another.

Examples of discursive practice analysis	Excerpt from newspaper article
<p><b><u>The construction of CBT:</u></b> CBT is constructed as systematic, practical and sensible, suggesting a discourse of 'reason'.</p> <p>This is aligned with a discourse of 'modern fashionability' through its difference to 'classic' therapies and due to the governments current interest in it.</p>	<p>This very practical, proactive approach is rather different from the classic modes of therapy, which one CBT convert describes as "frustratingly fluffy and meaningless" and "encouraging you to feel you are not responsible for your own personal wellbeing".</p>
<p><b><u>Discourse of therapeutic empowerment:</u></b> CBT is suggested to be 'different' from therapies that remove personal responsibility and is therefore suggested to empower.</p>	

<p><b><u>The construction of other therapies:</u></b> Other 'classic' therapies are <i>not</i> CBT. Polarisation occurs, with them being constructed as opposite to CBT - not modern, not sensible, not empowering. Traditional therapies are consequently marginalised, appearing outdated and unpopular.</p>	<p>Getting people to talk about their problems in a logical, meaningful way is not rocket science, but it is this sort of therapy that the government, with the help of its "happiness guru", economist</p>
<p><b><u>Discourse of professional power:</u></b> The government and Layard 'make' CBT 'available', suggesting a discourse of professional power and responsibility. This is reinforced by words such as 'guru' and 'Professor'. This discourse is supported by accounts of those who are mentally ill who 'convert' to CBT and 'receive' benefits due to their difficulties.</p>	<p>Professor Richard Layard, wants to ramp up and make available for the one million people receiving incapacity benefit in Britain because of mental illness.</p>

*Table 2: Example of analysis of discursive practices*

### *2.6.3 The consideration of wider social practices.*

The final stage of analysis related the discourses found within the text to wider social practices. Here there was an understanding that the dominant discourses that emerge within newspaper articles might parallel those that have historically shaped society. A particular focus during this stage was an exploration of whether power differences were constructed through the text and whether any marginalisation mirrored wider social action.

To guide a discussion of the analysis findings, wider socio-historical literature was considered to see if discourses arising within the study paralleled those previously documented. Whilst up until this point analysis stayed as close to the text as possible, this stage required stepping away from the articles, reading more widely and considering the findings more broadly. This often prompted the return to previous stages of analysis. For example, if dominant discourses were identified and then found within wider literature, that literature might influence a re-appraisal of the original

articles, creating new meaning. This is where the circular nature of CDA was realised and therefore whilst the ‘results’ and ‘discussion’ sections below are written separately, they represent a fluid process whereby the articles were analysed, reflected on and revisited several times.

Examples of the consideration of wider social practices	Excerpt from newspaper article
<p><b><u>Social practices relating to discourses of medicalisation:</u></b></p> <p>Discourse of medicalisation might reduce opportunities for those who are diagnosed with mentally illness to take control over treatment choices. Professional power subjugates such individuals. Problems might also be understood as originating within the individual. This might be seen at a wider social level within organisations such as the NHS who provide diagnoses and treatment.</p>	<p>CBT can be used to help anyone whose behaviour is negatively influenced by their thoughts, assumptions and beliefs. Therapists often use it to treat depression, eating disorders, obsessive-compulsive disorder, drug and alcohol addiction, panic attacks, phobias and bereavement.</p>
<p><b><u>Wider reading relating to discourses of medicalisation:</u></b></p> <p>Diagnosis and medicalised language pathologise emotional distress. Consequently professionals are placed in a position of power through offering treatment (Bentall, 2003; Newnes, Homes &amp; Dunn, 1999, etc).</p>	<p>It is not widely used to treat more severe psychiatric disorders, and those who feel a desire to explore the impact of childhood events on current behaviour should try psychoanalysis.</p>

*Table 3: Example of the consideration of wider social practices*

## 2.7 Ensuring Quality Control

It was felt that in order for the study to be deemed transferable and show rigour, several steps needed to be taken. Stiles (1993) recommended that the researcher’s orientation be made explicit to aid transparency. Alongside the previously mentioned statement of epistemological position, Appendix J gives an account of research expectations, written prior to beginning the study. Furthermore, the included critical

appraisal section provides reflections on the research following completion. It is believed that qualitative findings are not generalisable, with the researcher owning the individuality of the results through recognising that the context of analysis is unique. For this reason, accounts of orientation aim to provide the reader with an indication of the personal meaning the researcher inferred from the study.

Meyrick (2006) recommended that the methodological journey be made explicit. Whilst the approach taken has been described above, there was also an understanding that the *process* of carrying out the research was relevant. For this reason a diary was kept, giving an account of the researcher's thoughts and feelings throughout, especially during times when decisions were made. This assisted reflexivity, with the acknowledgment that researcher involvement inherently influences analysis. This diary was used within supervision to prompt reflection and was also drawn upon in the writing of the critical appraisal section. Several diary entries and the action they prompted are recorded in the Table 4 below.

Stage of research	Extract from research diary	Actions prompted
Planning	'I read some more articles today discussing IAPT. It seems to have really stirred up people's emotions. I'm a little concerned that my own strong feelings towards it will influence how I do this research. I don't want this to be just another rant about CBT like I've read so many times before. I want it to be a genuinely good bit of work that can help people think more about the way IAPT's presented.'	This was reflected upon within supervision and a statement of research expectations written. The guidelines for quality control in qualitative research were reviewed. The decision was made to stay as close to the text as possible, being open about findings that did not reflect personal opinions. An agreement was made for the researcher to be questioned within supervision about their interpretations and how they accounted for them.
Analysis	'I was a little bit disappointed that having found lots of examples of	Following discussion in supervision, the articles were



	<p>individuals with mental health problems being extremely passive, I found an example today of someone who seemed quite able, although still used CBT. I was really hoping I'd found a pattern in the articles. In my supervision meeting though we talked about this and I mentioned that the 'deviant' example was about a man. I'd not really realised that the other examples I'd focussed on were all about women before. I think I need to have a better look at gender in these articles and see if there are any other differences.'</p>	<p>revisited, considering gender. A pattern relating to this had been previously missed and this led to an additional finding being made. Initial findings regarding passivity were then reconsidered.</p>
Interpretation of results	<p>'I had supervision today. I got questioned about paying particular attention to female inadequacy in my draft 'discussion'. There was a sense that I'd run away with myself due to being a woman and had moved too far away from the text, putting my own biases into my work. This is probably the case if I'm honest because I feel angry about how women have been portrayed. I went back to my results though and realised that I'd completely played down the stuff about 'ill' men being constructed as weaker than 'normal' men. I think there's definitely more work to be done on writing this into my discussion to that it's a good reflection of the articles and not just me putting my biases out there. '</p>	<p>Following discussion in supervision, the findings were reconsidered in a reflexive manner. Trying to be aware of personal beliefs and biases, the discussion was re-drafted.</p>
Write-up	<p>'I read through my draft-write up today. It's such a shame that I have a word limit!! Cutting words is a nightmare. There are so many other things I'd like to say if I had chance to. I was talking today about the discourse of consumerism which I've not really gone into in too much depth. In some ways I feel used to the NHS being thought of in business</p>	<p>This contributed to the writing of the critical appraisal.</p>

	terms, but I know for some people who've known it for more years than me, it must be really hard to see it change so much. I really like the stuff I've written about psychoanalysis. It's funny how my friends seem to be really wary of psychoanalysis, but they use the terms in so much of what they say. It shows how it's really got ingrained in everything we say.'	
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*Table 4: Excerpts from research diary*

Madill, Jordan and Shirley (2000) discussed internal coherence. Whilst noting that complete coherence might be impossible due to the variety of contradictory discourses drawn upon in language, they stated that obvious contradictions should be avoided. The current study attempted to support findings through the presentation of multiple, layered examples, illustrating any opposing cases. Similarly, the study was open in suggesting whether findings supported or contradicted previous research literature.

One further level of quality control came from having two research supervisors. Whilst one assisted with study planning and analysis, the other began supervision around the time of interpretation and write-up. This second supervisor, as a consequence of being an outsider to the analysis process, was able to question accountability for findings, encouraging further reflection.

### 3. Results

#### *3.1 CBT and the Construction of Female Identity*

Mentally unwell females and males are constructed notably differently within the text. Accounts of females suitable for receiving CBT reveal interesting patterns in word choice. One article describes women ‘going through boyfriend hell, a job crisis, or even a plain old attack of the blues’ (Article 3, lines 9-10) . The words ‘hell’, ‘crisis’ and ‘attack’ are powerful, attention-grabbing and give importance to the scenario being described, but seem at odds with ‘boyfriend’, ‘plain old’ and ‘blues’ which appear colloquial and less dramatic. The use of such contrasts implies these stronger words are hyperbole and gives an impression of female exaggeration. The use of ‘boyfriend’ over, for example, ‘partner’ or ‘relationship’, and the use of ‘job’ over ‘career’ or ‘profession’ might also suggest female immaturity. A further example describes how a woman ‘fell into a deep depression after a blind date she had high hopes for turned into what she termed “a disaster”’ (lines 69-71).

Another article begins by giving a casual, light-hearted account of a CBT-users nicknames - “‘Fat Sharon”, inspired by Pauline Quirke’s character in *Birds of a Feather*, and the more self-explanatory “Womble” (Article 11, lines 10-11). This is then contrasted with her ‘long struggle’ with bulimia, characterised by her tendency to ‘trigger the vomiting reflex’, causing ‘chronic blisters’ (lines 15-16). Such a contrast suggests over-reaction and exaggeration through such an extreme response to the situation.

One article contrasts diagnostic labels such as ‘panic attacks, agoraphobia...and claustrophobia’ (Article 9, lines 30-31), with real-life examples including ‘she ran out of petrol’, ‘panicked she couldn’t find her way home’, ‘the police found her...sobbing’

and ‘she felt ‘trapped’ inside. But if she went into the garden it seemed too big - she feared she would ‘disappear into the hugeness of the sky’ (lines 32-35).

Similarly, another article initially uses medicalised language such as ‘seizure’, ‘frontal-lobe epilepsy’, and ‘a brain disorder’ (Article 11, lines 90-91). Once the psychological nature of the condition is recognised, the language becomes more informal and somewhat mystical. The female describes ‘fits that would put her in a trance’ (line 90), requiring her to ‘channel my energy’ (line 100). She explains how ‘One thing I discovered that sets off my seizures is...the cord of a telephone. If I stared at it for too long, I’d have a seizure’ (lines 97-99). Here, the contrast of a suggested brain disorder with a trance caused by prolonged staring at a telephone cord implies a level of exaggeration. The perceived seriousness of the difficulties consequently seems irrational. Through the use of such techniques, it could be perceived that female users of CBT over-react, lack common-sense, and are emotionally unstable.

Considering referential strategies, attention is paid to status in several instances. One article refers to ‘Sylvia’ as a ‘marketing manager’ (Article 3, line 35). Here, the job title gives meaning – that of an individual expected to show responsibility and communicate with others confidently. However, the article goes on to mention Sylvia ‘arriving later and later for work’ and if ‘asked to make a presentation in a meeting’ would ‘phone in sick’ or else ‘talk nonsense’ (lines 36-38). This suggests an inability to fulfil her professional role and the addition of ‘I was forced to speak in meetings where my boss was present’ (lines 37-38) implies a lack of power. Again, one could interpret this as implicitly suggesting that women who need CBT lack responsibility and competence.

The article then describes how CBT helped ‘Sylvia’ to realise “‘My boss might be disappointed when I don’t bring in new business, but will understand”” (lines 55-56)

and that he is “sometimes very demanding, but I know I can cope” (lines 61-62). Although ‘Sylvia’ feels better through CBT, she is still constructed as not being fully able, with a sense of her ‘playing’ at being able to meet professional requirements.

Later, ‘Jill, a fortysomething television producer’ (line 69) is introduced. Again, this reference suggests someone of reasonable intelligence and social skills, yet the article describes her having an ‘inability to form successful relationships’ and says she has ‘stopped making the effort to meet new people’ (lines 71-72). Whilst it is suggested that CBT helped her to realise self-worth doesn’t come from a relationship and that she will be alright alone, she explains “I started a new relationship soon afterwards” (line 77). This suggests although she claims to be empowered, as in the example above, she is only ‘playing’ at being in control and is ultimately dependent on having a partner.

Another article describes ‘Mrs B, 32, a mother of three’ (Article 9, line 30). Whilst emphasising her role as a carer, the article tells of how ‘Living far away from her original family, with a husband who worked long hours and three small children to care for, she had few close friends’, experienced ‘isolation’ and ‘feelings of abandonment’ (lines 85-88). This, again, suggests an inability to fulfil responsibilities due to emotional distress. There also appears to be a presupposed meaning that her emotional security and ability to maintain her role is dependent on her husbands’ presence. This might suggest that women cannot be emotionally stable when alone.

### *3.2 CBT and the Construction of Male Identity*

Whilst most articles describe female case studies, with one article even stating that ‘CBT can be particularly effective at tackling women’s self-esteem issues’ (Article 3, lines 78-79), there are several examples given of males appropriate for receiving CBT. Although women are repeatedly constructed as emotional unstable, exaggerating and lacking common-sense, males are constructed differently.

One article describes the case of a depressed and suicidal man is discussed, introduced through the sentence ‘The folly of sidelining this condition within the NHS has been brought home to us in a particularly tragic fashion by the bleak situation of John Hogan’ (Article 10, lines 22-24). This is a notably different introduction than those in female cases. The reader is reminded it is a ‘folly’ for the NHS to dismiss depression as unimportant, later describing this as ‘inhumanity’ (line 31). Here, responsibility shifts from the individual (as in female cases), to the system he is within. This is re-emphasised as the article states ‘his behaviour was entirely at odds with his normal loving regard’ and ‘it was because of his condition’ (lines 27-29). Whilst female examples appear to internalise difficulties, this male example externalises the ‘condition’ from the individual. The text also recognises that there has been a shift from the individual's *normal* behaviour to that shown as a result of mental health difficulties, recognising his inherent competence to be a caring father and husband, but noting how this has been suppressed through his emotional problems.

Similarly, an account of a man with schizophrenia explains his difficulties within the ‘context of his relationships’ (Article 11, line 188) and the reader is reminded that they are ‘not just “all in the mind”’ (lines 174-175). Again, a tragic picture emerges as he is described as ‘distressed’ (line 182) and ‘acutely troubled’ (line 180), with the text using very different language to the exaggerated accounts of women. Interestingly, whilst stating that ‘CBT was able to help him’, there is a description of how ‘he didn’t want to take drugs in the long term’ and how his therapist worked alongside him to review ‘how he was making sense of his experiences’ (lines 183-185). This suggests that whilst CBT was useful, he already showed some rationality himself.

Another article describes a male client who received CBT. ‘Will’ is introduced as a ‘workaholic property millionaire’ (Article 9, line 57) who became depressed after

‘losing a small fortune (since regained)’ (line 59). The reference to him being a ‘workaholic’ suggests he shows effort and commitment in his career. This might be a way of justifying his ‘millionaire’ status, with professional competence being implicitly suggested. The addition of ‘(since regained)’ also supports this. Becoming depressed after ‘losing a small fortune’ seems perhaps more socially acceptable than those reasons given in female accounts. There is also a suggestion of initial competence being masked through the development of emotional difficulties.

The account of ‘Will’ trying to ‘prevent myself sitting on negative thoughts’ and ‘remain active’ (line 61) following CBT suggests he used the techniques in an intelligent, pro-active manner, using self-agency and common-sense. Interestingly, the article adds that ‘It could be argued that this is good for him, except that he is involved in a constant struggle to control his thoughts, with depression always just around the corner’ (lines 63-64). Depression appears externalised here, with the individual victimised despite attempts to use his skills to resist.

It is implied that despite ‘Will’s’ sensibility, CBT was ineffective due to the externalised nature of his problems. This contrasts with female accounts, where difficulties appear to be internalised, relating to a lack of implicit common-sense, which CBT is helpful in combating. For men, whilst mental illness leaves them as ‘victims’, there is an impression of unfairness, evoking sympathy. This is absent in female accounts.

One final account of a man involves the phrases ‘CBT could make a huge difference’, ‘he will cope just fine’, ‘NHS staff are used to dealing with all kinds of additional problems’ and that he ‘certainly won’t be unique’(Article 2, lines 11-13). These appear to normalise his experiences, with a straightforward, simple solution being

proposed. There is again a suggestion here that the individual already has the in-built competence to regulate his emotional state, but that CBT could increase this.

Modality is interesting in this article, as whilst female accounts use phrases such as ‘you need CBT’ (Article 3, lines 7-8) suggesting it is essential for recovery, this piece says CBT ‘*could* make a huge difference’ before reassuring the individual that they are ‘sure’ things will be alright anyway (Article 2, lines 11-12) suggesting less dependency.

To summarise, throughout the text, males are discussed differently to females. Male mental health problems tend to be externalised, rather than internalised as in female examples. Whilst it is implied that women lack common-sense and exaggerate, leaving them unable to deal with responsibility, men are seen to possess inherent competence and ability, but surrender some of their skills when becoming the unfortunate victims of mental health problems. Whilst CBT is presented as a must-have for women, it is suggested to be a beneficial helper for men, but is often ineffective when dealing with externally-located problems.

### *3.3 ‘It could even combat infertility’ ..... CBT: A Potent Force*

CBT’s potency is recognised throughout. Not only is it constructed as contemporary, but also glamorous, sexy and in vogue. Articles state that CBT ‘undoubtedly appeals to our modern consumer instincts’ (Article 11, lines 30-31), is warranted as ‘the public want less pharmacology and more talk’ (Article 6, line 50) and is the ‘flagship product’ of ‘former dot-com darling’ Ultrasis (Article 7, lines 8-9), making it appear current and in-demand.

CBT’s trendiness and potency is paralleled with a discourse of female empowerment. One article describes how ‘Back in the dark ages....she would take herself off to the nearest psychoanalyst’s couch, lie back and sob about her mother’,



whereas now this scenario is ‘consigned to obscurity’(Article 3, lines 12-13) and that ‘In a world where everything...is delivered in double-quick time’, CBT has a ‘definite allure’ (Article 11, lines 32-33). Such statements suggest a development in therapeutic approaches over time, with the newly-found CBT offering women the chance to be modern consumers. The discourse implies a social transition for females – although historically, they may have been viewed as unequal in certain contexts, this ‘new age’ of CBT brings power and independence.

There is also the suggestion of CBT indicating a scientific revolution. Accounts of ‘traditional psychotherapy’ are challenged with descriptions of a much improved, modern-day society, marked by CBT. One article states that ‘The somewhat jaw-dropping speed at which CBT reaps results is, of course, particularly appealing in today’s fast-moving society, and marks a real cultural shift in the way mental health is treated’ (Article 11, lines 101-103) Whilst the article mentions CBT being ‘largely ignored until 10 years ago’ (lines 21-22), it adds that it has now been ‘rigorously scientifically tested’ (line 23) and that in ‘the most astonishing study yet, scientists ....suggested that it could even combat infertility’ (line 25-27). Here, CBT’s potency is exaggerated to its fullest.

Whilst some articles criticise CBT, there is no doubt that its power is still recognised. One article describes how CBT, ‘A therapy last used on a mass scale in China’s cultural revolution is to be unleashed on the NHS’ (Article 4, lines 3-4), and how ‘Separated from loved ones – having perhaps witnessed their murder – people were taught to deny the legitimacy of their symptoms’ (lines 40-42). Whilst in some articles, CBT's modernity is praised, here it is linked to a movement deemed by some to be abusive and inhumane. The suggestion that CBT shapes socio-cultural standards is strong.

Similarly, cultural references are made in another article, which states ‘CBT doesn’t work because it’s un-British’ and that ‘living in a rose-tinted bubble of positive illusions’ is an ‘American glass-half-full philosophy’ (Article 9, lines 109-112). Here, the suggestion of British culture evolving into that of the USA is punctuated with stereotypes of Americans such as ‘unrealistically optimistic’ (line 113) and having ‘falsely bloated self-esteem’ (line 116). Likewise, another article describes a debate entitled “‘CBT is the new Coca-Cola’”, suggesting it is “‘superficially appealing but overmarketed and has few beneficial ingredients’” (Article 11, lines 114-116).

The comparison of therapeutic progression with the development of a commercialistic society appears to polarise, with articles seeming to support or oppose this. One article further expresses this tension by stating that ‘In this new dark age, a century of sociology, anthropology, and history and philosophy of science has been ignored’ (Article 4, lines 38-39), suggesting that through the increasing focus on CBT as a cost-effective quick-fix, past achievements in related fields have been forgotten and devalued.

### *3.4 CBT and User Passivity*

One newspaper describes how it has ‘campaigned over the past four years for mental illness to be treated with greater humanity and effectiveness’ (Article 10, lines 13-14). Individuals experiencing mental health difficulties are depersonalised here and the newspaper's responsibility for campaigning suggests passivity.

Another article describes how one girl feels CBT has ‘come too late’, adding that her ‘problems were left undiagnosed and untreated for too long’ (Article 11, line 140). Here, the individual is constructed as dependent on others for treatment. A further example explains how ‘Some patients have to wait for two years for access to a

therapist – if they get on the waiting list’ (Article 10, lines 42-43). Such references to dependence on professionals position the individual as unequal and unable to take control of their wellbeing. Frequent dual constructions of individual responsibility for illness development, alongside dependence on others for treatment, create a vision of helplessness for mentally unwell individuals.

Whilst descriptions of mental health difficulties focus on the role of individual weaknesses in illness development, this is not the case within accounts that discuss those professionals who develop, promote and offer CBT. The previously mentioned example of ‘scientists’ using CBT to ‘combat infertility’ (Article 11, lines 25-27) suggests this type of therapy is suited to the treatment of biological problems, which the individual cannot control. This is supported by another article which discusses treatments for ‘cancer’ (Article 5, line 8) or a ‘heart attack’ (line 12), before adding that the ‘Trust developed a cognitive behavioural therapy treatment’, ‘now used in the NHS’ (lines 13-14). This removes the individual as an active agent, objectifying CBT as if it were medication created by professionals to treat a problem. By constructing mental health difficulties as tangible, they can be located and acted upon. Through removing the individual as an agent, there is a suggestion that treatment can occur without them being actively involved, similar to a surgical procedure. In doing this, professionals are constructed as powerful.

One further example comes in the aforementioned account of an individual with schizophrenia. The article tells of how schizophrenia, which ‘most people now accept, is a brain disease, can be ameliorated by...CBT’ (Article 11, lines 175-176). Here, in stating it ‘is’ a brain disease, uncertainty is removed and the claim appears factual. Later, the account states “‘he couldn’t change the way he felt...CBT was able to help him...’” (lines 183-184). Again, this suggests those with mental health problems are

passive in making change, being acted upon by their 'illness' and given medical explanations of distress by professionals.

One key finding, is that different forms of 'passivity' appear to arise within the articles. Whilst females are suggested to be 'done to' via CBT in an extremely passive manner, this account of a male with schizophrenia uses the word 'help' and might suggest that whilst CBT *is* active in its own way, changing something inside men, they still have some underlying capabilities themselves and use CBT as an 'assistant' to boost their recovery.

### *3.5 The Personification of CBT*

Despite many articles contrasting client passivity with the relative power of the medical profession, CBT's potency in its own right is not forgotten. The use of transitive actions (describing an agent acting upon an object) within the text suggest CBT 'did' something to the individual, rather than therapy prompting a process of change for the individual which they control.

The therapist as 'agent' is often deleted and replaced by CBT itself. For example, one article says that 'CBT does not dwell' (Article 3, line 25) and that CBT 'gave me back a lot of power and, ultimately, gave me permission not to be so hard on myself' (lines 76-77). Furthermore, describing relational processes over material ones gives CBT agency; for example 'CBT has been around since the 1960s' is chosen over a description of how *therapists have used a technique* referred to as CBT.

### *3.6 Getting Real through CBT*

One article asks ‘Why is everyone talking about CBT?’ (Article 3, line 19) Here the presupposed meaning is that everyone *is* talking about CBT and consequently an implicit invitation is offered to the reader, initially positioned as an outsider, to join the ‘insiders’ described as ‘in the know’ (line 13). Notably, in using the phrase ‘in the know’, the text suggests that being party to certain knowledge naturally results in a choice to receive CBT. Here, there is implied truth, with the suggestion that as a ‘fact’, CBT would be classed as the preferred treatment. This is supported by text relating to the scientific evidence base of CBT.

As well as CBT being seen as scientific, there is a sense that this well-researched, systematic approach is related to common-sense thinking – a ‘get real’, back to basics approach. One article states how discussing problems ‘in a logical, meaningful way is not rocket science’ (Article 11, line 61) and that it can be done by ‘anyone, in fact, who decides they want to practise CBT’ (line 43). CBT is constructed as a reasonably simplistic and straightforward approach, with examples of how for women, ‘CBT has taught me how to concentrate on just one tiny detail of the [telephone] cord, rather than the whole thing’ (line 99-100), whilst recognising that thoughts of being ‘ugly and fat’ came from eating a ‘whole loaf of bread’ (lines 55-56). This suggests CBT uses commonsensical methods, which are paralleled with science, to address female exaggeration and irrationality.

This said, the suggestion that women might come to rely on such approaches, reinforces the view that their difficulties stem from them being irrational and lacking sensibility. Phrases such as ‘It’s like going back to school’ (Article 11, line 96), ‘I feel that I now have the tools to draw on’ (line 156) and ‘it gave me back a lot of power’ (Article 3, line 76) support the suggestion that women need CBT to function in an

emotionally stable manner. Therefore, whilst explicitly CBT is suggested as empowering, the dependence of individuals on it implicitly disempowers, reinforcing passivity.

Interestingly, the difference in accounts of common-sense, rationality and emotional stability between males and females imply women are inadequate and need CBT to provide them with the competence that men already possess. Alternatively, men are suggested to have a straightforward, 'get real' approach to difficulties, but this is temporarily weakened through the onset of mental health difficulties and CBT is used to help strengthen these skills.

Notably, whilst pro-CBT articles suggest a sense of realness to the therapy – it is current, evidence-based, rational – those articles critical of CBT suggest the opposite. One article, discussing CBT's evidence-base states 'Each person's experience will be unique, and no real patients will have only one symptom' (Article 4, lines 27-28), before going on to say 'Real mental health policy has to recognise that there are no easy answers, that human beings are complex and contradictory' (lines 45-46). The use of the word 'real' implies that government/professional accounts of mental health are not real or to go further, are purposefully untrue. This theme is recurrent – 'The Department of Health says that there are as many as 60, 000 practitioners trained...this figure is *misleading*' (Article 11, line 85), 'In theory, your GP should be able to refer you. *In reality*, waiting lists can be vast.' (Article 6, line 19), 'Professor Layard *admitted* that CBT is appropriate for only about 40 per cent of patients' (Article 8, line 42). This splits those in favour of CBT and 'fact-based' science, from those who are doubtful of its suggested powers, conceptualising mental health difficulties as normal facets of human experience.

On some occasions, there is a more explicit focus on deception and poor treatment of patients through CBT. Parallels are drawn in one article to the act of brainwashing – ‘If the therapist is skilled, the patient becomes able to ignore many of their true feelings. When tested at the end of the treatment, like a well-coached pupil taking an exam, they often regurgitate the positive story’ (Article 9, lines 65-68) and ‘Another indication comes from testing the unconscious thoughts of those who have just finished CBT. When words are flashed subliminally on screens, they react faster to depressive ones. Their dreams reveal a similar hidden negativity’ (lines 75-78). The mention of the CBT therapist’s skill level, suggests that ability to exert control over an individual is key to success. The addition of ‘However filthy the kitchen floor of your mind, CBT soon covers it with a thin veneer of positive polish. But shiny surfaces tend not to last’ (lines 28-29) suggests a belief that despite the masking of symptoms, true emotions can never be altered.

This negative view of CBT’s use is contrasted with a sympathetic view to those with mental health difficulties. One extract states that rather than trying to ‘send the depressed worker back to work with a false smile on their face’ and trying to ‘Think Positive’, ‘we should pursue insight, maturity and authenticity’ and accept that ‘We weren’t put on this Earth to be happy’ (Article 9, lines 122-125). The use of ‘authenticity’ not only supports a suggestion of professional deception, but also gives those with mental health difficulties value and worth. This is reiterated within other articles – ‘A true exploration of psychological suffering is perfectly possible....if policymakers can think beyond mental hygiene and start listening to the patient’ (Article 4, lines 48-49), and ‘If only life were so simple. The truth is more complicated’ (Article 9, line 26). This seems an attempt to empower those with mental health difficulties, suggesting that psychological suffering is in no way irrational. Implicit in

this however, is the insinuation that those promoting CBT might want to portray the opposite.

### *3.7 Polarising the Reader*

There are numerous ways in which the articles appear to use polarisation to influence the reader. As mentioned previously, there seems to be a contrasting of masculine common sense with feminine irrationality, modern day trendiness (leading to empowerment) with historical ignorance, and scientific truth claims with compassion for emotional subjectivity. This might result in the reader taking a stance whereby in explicitly accepting one point of view, the other is implicitly dismissed. This polarisation appears at its strongest when other forms of therapy are discussed.

The majority of these examples compare CBT with psychoanalysis. One article states how with CBT ‘There is no couch, no “tell me about your childhood/dreams/father”’ (Article 11, line 52), drawing upon caricatured accounts of Freudian psychoanalysis from popular culture. The article tell of how one ‘CBT convert’ described their experiences of psychoanalysis as ““frustratingly fluffy and meaningless”” (line 59). The use of ‘convert’ suggests the individual, having previously tried and disliked psychoanalysis, has now turned to CBT due to its better approach.

Another woman using psychoanalysis would ‘lie back and sob about her mother – until she either ran out of time, or money, or both’ (Article 3, line 11). Later, the article counters that ‘CBT does not dwell on childhood events...nor does it go on for years’ (lines 25-26). Through the use of words such as ‘sob’ and ‘dwell’, along with a reference to a total consumption of time and money, psychoanalysis is constructed as a somewhat foolish self-indulgence. In contrast, CBT's description as a ‘fixed course of



task-orientated sessions' (line 27) which clients could finish 'in six weeks' (line 29) sounds purposeful, well-planned and appealing.

Another distinction states that 'those who feel a desire to explore the impact of childhood events on current behaviour should try psychoanalysis' (lines 99-101), over CBT. The use of 'desire' suggests a wish rather than a need. Furthermore, 'try' implies psychoanalysis is less suited to those needing immediate relief for distress and is more suited to those who are self-reflective, having spare time and money to pursue therapy as an interest. Conversely, with CBT 'Instead, the focus is on the patient's fearful and negative thoughts....by the end, the patient is 'cured'' (Article 9, lines 13-16). One article warns that 'If a therapist....suggests a long, open-ended relationship, beware' (Article 6, lines 41-42), suggesting therapies such as psychoanalysis to be dangerously ill-defined in contrast to CBT.

Interestingly, treatment *options* are considered crucial by many articles. One states that 'lack of choice can be problematic' (Article 6, line 66) and that 'our only chance of stemming the tide of antidepressants is to make alternatives more accessible' (lines 3-5). Another suggests it is 'crucial to maintain this [therapeutic] diversity to serve the complex mental health needs of the public' (Article 1, line 20). In creating therapeutic polarisation, the text appears to disempower the reader by serving to restrict choice. Furthermore, with empowerment, rationality and here-and-now fashionableness being aligned with the scientific potency of CBT, it makes a convincing argument for the reader to select this as a treatment option. This is particularly the case for female readers who appear to lose more if not making the rational choice.

## 4. Discussion

### *4.1 What is Normal and Where do I Buy it? : Gender, CBT and the Search for the Ideal*

Previous research has discussed gender representations within media discourse relating to health. Cranshaw (2007) and Roy (2008) found that health was considered a personal responsibility. To fulfil this, it was suggested that gender-specific attributes were necessary. Implicitly, it is assumed that failure to maintain health suggests a deviation from gender expectations.

In the current study, gender is also seen as important. Emotional difficulties appear to stem from female inability to show common-sense, to obtain emotional stability alone and to rationalise. This is suggested as a reason for women being unable to fulfil roles and responsibilities, such as caring for children or maintaining high-powered professions. CBT is suggested as a method of empowerment, by which such roles and responsibilities are obtained.

The ‘back to school’ approach of CBT implies that these newly discovered roles and responsibilities were once lacking; never acquired by females as they entered adulthood. The text then intimates that when women choose to undergo CBT they are modern consumers, selecting fashionable methods to better themselves. This supports Roy’s (2008) finding, that female empowerment was linked to making the ‘right’ choices. Interestingly, the current study’s findings suggest that there is something superficial about female empowerment. The discourse implies that CBT only allows women to ‘play’ at being competent, suggesting ultimately, they may never live up to responsibilities as a man would, though remain under an illusion that they can.

To summarise, when exploring accounts of female CBT-users within the current study, findings appear to mirror previous research suggesting health relates to personal responsibility and agency. However, whilst previous studies imply that failure to

maintain health is due to the inability to demonstrate gendered attributes, the current study goes further, with accounts of women differing to those of men. Whereas mentally unwell females are constructed as *never* having possessed agency, competency and potency, males are constructed as inherently having these things, but finding them temporarily weakened as a result of mental health difficulties.

Whilst males can be thought to possess the implicit skills needed to meet role requirements, the text suggests otherwise for females. Analysis suggests that female *identity* leads to a failure to meet responsibilities – that females are inadequate, in comparison to males. This finding mirrors Chananie's (2005) suggestion that television advertisements for psychopharmaceutical medication reinforced discourses of female inferiority. Notions of female inadequacy in the current study are strengthened by contrasting lack of female competence with male capability, implying that gender is central in determining such proficiency. In the finding that female emotional difficulties are located internally, this study also supports previous research that identified discourses of individual (biological) deficit (Coyle & MacWhannell, 2002; Lawrie, 2000).

In order to promote CBT, many articles suggest its ability to empower. Here, CBT is seen to be giving women something they lack, offering the ability to think rationally, show 'common sense' and take on roles and responsibility through being able and competent. Men are suggested to show these abilities prior to developing mental health difficulties. For this reason, CBT could be seen to offer women something men possess. CBT's potency, rationality, and common-sense in this respect becomes 'masculine' and consequently 'CBT' becomes a discursive device within the text - the explicit description of a therapeutic technique is lost and 'CBT' becomes an act of

transformation of identity and power, with the favoured concept of masculinity being introduced.

Alongside the discourse appearing to construct women as inadequate, males who experience mental health difficulties also appear inadequate to males who are 'well'. The transformation of 'mental ill health' into an active agent, with male clients unable to resist to its forces, suggests a weakness on the part of the individual. This male passivity does appear to warrant consideration for CBT. Interestingly, accounts of CBT use suggest it is less effective with men than women and consequently seems less of a *necessity* and more of a useful tool which *could* help. It could be suggested that whilst for women, their lack of masculine potency and competence can be addressed through CBT, for males, CBT only serves to increase masculinity temporarily weakened by mental illness. In male clients therefore, CBT can only be recommended for those who fall outside social understandings (or stereotypes) of a masculine male created through dominant discourse – powerful, potent, rational and resilient.

Not only do findings add to previous studies on health in the media, but they also provide an interesting contribution to wider literature relating to gender and mental health. Seem and Clark (2006) considered clinician perceptions of healthy males, healthy females and healthy adults whose sex was unspecified within the study. Healthy women were viewed significantly differently from both healthy men and healthy adults. In contrast, healthy men were not viewed to be significantly different from healthy adults. This may suggest that within society, judgements of health/illness might be based on 'normality' being male in nature. This study replicated one carried out over 30 years previously (Broverman, Broverman, Clarkson, Rosenkrantz & Vogel, 1970) and within this time, expectations had altered. In the later study, healthy women were

expected to additionally possess traditionally masculine traits, again suggesting that such qualities are considered an ideal.

Similarly, Benrud and Reddy's (1998) study suggested that gender perceptions were related to predicted health outcomes. Participants attributed male health disadvantages to controllable factors such as behaviour, but the same disadvantages in women to uncontrollable factors such as biology. This suggests that there may be a societal discourse that considers female gender as a predictor for ill health, with males being viewed as resilient. Furthermore, Cermele, Daniels and Anderson's (2001) study suggested that there was a gendered conceptualisation of mental illness in the DSM-IV Diagnostic Casebook, with males being the norm for comparison.

The current study builds on explanations of male normalisation through discussion of 'masculinity': findings suggest it may not be males *per se* that are considered 'ideal', but a concept of masculinity that involves potency, agency, competence and rationality.

#### *4.2 'Shiny surfaces tend not to last' : Misplaced Hope and the Repackaging of Historical Discourse*

There are two key areas where the text explicitly appears to favour new treatment methods over old approaches, whilst implicitly drawing upon the very traditions which are being discredited. These two areas are explored below.

##### *4.2.1 A history of hysteria.*

Micale (2008) noted that as far back as 1900 B. C. there are references to abnormal presentations within women. 'Hysteria', as these presentations came to be known, has been described throughout history, being viewed predominantly as a female

condition requiring treatment. The suggested causes of hysteria have changed throughout time and included movement of the uterus, sexual dissatisfaction and menstruation. Russell (1995) discussed treatment options, including surgery on the sexual organs, sometimes involving female castration. Micale (2008) described common beliefs that reduced masturbation and a solid marriage would reduce symptoms. It is interesting that perceived causes for emotional disturbance were attributed to intrinsic factors linked to female identity. Similarly, treatments focussed on de-feminising and increasing dependence on males. Busfield (1996) argued that similarly, rationality is central to the understanding of mental health, with women (and hysteria) being aligned with irrationality and men with reason.

Within the current study there was a strong echo of these previous dominant discourses, with the text seeming to construct women as inadequate through their identity and CBT acting in a potent way to masculinise, introducing commonsense and rationality. There is also a suggestion of females exaggerating what could be seen as trivial difficulties and, in one example, only feeling emotionally contained when a man was present.

As well as describing hysterical women, Micale (2008) discussed 'male hypochondria'. This diagnosis appeared to have been created in reaction to philosophical rationality, describing males who were sentimental and expressed emotions openly. It was believed that whilst this led males to experience life vividly, it put them at risk of exhaustion and illness. This suggests a historical discourse that constructs emotional expression as dangerous for males, causing them to weaken and be at risk of becoming like hysterical women.

In a similar way, traces of this discourse appeared present in the current study, with males with mental health difficulties being weakened through their emotional

experiences, unable to resist the onset of mental health difficulties and struggling to manage their roles and responsibilities due to their frailty. CBT consequently helps to restore their robustness and resilience, reinstating their masculinity.

The concept of hysteria was revisited in the nineteenth century, within psychoanalysis. Mitchell (2000) described how Freud's work focussing on hysteria suggested that sexuality and sexual identity were central to understanding its cause. From this Freud developed the Oedipus complex hypothesis, maintaining that as children, there is a desire towards the mother needing to be resolved. Freud believed this to be more of a challenge for females (due to them needing to switch desires from the mother to the father) and felt this explained the susceptibility of women to hysteria.

Within the current study, there seems to be parallels to Freud's theories. 'Masculine' males were constructed as the aspired-for norm, with women being rendered as 'hysterical' through not being masculine. Though they try to maintain responsible professions and control intimate relationships, they will never have the ability and competence of men, causing distress. This bears a resemblance to Freud's Oedipus complex, which suggests women become hysterical in their fight to develop appropriately gendered desires innate within the male sex.

In recent years, sexual identity has been explored further in psychoanalytic literature. Maguire and Dewing (2007) discussed the idea that 'hysterical' males who may over-identify with their mothers may be described as 'feminine' in nature. They also considered whether Freud's notion of the 'passive female' explains reduced help-seeking in men due to gender stereotyping (Galdas, Cheater & Marshall, 2005).

Throughout the history of psychoanalysis there has emerged a strong discourse that relates gender and perceived gender characteristics to emotional experience and behaviour. Showalter (1997) noted that this psychoanalytic dialogue, combined with

medical discourse has created a historical narrative regarding hysteria. She added that sources such as the media utilise this narrative, constructing illnesses and manifesting symptoms through talk.

Interestingly, text within the current study was frequently rejecting of psychoanalysis, with it often being viewed as ‘woolly’, old-fashioned, lacking evidence and self-indulgent. Instead, this ‘traditional’ approach is replaced with CBT, which promises to offer the opposite, being logical, evidence-based, trendy and to-the-point. In doing so, the reader is promised something ‘new’, with a suggestion that previous approaches have failed to ‘cure’ emotional distress.

With this acknowledged, it is notable that findings revealed gendered accounts of emotional distress, with hysteria-based notions of mental health treated by a therapy that seems to address sexual identity. This strongly mirrors the psychoanalytic discourse mentioned previously. This is however implicit, with the explicit focus of the text being on CBT’s contemporaneity, evidence-base and common sense approach. This reveals a deconstructive turn, with the text saying one thing, but at a deeper level reflecting another. Historically many psychological approaches have sought to resolve emotional distress. In wanting to promote CBT as something different and effective, the text explicitly divorces itself from such historic therapies, providing new hope that emotional difficulties can be eradicated for good through a new wave of therapy. However, discourse is inherently shaped by that which precedes it (just as new psychological therapies are shaped by previous approaches) and therefore the text cannot escape this. CBT, whilst seeming new, is constructed using discourse that has been encountered before. In being repackaged, it appears revolutionary, but offers false hope.



#### 4.2.2 *Back to basics using CBT: How a common-sense approach helps users get real.*

Whilst in the current study emotional difficulties were often viewed as the result of individual inadequacy, there were other times when the text constructed them as comparable to physical illness. Previous research not only refers to the biomedicalisation of distress (Bilic and Georgaca, 2007) but also suggests that through pathologising emotional experience, professionals are positioned centrally in offering health treatment (Bentall, 2003; Newnes, Homes & Dunn, 1999).

Interestingly, Chananie (2005) found media discourses that served to infer *both* individual blame and the legitimacy of medical professionals in offering treatment. The current study's findings, whilst reflecting these two discourses, might add to the understanding of how they are combined. Not only are emotional difficulties blamed on individual weakness, with medical professionals offering suitable solutions, but the source of these weaknesses - lack of 'masculinity' – *becomes* an illness in itself.

Similar merging of contradictory discourse is apparent within accounts of CBT. It is constructed as a straightforward and sensible therapy that, rather than being 'rocket science', is more likened to 'going back to school'. In highlighting common-sense, there is a real feeling of a back-to-basics approach. This, paralleled with masculinity, constructs a therapy derived from notions of 'bloke-ish' straightforwardness.

This discourse appears at odds with that presenting CBT as powerful, scientific and advanced. It seems strange to construct a commonsensical approach and then imply, for example, that it can 'cure' infertility. However, this can be explained by the text reiterating a discourse of individual weakness being to blame for emotional difficulties, whilst supporting an impression of individual passivity and dependence on professionals to offer solutions. In doing this, the articles could be seen to offer health

professionals, scientists and the government power and legitimacy, but ultimately to excuse them from addressing the social aspects of mental health difficulties. To clarify: the text overtly offers a revolutionary, scientific treatment but inherently draws on former models of individual responsibility.

By professionals supporting such a ‘common-sense’ approach as CBT, sensibility is aligned with power, which is seen as a universal aspiration. As the government is reported as funding the IAPT scheme, it is consequently constructed as the distributor of sense, its reportedly systematic approach as the epitome of what is ‘right’ and desirable. In this context, ‘commonsense’ becomes a bigger and more powerful rhetorical device.

With the UK Labour government backing CBT, there is a reflection within the discourse of their traditional ideology. Fairclough (2000) noted that Labour discourse frequently reflects the desire for a knowledge-driven economy, and therefore it can be assumed that scientific, evidence-based approaches are key to this, due to the ‘factual’ nature of their development.

What is interesting, however, is that there are also traces of previous UK Conservative government discourse, which stressed the need to get ‘back to basics’, valuing common-sense and stressing self-reliance and individualism (Wintour and Bates, 1993). What emerges is a suggestion of Labour promise in the form of a revolutionary approach (CBT), which is ultimately grounded in former Conservative discourse. This can be said to reflect New Labours’ ideological shift from the traditional left to a new ‘Third Way’.

### 4.3 How Potency Persuades

Throughout articles promoting CBT, there was an impression of hope given to those experiencing mental health difficulties. Terms such as ‘cure’ imply that difficulties are tangible and that CBT has the power to act upon them, making the individual well. Whilst constructing CBT as potent, the text also suggested individual inactivity and passivity. In saying this, CBT acts *on* individuals, rather than being used as a technique to guide individual transformation. This is questioned by some articles, critical of IAPT. Much of the discourse implied that this passivity is not chosen, but is forced onto the individual. This is done through the personification of CBT, not referencing the client as an independent agent of change and suggesting that CBT-users are tricked into suppressing *real* thoughts and feelings.

With emotional difficulties often biomedicalised, CBT was constructed as a scientific treatment, similar to medicine. This served to add to the inactivity of the individual, portrayed as being treated by professionals without having to do anything themselves. This reinforces CBT’s potency, yet seems to simplify mental health difficulties, giving the impression that there is somehow a ‘quick fix’. Articles that question IAPT’s claims appear to challenge this simplicity, referring to the complex and contradictory nature of emotional experience. They also appear to validate emotional distress, suggesting how commonly it occurs in response to everyday challenges.

The debates arising within the articles mirrored those found within wider literature. Potency appears to be a factor which is either emphasised or deemed unwarranted. Results from the Doncaster and Newham IAPT pilot study (2008) made bold statements to exaggerate CBT’s power, often sidelining minor details. For example, an initial glance at the findings would suggest a 1 in 2 chance of complete recovery with increased likelihood of employment, following an average of 2.6 hours of

treatment. This constructs CBT as almost magical - able to 'cure' all of the country's ills through its immense force. However, what was marginalised was the information regarding high drop-out rates, CBT's limitations at addressing complex cases and the previous research, suggesting many individuals would have improved similarly whilst awaiting therapy. This information may weaken the impression of certain success and consequently might be 'played down' by those promoting IAPT.

Amongst articles that questioned CBT's potency, both Hagan and Donnison (1999) and Newnes (2007) discussed the difficulties of suggesting an individual-focussed approach for emotional problems that may arise between people, within a complex social context. In taking this view, it would seem unlikely that a simple 'cure' could be found by professionals, aimed at changing the individual alone.

Whilst academic literature relating to IAPT is relatively limited, much of the debate reflecting issues above took place within more popular publications. Within 'The Psychologist' – the monthly magazine of the British Psychological Society – polarisation seemed to occur, with writers either praising CBT's potency to change the face of mental health or suggesting the perceived injustice done to those with emotional difficulties. Marzillier and Hall (2009, May) noted the use of a simplistic 'illness' model, suggesting that terms such as 'cure' serve to pathologise the distress of living within difficult circumstances. Gilbert (2009, May), suggested CBT be viewed as a model to influence therapeutic work, rather than a 'science' of the mind, treating all individuals alike. Casement (2009, May) noted that the described practicality of CBT looked appealing to providers, dispelling the mystery associated with other forms of therapy. He added that CBT might look closer to what mentally unwell individuals feel they are searching for.

Casement's (2009, May) comment regarding public desirability merits further discussion. As media focus tends to reflect public demand, accounts might give a suggestion of what the public found appealing at the time of publication. Perhaps these articles reflect a culture whereby people want emotions to be tangible and understandable, complexity to be done away with and where faith can be invested in something which 'sorts out' distress logically. There might be a belief that solutions need to be delivered quickly and effectively, be based on the latest technology and where the most advanced scientific techniques are equated with power. In this regard, those who deliver such techniques are given control, with the individual content to sit back and be passively 'done to'. This of course is made easier if they believe that mental health difficulties are self-derived. With professionals defining what is 'well' and 'unwell' and consequently able to offer treatment, the individual is forever passive. However, through accounts of CBT in the media such as those within the current study, a superficial empowerment is offered. This renders the individual in a position of naïve contentment – feeling they have control, but forever searching for help from those who claim to hold 'the cure'.

#### *4.4 Clinical Implications*

The current study's findings suggest language can be used to create definitions of normality within the media. For clinicians, it might be useful to recognise how such language can be powerful, not only describing the unwell, but also creating them. The danger in using discourse within the media such as that revealed within the current study is that the public's understanding of health may be shaped in ways that could be seen as negative. For example, articles might give the impression that women are less rational, competent and healthy than men and that the psychological profession support

that view. Another danger might be that women are shown less understanding when distressed and that men find it harder to seek support due to the gender stereotypes that exist.

The findings also show that old discourses are often used to repackage new ideas. It is interesting here to think about the development of psychological therapies throughout history. Behaviourism was based around systematic, logical and tangible theories. This arose as a response to psychoanalysis, which focussed on the emotional, often unconscious, content of experiences and recognised the relational aspect of therapy. Psychoanalysis added complexity to understandings of mental health and suggested that emotional difficulties could not be resolved in a fast, straightforward way by the therapist alone. This type of approach was, however, often time consuming, difficult to evaluate objectively and led to greater uncertainty within the therapeutic context.

Critics of the ‘second wave’ of behaviourism responded by developing approaches where individual uniqueness was acknowledged and the role of society in the development of emotional difficulties considered. These ways of working shifted responsibility away from the individual alone and attempted to normalise such experiences in the context of everyday life. They also suggested that the therapist relinquish or at least acknowledge some of their power.

Of interest, IAPT may reflect a ‘third wave’ in therapy, comparable to behaviourism. Similarly, CBT is rational, straightforward and commonsense. It seems important for clinicians to question why this new wave has occurred and what it tells us about current societal understandings regarding mental illness. This may provide them with a way of addressing some of the unease felt towards IAPT and enable them to respond in a thoughtful manner, rather than reacting emotionally and defensively.

With the Labour government drawing on previous Conservative discourse, attempting to re-sell unsuccessful approaches under new guises, there is a sense of them grasping for hope, wanting to find a solution to social difficulties and turning to science for answers. In the face of the second wave of psychological theories, which suggested that emotional distress is normal and cannot be eradicated, it seems understandable that people might want to cling on to science for hope that this is untrue. In CBT's rational and logical construction, those who are unwell have a therapy that makes them feel safe, secure and which they can trust to act on their tangible emotions without having to take responsibility for doing so.

The findings suggest passivity on the part of the individual being treated, with the potency of CBT being aligned with professionals. Again, this may suggest that the public looks towards such professionals for hope and containment. One clinical implication of this might be that clinicians need to be mindful of the power sometimes created for them through language and need to consider how best to contain those that they support without making false promises of a 'magical' cure. There may also be a benefit in promoting the effectiveness of other approaches less systematic and easily evidenced, by engaging others in meaningful dialogue about the complexity of emotional distress.

Whilst the above discussion involves hypotheses, considering IAPT in this way gives an opportunity to reflect on how human anxiety might create a search for an answer in the form of CBT and what it might mean to remove this hope of a simple solution to distress. Whilst many have responded in an emotionally negative way to IAPT, a study such as the current one allows the opportunity to reflect on what is unsettling about how CBT is presented and to respond with sensitivity and understanding.

## 5. Critical Appraisal

### *5.1 Strengths and Weaknesses of the Study*

In reflecting on the research process as a whole, it feels useful to initially consider the strengths and weaknesses of a study such as this, noting what it offers and what it does not. In focussing on a topic such as CBT that is very relevant and current within the field of clinical psychology, I have tried to utilise the discussions that I have noticed and experienced within my profession to guide the development of my research. In doing so, I have attempted to provide an interesting critical commentary that aims to explore in more depth how and why these day to day debates surrounding CBT might come to be. In using newspaper articles, I have also considered how a therapy such as CBT might be presented to the public and the possible implications of how this is done.

By using a small number of articles, I aimed for the findings to be richer. Not only are the articles explored at a linguistic level, but dominant and subjugated discourses are also noted. Furthermore, these discourses are then compared to social practices, which have arisen historically. Whilst this level of working takes considerable time and the limited number of articles leads to narrower findings, I believe what is gained through this approach is work that is engaging in its level of complexity.

What must be noted, however, is that the current study does not attempt to make claims that can be generalisable. I approached the text with the personal stance that authoritative claims of 'truth' should be questioned, due to the socially constructed nature of our understandings, and therefore I believe that my discussions involve interpretations, rather than statements of 'fact'. Despite saying this, I still believe that my study attempts to show transferability and the quality controls taken support this.



## *5.2 From Literature Review to Present : Plotting the Research Journey*

At the time of planning my literature review, I had developed a keen interest in systemic models of working, though was finding it challenging to integrate such an interest into my day-to-day working due to the individualistic nature of the sessions the service offered. I was curious about the aetiology of psychological difficulties and at the time felt uneasy taking the view that experiences such as depression and anxiety were located within the individual alone. I saw many individuals from low-income backgrounds and heard how their day-to-day struggles to pay bills affected their health. I met with individuals from minority ethnic groups who felt isolated in their communities due to the lack of others sharing their cultural background. I saw those who were in controlling relationships who felt powerless to break free due to their lack of family support. I began to feel that there was a complexity to emotional distress that was not always explained in psychological literature and policy.

Around this time I began to really question my role as a trainee clinical psychologist. I had frequently heard other therapists describe working with someone living in a complex and chaotic environment and feeling that their individual work with them felt meaningless, due to the difficulties within their social context. Often they would go on to reflect on the constraints of service demands. I started to feel uncomfortable in promoting the models I had come to rely on previously and questioned the messages that they were giving to the individual about the cause of their difficulties. It was not that I felt they were ineffective, but believed that some of the language used in more manualised approaches could appear blaming and disempowering if used thoughtlessly.

My decision to review research that explored links between socio-economic status and depression in my literature review flowed naturally from the position I found

myself in at that time. My findings suggested that there was something important about an individual's social context that might influence the likelihood of them becoming depressed. I used this work to guide my professional development, adapting my approaches where possible to consider social experiences.

Reflecting on the literature review, I can see that it was originally approached and written in a style that did not take a social constructionist stance (as the following research paper attempted to). For example, I often refer to 'cognitive factors' as if they were static 'things' within the individual, tangible and measurable. I also write of generalisability as if there is a belief that it is possible to apply one research finding factually to all individuals. This reflects the epistemological understanding that I had at the time of writing and the discourses drawn upon to construct the piece were mainly positivist in nature. Though this piece has been revisited and reshaped more recently, I wanted to leave some of the original text within it to demonstrate the epistemological and methodological journey that I have made.

Following the writing of my original literature review, the promotion of the IAPT agenda caught my attention and left me feeling uneasy about the future of my profession. This was something that seemed to also cause strong feelings in others. At the time of planning my research I worked within a primary care team and daily discussions took place about IAPT, with some investing all of their hope in it and others feeling hopeless. I noticed that IAPT seemed to split teams either for or against, with few taking the middle ground. I also noticed that responses appeared to be emotionally reactive, with individuals either frantically booking onto IAPT training courses (having often never even read the Doncaster/Newham reports) or else contemplating looking for jobs in other areas that might be less effected by IAPT. I too felt frequently torn between such responses.

I began to contemplate whether it was the way in which CBT was being talked about within the IAPT agenda that caused such responses. I also noticed that this seemed to be translated to the public, as those I was seeing therapeutically would arrive for sessions talking of how CBT, if *done* to them, would solve all of their problems. This presented a range of difficulties for me as it often meant that they were reluctant to engage in work we had carried out to that point (feeling it did not offer the quick ‘cure’ they were searching for) and left me wanting to respect their choice, but not always believing that CBT would be effective.

Again, my research questions flowed naturally from what I was encountering at that time. Pursuing this type of study helped me to pause and consider what might be being done through talk about CBT. It allowed me to explore where this type of narrative may have arisen from, what function it might serve and how it might impact on those who draw upon it. It has allowed me to respond to IAPT in a more thoughtful and less emotionally charged, reactive manner. Furthermore, it has suggested to me that the way in which we talk about therapy to those individuals we support is just as meaningful as the type of therapy we actually do, with therapeutic ‘models’ being seen as different narratives that we draw upon in any given moment. This has helped me to resolve the unease that I have previously felt when using CBT.

### *5.3 Methodological Reflections*

When I came to developing a research proposal, I had some ideas of where my interests lay. I recognised my growing fascination with how individuals talked about things, creating meaning, but had not heard of discourse analysis as an approach. When a colleague mentioned it to me, I began to read about it and felt it fitted my research

question well. However, although I felt intrigued by this new approach, I also felt very unsettled.

As mentioned previously, I had in recent months taken a strong interest in critical and community psychology and had begun to explore different epistemological positions. Despite feeling inspired to develop my style of working, I still felt a lot 'safer' using positivist approaches. Not only had the majority of my previous research work been quantitative in nature, but I was also aware of the strong dominant discourse present within the profession, which favoured 'evidence-based' working. Having carried out quantitative research in the past, I was aware that there was considered to be a systematic way of working and felt reassurance when aware that I was doing the 'right' thing. In spite of this, I felt that at times, this approach had restricted me creatively.

As time progressed, I began to feel that my worldview and my understanding of the construction of meaning were more suited to qualitative approaches. However, I knew that such ways of working involved subjectivity and would lead to a certain amount of anxiety on a personal level, due to my tendency to be concerned with getting things right. An extra level of complexity was added to the methodological decision, when I realised that I was the only individual to be contemplating discourse analysis in my university cohort and that there was no rigid methodological approach to follow.

Van Dijk (1997) described discourse analysis in terms of a range of approaches that may be drawn on when studying language. This was reflected in my initially desperate scramble from book to book in an attempt to track down the ultimate step-by-step guide that would tell me exactly how to carry out analysis. I was met instead by what seemed to be extremely intellectual and academic philosophical discussions, which I could never imagine myself being able to understand fully. I read more and

more in the search for understanding and was left with more and more questions and uncertainty and for a while considered abandoning the whole idea of using discourse analysis altogether.

However, through reflection, I began to notice my desire to be creative, take on a new challenge and step 'out of the box' for once, doing something that I really felt passionate about. Whilst this would mean that I would need to challenge my own feelings of inadequacy regarding the approach and consequently move away from my previously safe and conformist self, I decided to give it my best efforts.

Once I had accepted the challenge of using discourse analysis, my decision to use *critical* discourse analysis in particular felt quite simple due to the reasons stated in my methodology section. On reflection, I feel like this was the right choice of approach. It fitted my research question well and the multiple levels of analysis gave the detail I was aiming for, considering not just what the text was saying, but how it was doing so and how this might relate to wider social practices. My choice to draw on the approaches of Richardson (2007) stemmed mainly from the fact that he had used his method to analyse newspapers and included the multiple levels of analysis I refer to above. However, I was also swayed by Richardson's slightly more 'user-friendly' language and the way he described his approach thoroughly. Looking back, I imagine that my uncertainty was probably contained somewhat by this and I wonder whether if I were to attempt another similar study (with new found confidence), I might feel more able to explore other types of critical discourse approach or at least to be more questioning of Richardson's work in the planning stages. In particular, his view of context often seems contradictory and there is a suggestion that he believes it possible to 'guess' the authors' intentions and the readerships' relationship with the text.

I found the circular nature of critical discourse analysis to be important, as I was aware that I moved several times between analysis and interpretation, with findings influencing the wider literature I referred to and consequently these texts influencing how I revisited and reappraised the articles. This did lead to some challenges at times. I tried to stay as close to the text as possible during my initial analysis, adopting a bottom-up approach. By this I mean that I attempted to approach the articles with awareness of my potentially biased self-interests, but tried to remain as open as possible to what I might find, using the text as a guide. In analysing linguistically and at a discourse level, I became very engulfed in the process and excited about what I might find. However, when I began to compare the emerging discourses to those apparent at a wider historical and social level, I found that I easily became so engaged and interested that I began to make claims about the newspaper articles which fit with these wider accounts, resorting to a top-down approach.

This is where supervision became essential as I found that I really needed to be reflective, questioning not only how the research articles might mirror wider discourses, but also how they did not. Through supervisors questioning my accountability, I was able to see where I had divorced myself from the articles and I often disproved my initial beliefs that I had found something grander than the text suggested. Whilst this at times felt disappointing, I believe that it added a level of rigour to the analysis, restricting me from making suggestions that were unfounded.

The use of a research diary also felt essential within this process. The extracts included previously indicate moments where I feel the research might have taken a different, less transparent route, had I not shown reflexivity. For example, in making my initial views towards IAPT apparent, I was able to approach the study with honesty and self-awareness, rather than simply shaping the analysis to fit my views. Similarly, as the

findings regarding gender were so unexpected yet so powerful, the diary helped me to describe the meaning created through the text for me and to attempt to limit any biases in my approach to the work that this meaning might have influenced.

One final topic for reflection concerns the epistemological stance that I took throughout my research. Epistemology was always something that I found challenging, especially due to my shift from a positivist stance, having previously lacked awareness of other positions. I chose to approach the research from a social constructionist position, due to my belief at the time that meaning was constructed through language and that there could be no known 'objective' reality, due to language being context specific. This left me feeling frequently anxious as it seemed a far step away from my previous assumptions and left me questioning everything I had once taken for granted.

Once this initial anxiety had reduced somewhat and I grew in confidence as the research progressed, I was able to think a little more critically about social constructionism. I felt that sometimes, taking the view that meaning was only constructed through language showed what felt like a lack of respect to those individuals who were in desperate situations. For example, it might appear to suggest that a mother struggling to feed her starving children might be fine if she simply talked about her situation differently. I believe that ignoring the material world is somewhat uncomfortable, a view shared by others (Bhaskar, 1989; Nightingale & Cromby, 1999; Sims-Schouten, Riley & Willig, 2007).

Furthermore, I was interested when reading some of the neuropsychological literature that suggested brain development was influenced by social environment (Beatson & Taryan, 2003; Schore, 2001). This made me refer back to the findings from my literature review and question whether socio-economic status affects the individual through the language used to construct it, or whether there might be a more tangible,

embodied effect, which does not support a social constructionist view of the world. In saying this however, I question whether any such embodiments are only given meaning once made available through language.

Due to this epistemological questioning, there have been times when I have felt more drawn to a critical realist approach. However, I feel that definitions of critical realism bring their own concerns. In particular, I find it difficult to justify and prove that there may be some things we can truly 'know'. I feel that my main unease with epistemological 'definitions' is that they appear to be constructed rigidly when discussed in many sources, with the suggestion that one stance *or* another should be taken definitively. It might be possible to view these 'stances' as narratives, with them being drawn upon in the moment and less static. Despite this suggestion, I do recognise the value of making stance at any given point explicit within research, in order to provide clarity for the reader. I feel that epistemology is an area that I will continue to be interested in, with my position continuing to develop with time.

#### *5.4 The Personal Impact of the Research*

Throughout the research process, I experienced polarised emotions, becoming extremely excited and energised at times, then confused, anxious and hopeless at others. I make sense of this now in two ways. Firstly, I think I felt excited to break out of my previous tendency to conform by engaging in a process that felt different and challenging. This let out a passion in me that I had not seen before and I felt proud that I had been able to, in some respects, face up to the anxiety arising through a fear of inadequacy and failure. At other times, the process of doing a new piece of work alone and with no 'correct' methodology overwhelmed me and I became convinced that I was simply making things up as I went along and would be soon caught out.



The other way in which I make sense of my polarised feelings is in response to the polarisation that was revealed within the articles themselves. As someone who uses CBT, but generally prefers other approaches and is uneasy about the suggested power of IAPT, I frequently feel a sense of hopelessness about the future of clinical psychology. At times, I feel constricted by the service demands that determine which approaches clinicians should use and do not always feel that it does justice to the uniqueness of the individuals I work with. These views are paralleled within the text by those critical of IAPT. At other times however, I feel excited to be part of a profession that can question IAPT and have had moments where I have believed that my research can really make a difference. Again, there are times when this hope is echoed within the articles by those who point out IAPT's limitations.

In reaching the end of the research process, I have noticed that more frequently of late I feel somewhere in the middle of these emotional extremes – pleased and proud of the work I have produced, yet aware that it is only one contribution to an ongoing discussion regarding an extremely complex subject. Perhaps this reflects my growing understanding of, and sensitivity to, how those discourses relating to IAPT have arisen.

Whilst the process of carrying out the research had a sizeable impact on me emotionally, I also feel that it has had a lasting impact on how I see myself as a clinician. My need to think critically has been encouraged through the research and this has been extended to my clinical work, where I now make use of supervision as a time for critical reflection. The questioning approach that I have taken has led to, in my opinion, some interesting findings and a better understanding of the topic. This has encouraged me to frequently question my ways of working, considering what the consequences might be of the language I use. As mentioned previously, in therapeutic work, I feel less constricted by approach. Whilst I may always feel more drawn to those

approaches that focus on relational factors and social context, if an individual feels CBT might be of use, then I believe I can draw on certain CBT techniques and use them with flexibility and awareness of language, as part of a broader understanding of emotional distress.

The other way in which the research has had an effect is on the way in which I view myself personally. On approaching the study, I had not anticipated finding such a strong discourse relating to gender. I had also never aligned myself with 'feminism', naively thinking that this was an out of date movement, which did not apply in the modern world where I believed that the majority of the time in my own local culture, men and women were classed as equal. I possessed all sorts of ignorant views about feminists, mostly constructed through discussions I had had with friends and peers. I am shocked by looking back on my own ignorance and lack of respect for the history of my own gender. Being female did not mean very much to me as I approached the research.

Not only was I surprised to discover such discourses relating to gender in modern newspapers, but I was saddened that this could be the case. Once I began the process of analysis, I began to view my entire world differently, scrutinising television adverts, my friend's conversations, my partner's magazines, amongst other things. These types of discourse cropped up everywhere and I was unsure of how I could have been oblivious to them previously.

In reading about feminism and the history of women's treatment in the field of medicine and psychiatry, I felt deeply distressed at what not only had occurred historically, but what appeared to be maintained through language in modern society. This changed my view of myself as an individual. Being a female feels important and not only that, but it feels necessary to continue to uphold the views of feminism, fighting for equality even now. Of interest, not only does the research suggest that

women are constructed as inadequate, but a ‘normal’ and healthy view of a man is also suggested. This leads me to believe that not only is being aware of my own gender valuable, but that it might be useful to reflect further on the socially accepted norms that arise when considering a particular gender more generally.

Overall, I feel that the research has had a profound effect on my development both personally and professionally and hope that through the process I have become a more curious, questioning and critical individual who shows increased awareness of the personal and professional context that I find myself within.

### *5.5 Suggestions for Future Research*

Although I have previously suggested the clinical implications of the research findings, recommending that others might use these for further reflection, I am also aware of how restricted I have felt by the study word count. On reading through my final research report, I have noticed two areas where I feel I would have liked more opportunity to expand.

Having mentioned CBT's potency and trendiness in modern society, I would have been interested to pay more attention to the arising discourse of consumerism alluded to in my findings. I recognise that over time, the NHS has changed significantly and whilst during my clinical training I have always regarded it as a business aiming to meet consumer demand, I question if it has always been viewed by others in a similar way. Future research might consider societal discourses relating to consumerism and ask what role the NHS plays in maintaining or opposing these.

Similarly, I would also like to have spent more time considering how psychoanalytic discourse is used within wider social practices. After finding such strong traces of it within the articles analysed and then writing up my findings, I began to

notice it within many environments I encountered. In particular, those who were often dismissive of such a therapeutic approach frequently drew upon psychoanalytic terms within their everyday speech. This again, would be a further area for consideration.

Finally, I offer a number of suggestions for future research. It feels useful to question what members of the public believe should be offered as treatment options for emotional distress and what they think the NHS should provide. It would be interesting to explore the beliefs of those commencing CBT with regards to what the therapy has to offer and to compare this to beliefs after treatment. It might also be of interest to use discourse analysis to explore CBT-based treatment manuals, with a particular focus being on the construction and role of gender. A further piece of work might examine the commercialisation of the NHS and question what role CBT has to play in this.

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## **Appendix A: Guidelines for authors for submission to the journal 'Social Science and Medicine'**

Retrieved 26/04, 2010, from

[http://www.elsevier.com/wps/find/journaldescription.cws\\_home/315/authorinstructions](http://www.elsevier.com/wps/find/journaldescription.cws_home/315/authorinstructions)

### **Submission of Papers**

Two types of contribution are welcomed:

1. Full papers. These are original research reports or critical reviews of a field, and may be up to 8000 words including abstract, tables, figures, endnotes and references as well as the main text. Papers below this limit are preferred. The editors are prepared to consider longer papers in exceptional cases, though justification for this must be made at submission by the author.

2. Short items. These are reports of research findings, commentaries on topical issues of between 2000 and 4000 words.

Submissions will be considered on the understanding that:

- the article comprises original, unpublished material (except in the form of a conference abstract or as part of a published lecture or a thesis submitted for an academic qualification).
- it is not under consideration for publication elsewhere.
- the studies on which it is based have been subject to appropriate ethical review.
- its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out.
- if accepted, it will not be published elsewhere in the same form, in English or in any other language, without the written consent of the Publisher.

Authors are required to confirm the above points during submission.

### **Manuscript Preparation**

**General:** We accept most word processing formats, but MSWord files are preferred, with all author-identifying text removed. They are acceptable in US or UK English, but the use of either must be consistent throughout the manuscript. Submissions should be double spaced and use between 10 and 12pt font, and any track changes should be removed. The editors reserve the right to adjust style to certain standards of uniformity. Authors should retain an electronic copy of their manuscript.

**Abstract:** An abstract of up to 300 words must be included in the submitted manuscript. An abstract is often presented separately from the article, so it must be able to stand alone. It should state briefly and clearly the purpose and setting of the research, the principal findings and major conclusions, and the paper's contribution to knowledge. For empirical papers the country/countries/locations of the study should be clearly stated, as should the methods and

nature of the sample, and a summary of the findings/conclusion. Please note that excessive statistical details should be avoided, abbreviations/acronyms used only if essential or firmly established, and that the abstract should not be structured into subsections.

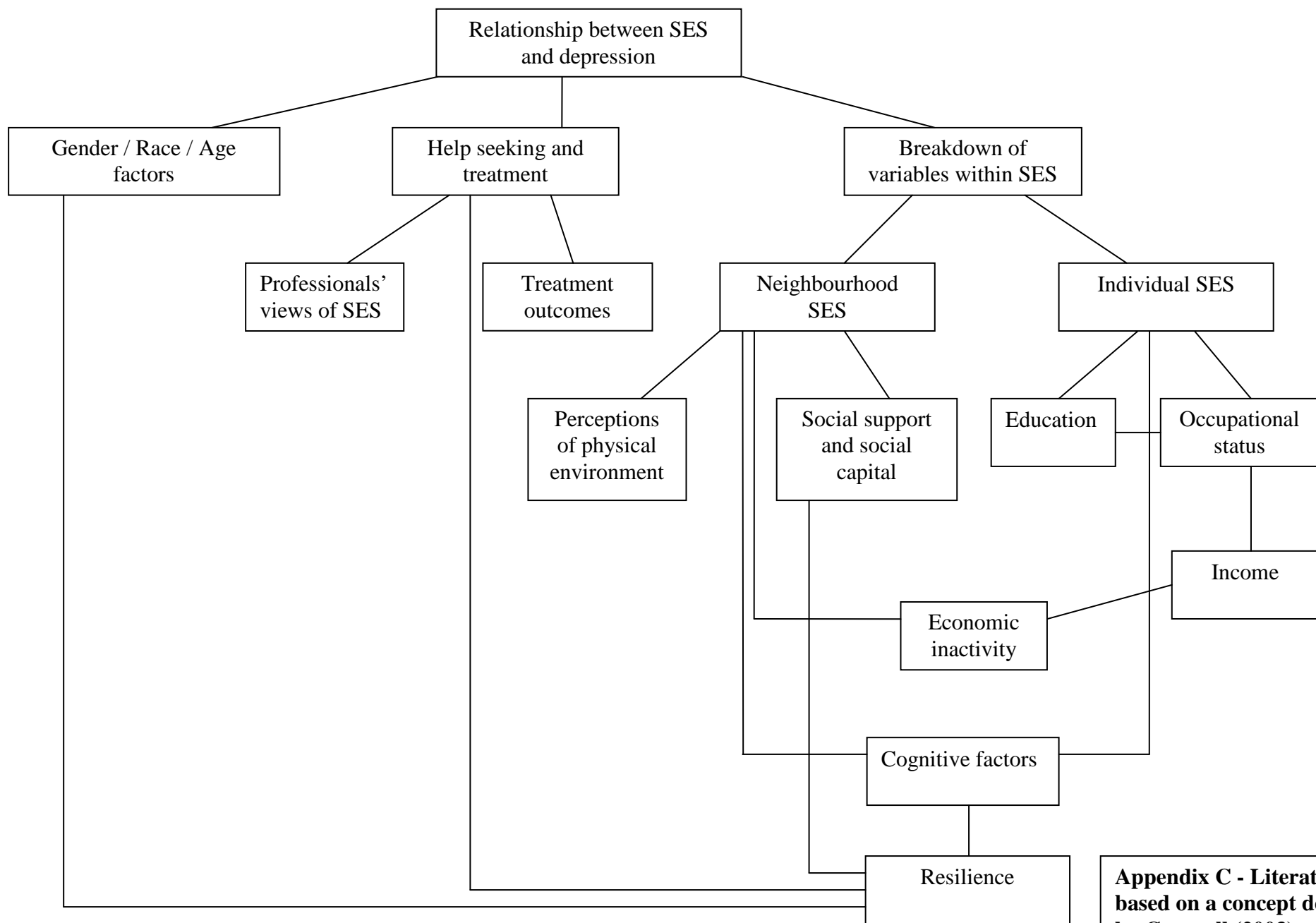
**Text:** In the main body of the submitted manuscript this order should be followed: abstract, main text, references, appendix, figure captions, tables and figures. Do not place tables or figures in the main text. As with author details and keywords, acknowledgements are entered separately during the online submission process. Please use a concise and informative title (avoiding abbreviations where possible), as these are often used in information-retrieval systems. During submission authors are asked to provide a word count; this should include all text, including that in the tables, figures, references etc. The use of endnotes and footnotes should be avoided if possible, though if necessary they should be listed separately at the end of the text and not at the bottom of each page. All endnotes (except for table footnotes) should be identified with superscript Arabic numbers. All pages must be numbered in the bottom right-hand corner.

**References:** *Social Science & Medicine* uses the APA referencing system.

## Appendix B – Database search details for literature review

Database searched	Date searched	Search terms	Relevant articles
Cochrane library (search for systematic reviews)	14/01/2010	(SES OR social class OR social status) AND depression	0
Web of Science	04/03/2010	(SES OR social class OR social identity OR social ranking OR social status) AND (depression OR mental health)	56
PsychInfo	04/03/2010	(SES OR SE class attitudes OR social class OR social identity OR lower class OR middle class OR upper class) AND (depression (emotion) OR major depression OR mental health)	22
Medline	11/03/2010	(SES OR social class OR SE factors OR social identification OR hierarchy, social) AND (depression or mental health)	29





**Appendix C - Literature map,  
based on a concept described  
by Creswell (2003)**

**Appendix D: Data extraction form. Based on template retrieved 25/01, 2008, from <http://www.york.ac.uk/inst/crd/report4.htm>**

**Data extraction form**

**General Information**

Review date:

Title:

Author:

Journal:

Publication date:

Volume:

No:

Country:

**Population characteristics**

Target population:

Inclusion/exclusion criteria:

Was SES/social class defined and if so how?

Characteristics –

Age:

Ethnicity:

Gender:

Class:

No of participants in each condition:

A

B

C

Response rate:

Control group:

Recruitment:

**Methodology**

RCT

Cohort study

Case-control study

Cross sectional study

**Measures**

Measures used:

Reliability/validity:

**Analysis**

Statistics used:

Quantitative results

**Quality**

Low – difficulties in three or more of the following areas: sampling, defining variables, measures, analysis or interpretation

Medium – difficulties in two of the above areas

High – no methodological problems or difficulties in one of the above areas

**Relevance**

Low – discusses SES and depression but does not attempt to link the two

Medium – discusses association between SES and depression though this is not the focus of the study

High – main focus of the piece is the association between SES and depression

### Appendix E: Table highlighting main characteristics of included studies

Study ID no., authors and date of publication	Population characteristics	Methodology	Analysis	Brief overview of main results
<b>1</b> Almeida-Filho et al. 2004	$N = 2,302$ (1,052 males). All were residents of Bahia, Brazil. Age 20+. Participants were recruited using a three-stage random sampling procedure	SES data on education, income, occupational history, migration and family social status and consumption was collected. Emotional distress was measured by a subscale of the QMPA, derived from the GHQ measure.	Mantel-Haenszel Chi-Square. Fisher's exact tests.	The prevalence of depression was three times greater among working class, poor women compared to upper-middle class women. For men, no significant differences were found across class levels. A marked gradient of depression prevalence by educational level was highly significant.
<b>2</b> Fone & Dunstan 2006	$N = 29,874$ (11,331 males). All residents of Wales. Age 17-74. Data was collected using a previous health survey where participants were randomly recruited. 61% response rate.	SES data on employment status, housing tenure, occupational social class was collected. The Townsend Deprivation measure was also completed, as well as the SF-36 to measure mental health status.	Multilevel modelling analysis.	Mental health was significantly associated with the Townsend Deprivation score and this effect was strongest in participants who were economically inactive.
<b>3</b> Fone et al. 2007	$N = 10,653$ (4,770 males). All residents of Caerphilly, Wales. Age 18-74. A random sample of participants was recruited, stratified by ward area. 62.7% response rate.	SES data on occupational social class, employment status, income, housing tenure and household council tax valuation band was gathered. The MHI-5 was also completed to measure mental	Multilevel linear regression	Mental health was associated with ward-level economic inactivity. This had a greater effect than individual economic inactivity.

		health status.		
<b>4</b> Frojd et al. 2006	<i>N</i> = 3,278 (1,669 males) Aged 15-16. Ninth grade students of all secondary schools in two Finnish cities were given a survey.	SES information was collected on family structure, parental employment and parental education levels. BDI was completed to measure for depression.	Logistical regression	Perceived financial difficulties of the family were associated with poverty risks and depression. Perceptions alone were as important as actual financial difficulties.
<b>5</b> Gilman et al. 2003	<i>N</i> = 1,089 (573 males). Randomly recruited from individuals taking part in a perinatal project in Rhode Island, USA. Age 18-39, though retrospective (childhood) data used. 71.2% participation rate.	Longitudinal cohort study. Parental SES, family disruption and residential instability measured. Lifetime diagnosis of major depressive episode was measured using the DIS and information was collected on onset and duration of all episodes.	Poisson regression.	Low parental SES, family disruption and a high level of residential instability was associated with higher levels of depression across the lifespan, but most pronounced at age 14. Childhood adversity also associated with recurrent relapse and reduced chance of remission
<b>6</b> Lever et al. 2005	<i>N</i> = 918 (462 males). Age 19-50 years. A non-probabilistic stratified method was used to select the sample. Participants were matched for gender age and SES in each sample area.	SES was recorded, based on income and consumption levels, allowing individuals to be placed in one of three categories according to the poverty line. Measures of depression, self – esteem, competitiveness, mastery, locus of control and	Analysis of variance. Structural modelling analysis of co-variance.	Poverty had an association with subjective well being and life satisfaction. It also effected coping and competitiveness. There are different trajectories through which poverty effects subjective well being.

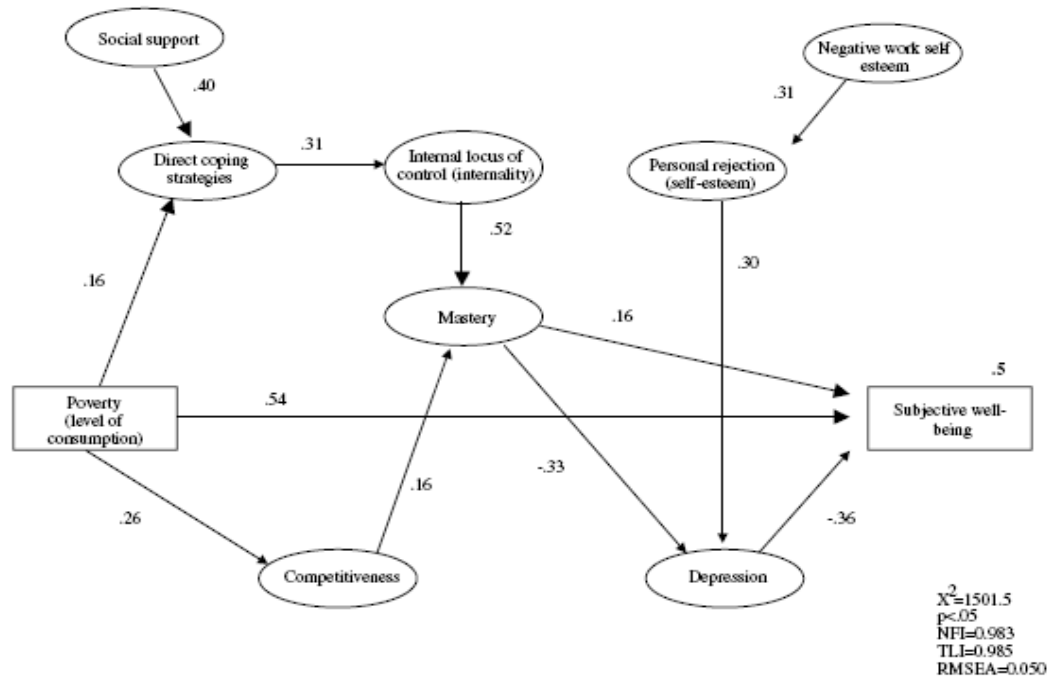
		strategies for coping with stress were taken.		
<b>7</b> Miech & Shanahan 2000	<i>N</i> = 1,883 (missing data on male/female ratio). Age 18-90 years. Recruited from a previous national survey of US households. 82.3% response rate.	SES data was collected on household income, education, economic strain, social support, coping resources, social stressors and physical difficulties. The CES-D scale was used to measure depression.	Bivariate and multiple regression	There was a significant association between low levels of education and depression. This relationship strengthened with age.
<b>8</b> Mirowsky et al. 1996	<i>N</i> = 2,031 (749 males). Age 18-90. Participants were recruited through a national probability sample of US households. 82.3% response rate.	SES data was collected on race, education, household income and economic hardship. A scale created to measure personal and national instrumentalism was administered. Depressive symptoms were measured using the CES-D scale.	Analysis of covariance	SES strengthened views of instrumentalism. A firm sense of personal control (or when that was not present, a sense of American instrumentalism) reduced likelihood of developing depression
<b>9</b> Phongsavan et al. 2006	<i>N</i> = 13,008 (6,348 males) Age 16+. Participants randomly selected through a national survey of Australian residents. 67.9% response rate.	SES data was collected on education level, employment status, home ownership, living arrangements and Socio-Economic Indices for Area (based on previous study data). A measure of social capital was also taken. The K-10 was	Multivariate analysis.	Having trust, feeling safe and social reciprocity were associated with resilience from distress. SES played some part in moderating this relationship.

		used to take a measure of emotional distress.		
<b>10</b> Ross 2000	<i>N</i> = 2,482 (1,018 males). Age 18-92. Uses data from a previous survey on community, crime and health which randomly sampled residents of Illinois, USA. 73.1% response rate.	SES information collected through census data on employment, income, education, household crowding, parental information, urban residence and perceived neighbourhood disorder. A measure of neighbourhood disadvantage was also taken based on census tract. Depressive symptoms were measured by the CES-D scale.	Multilevel regression	Neighbourhood disadvantage was associated with depression, even after controlling for individual factors, with communities containing poor, single mothers being experienced as particularly distressing. Perceived neighbourhood disorder was also a major predictor of depression
<b>11</b> Skapinakis et al. 2006	<i>N</i> = 2,406 (1,020 males). 750 with depression, 1,656 without. Age 16-74. Participants were recruited using a two stage process – postcodes were stratified based on SES, then individuals randomly selected for inclusion. 68% response rate.	Longitudinal cohort study. SES data collected included occupation, education and standard of living. Mental health was assessed using the CAS-R and the ICD-10. Participants were stratified according to mental health status at baseline and were assessed at two time points, eighteen months apart.	Logistic regression analyses	SES was not associated with depression at follow up, but perceived financial difficulties at baseline were associated with depression at follow up in both cohorts.

<b>12</b> Turner & Turner 1999	<i>N</i> = 1,393 (missing data on male/female ratio). Age 18-55. Recruited through probability sampling from residents of Toronto, Canada. 77% response rate.	SES data was collected on occupational prestige, employment status, parental and marital status and household income. A measure of emotional reliance was also taken. Depressive symptoms were measured using the CES-D.	Multiple regression analysis	There was a significant association between emotional reliance and depression – this differed between gender and this was moderated by SES. Education and occupational prestige reduced reliance, particularly in women. Marriage increased reliance for men.
<b>13</b> Turner et al. 1999	<i>N</i> = 1,391 (603 males). Age 18-55. Randomly selected from residents of Toronto, Canada. 76% response rate.	SES data was collected on occupation and marital status. Measures were also taken of self-esteem and mastery. The CES-D was used to measure depressive symptoms.	Multiple regression analysis	Lower SES was associated with reduced availability of resources such as mastery and self esteem. This was consequently associated with increased depressive symptoms.
<b>14</b> Wen et al. 2006	<i>N</i> = 229 (112 males) Age 50-67. Recruited through probability sampling from Illinois, USA.	Individual SES information included marital status, household income and education. Neighbourhood SES data included neighbourhood poverty levels, education levels and perceptions of neighbourhood quality. Self rated health was assessed using the SF-36 scale.	Analysis of covariance	Effects of neighbourhood SES on self-rated health were viewed as acting through sequential pathways of individual SES, perceptions of neighbourhood quality and psychosocial status.



**Appendix F: Structural model showing the association between poverty, depression and subjective well-being (Lever et al., 2005)**



## **Appendix G: Statement of epistemological position**

The current study has been approached from a social constructionist epistemological stance. Such a stance assumes that realities are socially constructed and created through language, with narratives shaping and maintaining those realities (Gergen, 1985). Social constructionism also assumes that there is no objective reality that can be known by human subjects and commented upon by them. This means that only interpretations can be made regarding experience, as the notion of ‘knowing’ is rejected. For this reason, the current study was at the level of suggestion, avoiding claims of ‘truth’ throughout.

There was an assumption in the study that not only does language create reality, constructing the social world through its use, but that the social world consequently shapes language use (Bloor & Bloor, 2007). This is a circular process. For this reason, it was presumed that not only will the analysed text shape meaning, but that the researcher might draw on previously constructed discourses in order to approach the work and search for such meaning. In this respect, the work produced will have a uniqueness.

Throughout analysis there was a stance taken that context is temporary. Lepper (2000) discussed how context can refer to the *interpretation* of meaning and suggested that rather than being viewed as a pre-existing template within which interaction takes place, meaning is generated in the moment, through interaction. In the case of the current study, the context was believed to be the interactional relationship between researcher and text.

## **Appendix H: Copy of email confirming ethical approval by the University of Leicester**

FW: PC\_ethics2008 - Laura Hickman  
De Lillo, Dr C. [cdl2@leicester.ac.uk]  
Sent: 11 February 2009 14:46  
To: '[ljh32@le.ac.uk](mailto:ljh32@le.ac.uk)' [[ljh32@leicester.ac.uk](mailto:ljh32@leicester.ac.uk)]  
Cc: [Kocik, J. \[jk17@leicester.ac.uk\]](mailto:Kocik, J. [jk17@leicester.ac.uk])

Dear Laura Hickman,

Your project "What does newspaper reporting regarding increased cognitive behavioural therapy within the NHS tell us? An exploration using critical discourse analysis" has been approved by the Psychology Research Ethics Committee.

This e-mail is the official document of ethical approval and should be printed out and kept for your records or attached to the research report if required - this includes all undergraduate and postgraduate research. This approval is valid for three years. For research projects lasting more than one year a yearly statement must be sent to the Chair of the Psychology Research Ethics Committee confirming that the research project has not been changed.

We wish you every success with your study.

Carlo De Lillo  
Psychology Research Ethics Committee Chair

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Web-page: <http://www.le.ac.uk/pc/cdl2/>

## **Appendix I: Newspaper articles identified for analysis**

## **Article 1**

1 The Guardian (London) - Final Edition

2 March 28, 2008 Friday

3 Reply Letters and emails: People living in poverty also have mental health  
4 needs

5 **BYLINE:** Malcolm Allen

6 **SECTION:** GUARDIAN LEADER PAGES; Pg. 37

7 **LENGTH:** 198 words

8 As evidence for Zoe Williams' claim that psychodynamic therapy is now unfashionable  
9 and superseded by cognitive behaviour therapy, she says the talking cures the  
10 government pays for are all based on a cognitive model (The getting of wisdom, March  
11 26). In fact, psychodynamic psychotherapy is extensively used throughout the NHS in  
12 both primary and secondary care. A recent survey found that around half of 525 primary  
13 care psychological therapy services offered psychodynamic therapy. A significant  
14 proportion of our membership works within the NHS, as well as in the voluntary and  
15 independent sector.

16 National Institute for Health and Clinical Excellence guidelines, for example on  
17 depression, refer to psychodynamic psychotherapy as a treatment option, as well as  
18 other approaches for certain disorders such as interpersonal therapy, which has its roots  
19 in psychodynamic therapy. The NHS prospectus Commissioning a Brighter Future  
20 (May 2007) refers to talking treatments as including "counselling, CBT, psychoanalysis  
21 and psychodynamic therapies". It is crucial to maintain this diversity to serve the  
22 complex mental health needs of the public.

23 Malcolm Allen

24 CEO, British Psychoanalytic Council

## Article 2

1 The News of the World (England)

2 January 20, 2008 Sunday

### 3 Outdoor fear

4 **BYLINE:** Dr Hilary Jones

5    **SECTION: THE TV DOC; HEALTH; LETTER; SUNDAY EXPERTS**

6 **LENGTH:** 94 words

7 Q My husband has to go to hospital for a hernia operation, but he's had agoraphobia for  
8 15 years. He has no fear of hospitals or the op, but can barely leave our home. How can  
9 we get him to hospital?

10 A Recruit your local psychiatric nursing service for assistance. Medication and some  
11 talking therapy (CBT) could make a huge difference, and provided he is accompanied  
12 by familiar faces when he goes in for his operation, I am sure he will cope just fine.  
13 NHS staff are used to dealing with all kinds of additional problems, so your husband  
14 certainly won't be unique.

### Article 3

1 The Sunday Times (London)

2 December 16, 2007

3 Help yourself

4 **BYLINE:** Anita Chaudhuri

5 **SECTION:** FEATURES; Style; Pg. 54

6 **LENGTH:** 1397 words

7 ANXIETY? DEPRESSION? LIFE PROBLEMS? YOU NEED COGNITIVE  
8 BEHAVIOURAL THERAPY. ANITA CHAUDHURI REPORTS

9 Back in the dark ages, when a woman was going through boyfriend hell, a job crisis, or  
10 even a plain old attack of the blues, she would take herself off to the nearest  
11 psychoanalyst's couch, lie back and sob about her mother -until she either ran out of  
12 time, or money, or both. More recently, the life coach supplanted this role. Now, both  
13 have been consigned to obscurity: those in the know are opting instead for a course of  
14 cognitive behavioural therapy (CBT).

15 CBT has been around since the 1960s, but is currently enjoying unprecedented  
16 popularity. Indeed, demand is so high that the government recently pledged £ 170m to  
17 train new CBT therapists, so that an estimated 1m more people will be able to benefit  
18 from the therapy on the NHS.

19 WHY IS EVERYONE TALKING ABOUT CBT?

20 A report by the London School of Economics, published in June 2006, says that the  
21 success rate for CBT is 50%, which is very attractive for those who don't want to spend  
22 months on a therapist's couch getting nowhere. Another reason why people are queuing  
23 up for sessions is that CBT is used to treat a wide range of issues, from depression and  
24 panic attacks, through eating disorders and body-image issues, to social anxiety,  
25 phobias and relationship problems.

26 Unlike other forms of therapy, notably those of a Freudian persuasion, CBT does not  
27 dwell on childhood events or past traumas, nor does it go on for years.

28 Instead, it offers a fixed course of task-oriented sessions. Between visits, you're  
29 expected to complete "homework" assignments and, depending on what the issue is, you  
30 could finish treatment within six weeks.

31 There are other reasons for its increased appeal, too. Psychologist Rhena Branch, who  
32 practises CBT at the Priory, believes it is more empowering than some other forms of

33 therapy. "CBT doesn't just provide someone with an hour of introspection, which is then  
34 forgotten until the next session," she says. "There is much more interaction, and the aim  
35 is to give someone the tools to be able to function as their own therapist in the future."

36 Sylvia, a marketing manager, was referred to a CBT therapist by her GP to help with  
37 chronic work-related anxiety. "I started arriving later and later for work, and if I was  
38 asked to make a presentation in a meeting, I'd phone in sick," she says. "When I was  
39 forced to speak in meetings where my boss was present, I would feel physically ill, talk  
40 nonsense and spend days beating myself up afterwards, which made me want to avoid  
41 work even more."

42 CBT helped Sylvia to reframe negative thoughts. "I was asked to go through a typical  
43 stressful scenario with my boss -say, at a client meeting to pitch for new business -and  
44 to write down all the thoughts that this 'trigger situation' brought up. We then looked at  
45 how these beliefs created negative emotions that influenced my behaviour -for example,  
46 staying off work or binge drinking to make myself feel better."

47 Establishing the links between the activating incident, unhelpful thoughts and negative  
48 behaviour is key to the way CBT works to bring about positive change.

49 "The therapist went through each statement I made and questioned each one in turn,  
50 asking me to suggest evidence to 'prove' that what I was saying was 100% accurate.

51 She also labelled the different types of thinking I was coming up with, which was  
52 useful."

53 For example, when Sylvia wrote down, "If I don't win this new account, my boss will  
54 think I'm worthless", the therapist asked her to come up with evidence to support this -  
55 and she found herself unable to pinpoint anything her boss had specifically said or done  
56 that proved the belief was true. "She pointed out that my statement fell into a category  
57 known as 'all or nothing' thinking, where the only two concepts you can envisage are  
58 total success or outright failure. Then she gave me an alternative thought to try out: 'My  
59 boss might be disappointed when I don't bring in new business, but will understand that  
60 the competition from other agencies is very tough.'" Another negative statement, "I'm  
61 not cut out for this line of work, I'm going to end up on the dole and then my flat will be  
62 repossessed", was given the CBT label "catastrophising", which is where a person takes  
63 on the worst-case scenario as fact.

64 Over the next few sessions, Sylvia and her therapist worked together to come up with  
65 alternative thoughts and beliefs, such as, "My boss is sometimes very demanding, but I  
66 know I can cope because I have coped with stressful presentations many times in the  
67 past". In a short time, Sylvia started to turn up for work with a more realistic attitude.

## 68 HOW IT WORKS

69 The philosophy behind CBT is that it is not events per se that upset us, but the meaning  
70 we attach to those events. So, if we can learn to change our "faulty" thinking and



71 entertain alternative feelings and beliefs, then our fears are kept in check and we can  
72 change our behaviour.

73 Jill, a fortysomething television producer who had gone through a painful divorce, fell  
74 into a deep depression after a blind date she had high hopes for turned into what she  
75 termed "a disaster". She started to dwell on her inability to form successful relationships  
76 and stopped making the effort to meet new people. Eventually, a friend recommended a  
77 private CBT therapist whom she saw for three months. "CBT helped me to look at my  
78 core beliefs and reframe the way I was looking at my situation. Soon, I began to  
79 understand that my sense of self-worth comes from who I am and what I do, not who  
80 I'm in a relationship with, or whether I'm even in one at all. It gave me back a lot of  
81 power and, ultimately, gave me permission not to be so hard on myself. I started a new  
82 relationship soon afterwards."

83 Branch observes that CBT can be particularly effective at tackling women's self-esteem  
84 issues. "I've successfully worked with a lot of women who are overly concerned with  
85 other people's opinions of them, to the extent that it inhibits their ability to socialise  
86 freely, express opinions and form relationships," she says. "This type of anxiety often  
87 manifests itself as social phobias, or unofficial eating disorders where they're not  
88 starving or bulimic, but have a severely inconsistent pattern of food intake directly  
89 related to their physical attractiveness. I have also used CBT effectively on women who  
90 are abusing alcohol as a coping mechanism for social anxiety."

91 However, before you rush to book an appointment, bear in mind that CBT does have its  
92 limitations. For more serious mental-health conditions, such as schizophrenia and  
93 psychosis, it is not generally recommended, and for some people, the opportunity to  
94 focus on childhood trauma might be the very thing they need to move on. "CBT works  
95 for some people, but not for everyone, and in therapy there are no guarantees," says  
96 Matthew Finnegan of the British Association for Behavioural and Cognitive  
97 Psychotherapies. "It's important when you first meet a therapist that you make a  
98 judgment about whether it feels right for you. They might have all the best  
99 qualifications and expertise in the world, but if you're not comfortable talking to that  
100 person, then it's not going to work."

## 101 CAN CBT HELP YOU?

102 CBT can be used to help anyone whose behaviour is negatively influenced by their  
103 thoughts, assumptions and beliefs. Therapists often use it to treat depression, eating  
104 disorders, obsessive-compulsive disorder, drug and alcohol addiction, panic attacks,  
105 phobias and bereavement. It is not widely used to treat more severe psychiatric  
106 disorders, and those who feel a desire to explore the impact of childhood events on  
107 current behaviour should try psychoanalysis.

108 Further reading Cognitive Behavioural Therapy for Dummies by Rob Willson and  
109 Rhena Branch (John Wiley £ 16). Don't be put off by the title -this is one of the most  
110 comprehensive guides to CBT.

111 How to find a therapist CBT is available on the NHS, subject to GP referral, though  
112 waiting lists in some areas can be up to six months. You can find a private therapist  
113 through the British Association for Behavioural and Cognitive Psychotherapies  
114 (BABCP); [www.babcp.org.uk](http://www.babcp.org.uk). Prices start from about £ 30 an hour for a counselling  
115 therapist; clinical psychologists and psychiatrists, who can prescribe medication, charge  
116 more. If you are seeking a private therapist, make sure they are accredited by the  
117 BABCP.

#### **Article 4**

1 The Guardian (London) - Final Edition

2 October 13, 2007 Saturday

3 Comment and Debate: A dark age for mental health: A therapy last used on  
4 a mass scale in China's cultural revolution is to be unleashed on the NHS

5 **BYLINE:** Darian Leader

6 **SECTION:** GUARDIAN COMMENT AND DEBATE PAGES ; Pg. 34

7 **LENGTH:** 628 words

8 It looks like good news. In an era where psychological problems are increasingly  
9 explained in terms of biological deficits, the government has announced that it will  
10 spend £170m by 2010 on talking therapies for depression and anxiety. The scheme  
11 should pay for itself as better mental health will mean fewer sick days and benefits -  
12 £170m isn't much compared with an annual £12bn cost to the economy. But will it  
13 really help?

14 The answer, sadly, is negative. Talking therapy means not psychotherapy, but cognitive  
15 behavioural therapies (CBTs). These aim at the removal of symptoms and the return to  
16 work of sufferers, who will have learned to identify and manage patterns of undesirable  
17 behaviour. However, clinicians know that patients are likely to be back on a waiting list  
18 within a year to 18 months. Their underlying problems will not have been resolved,  
19 resulting in new symptoms or the return of old ones.

20 Given these well-known problems, why has the government bought into CBT? The  
21 answer is simple: it produces results on paper that keep NHS managers happy.  
22 However, these results come from evaluation techniques that are mostly devised by the  
23 makers of the therapies, and are designed to avoid the complexity of human suffering -  
24 shortcomings highlighted by Paul Verhaeghe, the professor of psychodiagnostics at  
25 Ghent University. Therapy trials tend to follow the medical model, with two groups of  
26 patients who have the same profile and the same symptom. Treatments are then  
27 standardised to rule out the influence of the therapist. Trials are short, usually a few  
28 months. But these basic features are seriously flawed.

29 First, there is really no such thing as the same profile or, indeed, the same symptom.  
30 Each person's experience will be unique, and no real patients will have only one  
31 symptom. Second, since therapy traditionally relies on the personal and unpredictable  
32 input of the therapist, removing this means we are no longer measuring therapy but  
33 something else. The irony is that those therapies that cannot be tested in this way are  
34 deemed unscientific and unsupported by evidence. Rather than recognising that the

35 methods of testing need to be radically changed, evidence-hungry NHS managers  
36 embrace short-term behavioural treatments - and who can blame them?

37 When patients are back on the waiting list, the answer is another dose of CBT.  
38 Treatment becomes part of our management culture: instead of getting to the root of the  
39 problem, we just address the surface symptoms. It's like imagining that killing a few  
40 terrorists will get rid of terrorism, rather than exploring the factors that give rise to it. In  
41 this new dark age, a century of sociology, anthropology, and history and philosophy of  
42 science has been ignored.

43 CBT-style therapies were last used on a mass scale in China in the cultural revolution.  
44 Separated from loved ones - having perhaps witnessed their murder - people were  
45 taught to deny the legitimacy of their symptoms: depression was just the outcome of  
46 false beliefs.

47 Where CBT aims to get rid of symptoms, other psychotherapies seek to give symptoms  
48 a voice: to hear what is being expressed in them, rather than stifle them. This requires  
49 not only time, but the effort and commitment of the patient. Real mental health policy  
50 has to recognise that there are no easy answers, that human beings are complex and  
51 contradictory, and, most important, that we can never know in advance what will be  
52 best for a patient.

53 A true exploration of psychological suffering is perfectly possible in the framework of  
54 the NHS - if policymakers can think beyond mental hygiene and start listening to the  
55 patient.

56 Darian Leader is the author of *Why Do People Get Ill?*; Paul Verhaeghe's paper is  
57 available at Health4Life Conference 2007 [www.darianleader.com](http://www.darianleader.com)

## Article 5

1 The Times (London)

2 June 30, 2007, Saturday

3 Making the difference

4 **BYLINE:** Kate Wighton

5 **SECTION:** FEATURES; Body & Soul; Pg. 5

6 **LENGTH:** 110 words

7 How charities have improved our health

8 Cancer Research UK spent £ 257 million last year on research into cancer treatment.

9 Over the years it has developed temozolomide, a treatment for brain cancer, and  
10 carboplatin, one of the most commonly prescribed cancer drugs in the world.

11 British Heart Foundation A foundation scientist was the first to pin down the exact  
12 cause of a heart attack -a clot in the coronary artery, which has saved lives.

13 The Wellcome Trust developed a cognitive behavioural therapy treatment for bulimia,  
14 now used in the NHS.

15 Alzheimer's Research Trust is funding the biggest trial into whether B vitamins can  
16 slow the progression of the disease.

## Article 6

1 The Guardian (London) - Final Edition

2 May 29, 2007 Tuesday

3 g2: Wellbeing: The therapy minefield: Doctors and patients agree that our  
4 only chance of stemming the tide of antidepressants is to make the  
5 alternatives more accessible. But what exactly are the drug-free options?  
6 Lucy Atkins reports

7 **BYLINE:** Lucy Atkins

8 **SECTION:** GUARDIAN FEATURES PAGES; Pg. 16

9 **LENGTH:** 887 words

10 'I'd been cutting myself since the age of 15," says Angela Harper, 21. "My friends told  
11 the school and the teacher made me an appointment with my GP." Harper's GP referred  
12 her for counselling, but there was a six-month waiting list. During those months, Harper  
13 was left to fend for herself. "I was only 17. I didn't want tell my parents. There were no  
14 check-ups or follow-ups from the GP. It was down to me to keep calling the counselling  
15 service to check on the waiting list. My self-harming got worse and worse - I was  
16 cutting myself every day."

17 At any one time, about one in six adults in the UK has a mental health problem such as  
18 depression or anxiety. Many talking therapies, such as cognitive behavioural therapy  
19 (CBT), are known to get excellent results, particularly for those with mild to moderate  
20 depression and anxiety. But finding a therapist on the NHS can be a massive challenge.

21 In theory, your GP should be able to refer you. In reality, waiting lists can be vast,  
22 therapists few and far between, and specialist help almost impossible to find. In some  
23 parts of the country it is not unusual to wait two years.

24 The National Institute for Health and Clinical Excellence, which sets guidelines for  
25 doctors, recommends that a range of psychological therapies be made available on the  
26 NHS. While the government is trying to make this easier, "Progress is slow, to say the  
27 least," says Moira Fraser, head of policy for the Mental Health Foundation. According  
28 to the mental health charity Mind, 93% of GPs admitted in a survey last year that they  
29 were prescribing antidepressants purely because they lacked viable talking alternatives.

30 More than 31m prescriptions for antidepressants were written last year - an all-time  
31 high. Economically, none of this makes sense. The NHS spends £338m a year on  
32 antidepressant medication alone and GPs have been accused of dashing off Prozac  
33 scripts willy-nilly to save time and money. "We reject the suggestion that GPs prescribe  
34 antidepressants too readily," says Professor Mayur Lakhani, chair of the Royal College

35 of General Practitioners. "We are determined to reduce the prescribing of  
36 antidepressants, (but) some hard choices have to be made."

37 Many people go private but, at up to £50 a session, it is not an option for all. And  
38 finding a good independent therapist can be hit-and-miss. "It is sensible to go via an  
39 organisation such as the British Association for Counselling and Psychotherapy or the  
40 UK Council for Psychotherapy," says Phillip Hodson, fellow of the British Association  
41 of Counsellors and Psychotherapists. "They have a register of qualified, accredited  
42 counsellors or psychotherapists." This gives safeguards, but it is not foolproof.

43 If a therapist asks you to pay for several sessions in advance, or suggests a long, open-  
44 ended relationship, beware. "It is unusual to be asked to pay up front," says Hodson,  
45 "and there should never be an obligation to continue at any point." Vagueness over  
46 terms should also set alarm bells ringing. Your initial meeting should cover their  
47 qualifications, therapeutic approach, fees, when and where you will meet, and their  
48 review procedure - these should not change. Furthermore, says Hodson, anything that  
49 makes you feel "as if you have a new friend" is a cause for concern. Touch is  
50 inappropriate, as is letting a session continue after the time is up. Basically, if anything  
51 your therapist does makes you uncomfortable, check them out (you can call the BACP  
52 information line and talk it over).

53 Studies show that the public want less pharmacology and more talk. A huge public  
54 consultation conducted by the Department of Health in 2005 showed that the second  
55 most popular thing people wanted from the NHS (after free care for the elderly) was  
56 access to more counselling. Certainly, there is evidence that talking therapies such as  
57 CBT can work wonders, but some say it is being overhyped. "CBT is the current big  
58 trend," says Hodson, "but this is partly because it is easier to evaluate than other forms  
59 of therapy. This does not mean that CBT is necessarily 'better'."

60 "CBT helps a lot of people," says Fraser, "but it is not the only solution. We need a  
61 range of evidence-based therapies so that people can get the kind of therapy they really  
62 need." People with eating disorders, for instance, or those who self-harm, need to see  
63 specialist therapists trained to tackle these issues.

64 Part of the problem, says Hodson, is that the majority of GPs have no understanding of  
65 the different types of therapy available. Even those who understand the subtleties of  
66 psychodynamic therapy are not going to be in a position to choose between Kleinian,  
67 Jungian and Rogerian practitioners. Only about 60% of GPs' surgeries even have their  
68 own counsellor attached - the rest use pooled counselling resources or subcontract local  
69 counsellors.

70 This lack of choice can be problematic. By the time Harper's appointment with a  
71 counsellor came up, her self-harming had become acute. "The counsellor was a general  
72 counsellor," Harper says. "She didn't know anything about self-harming. I felt I was  
73 teaching her about it from what I'd learned off the internet, rather than the other way

74 round." Eventually, Harper "just stopped", by herself. Others in her situation may not be  
75 so fortunate \*

76 BACP information line: 0870 443 5252. [www.bacp.co.uk](http://www.bacp.co.uk)



## Article 7

1 The Times (London)

2 January 11, 2007, Thursday

3 Ultrasis

4 **BYLINE:** Robert Cole

5 **SECTION:** BUSINESS; Pg. 51

6 **LENGTH:** 145 words

7 Has Ultrasis beaten the blues? The maker of self-help computer software to treat people  
8 suffering from depression is a former dot-com darling whose shares boomed and then  
9 bust at the turn of the millennium. But last year the company's flagship product, a  
10 computing assisted cognitive behavioural therapy called Beating the Blues, was  
11 approved by the National Institute of Health and Clinical Excellence (NICE) for use in  
12 the NHS.

13 Ultrasis is in talks with the Department of Health about a possible launch of the product,  
14 which is cheaper and more flexible than providing one-on-one counselling services.  
15 Yesterday Ultrasis said that the product would be used by the Priory Group as part of a  
16 contract with Croydon Primary Care Trust. With an annual turnover of just £ 1.2 million  
17 and no profits, this is not a stock for the faint hearted. Brave investors should buy,  
18 however.

## Article 8

1 The Times (London)

2 November 4, 2006, Saturday

3 Talking cure is cheap

4 **BYLINE:** Phillip Hodson

5 **SECTION:** FEATURES; Body & Soul; Pg. 5

6 **LENGTH:** 622 words

7 The five main mental health charities have announced their support for the planned  
8 expansion of NHS psychotherapy, with a broad emphasis on Cognitive Behavioural  
9 Therapy (CBT). But is CBT -a talking therapy that attempts to train your thought  
10 patterns then alter your behaviour -the best investment?

11 An ideological struggle has broken out between two of our leading "happiness thinkers"  
12 about whether the claims made for CBT can be justified. On one hand, Tony Blair's  
13 advisor the economist Professor Richard Layard, is about to launch a health service  
14 programme of CBT nationwide employing 10,000 novice recruits. On the other,  
15 psychologist Oliver James tells Daily Mail readers that CBT only appeals to Tony Blair  
16 because it is "quick, cheap and simplistic" but is seriously lacking in long-term efficacy.

17 So what does the evidence say? First, that it is reasonable for the Government to turn to  
18 the psychological therapies as the frontline treatment for conditions such as anxiety and  
19 depression when the routine prescription of benzodiazepine tranquillisers and  
20 antidepressants costs more than £ 11 billion a year and can yield disappointing results.

21 In CBT's favour is the fact that, as a talking therapy, it does what it says on the label. To  
22 take the simplest example, if you believe nobody loves you then CBT therapists believe  
23 they need only to produce evidence that one person does love you for you to be proved  
24 wrong and for your behaviour to change.

25 The fact that, in a relatively short period, CBT has produced an impressively positive  
26 research base must be qualified by the observation that because CBT is tasked with  
27 "symptom removal", not "treatment of the whole person", research has proved relatively  
28 easy and cheap to undertake. Setting out to measure whether someone has got rid of a  
29 single symptom (such as spider phobia) leads to only two relevant answers: yes or no. It  
30 is much more difficult to evaluate a therapy seeking to show whether you have gone  
31 from "greater" to "lesser" unhappiness but the experience in itself might prove more  
32 life-changing.

33 Critics also observe that the case for standard CBT has been favoured by the way the  
34 guidelines on anxiety and depression, sponsored by the National Institute for Health and  
35 Clinical Excellence (NICE), are presented. Much of the pro-CBT information is to be  
36 found in headline summaries; significant qualifying remarks about other valid therapies  
37 are found in the small print.

38 This matters because Oliver James is right about research in the longer term.

39 According to the most authoritative sources, at least half those patients receiving CBT  
40 for panic disorder had suffered relapse or sought new help after 24 months, which isn't  
41 very cost effective.

42 Last Monday, at a conference on Practice-Based Commissioning in Manchester,  
43 Professor Layard admitted that CBT is appropriate for only about 40 per cent of patients  
44 overall. Stunningly, the largest body of evidence into counselling outcomes, the 35,000  
45 cases comprising the CORE Survey, has been totally ignored by NICE and Layard  
46 alike. Looking at the figures just for depression, CORE shows there is no significant  
47 difference in the long-term success rates for CBT over traditional forms of therapy such  
48 as "person-centred" or "psycho-dynamic": CBT works for 75 per cent of patients; the  
49 rest for 76 per cent.

50 So a summary of the evidence tends to show that all talking treatments are roughly  
51 equal in effectiveness because it is the relationship with the therapist that counts. Patient  
52 choice should count, too. I suggest the NHS would be unwise to put all its eggs into a  
53 CBT basket.

54 Phillip Hodson is a Fellow of the British Association for Counselling and  
55 Psychotherapy ([www.bacp.co.uk](http://www.bacp.co.uk)) Mark Henderson is away

## Article 9

1 Daily Mail (London)

2 October 24, 2006 Tuesday

3 Therapy on the NHS? What a crazy waste of Pounds 600million!;  
4 As the government promotes Cognitive Behavioural Therapy as the  
5 panacea for all mental ills, a psychologist gives his scornful response  
6 GoodHealth

7 **BYLINE:** OLIVER JAMES

8 **SECTION:** ED 1ST; Pg. 57

9 **LENGTH:** 1461 words

10 DEPRESSION and anxiety cost the economy Pounds 17 billion a year. Forty per cent of  
11 those claiming disability allowance do so as a result of mental illness. It's an expensive  
12 business, but the Government has found a quick-fix solution: cognitive behavioural  
13 therapy (CBT).

14 Unlike traditional psychotherapies, CBT does not dwell on past events or traumas.  
15 Instead, the focus is on the patient's fearful and negative thoughts - the therapist helps  
16 the patient deal with these by thinking positively. It takes between six to 16 sessions,  
17 but by the end, the patient is 'cured'.

18 Being cheap, quick and simplistic, CBT appeals to Tony Blair.

19 In June this year, Professor Richard Layard - labelled the government's 'happiness tsar' -  
20 proposed the training of 10,000 CBT therapists to be based in 250 centres across the  
21 country. A trial is planned.

22 Layard claims CBT 'can lift at least a half of those affected out of their depression or  
23 their chronic fear'.

24 Since a course of CBT costs only Pounds 750 - about the same as a month's disability  
25 allowance - the treatment would pay for itself by getting patients back to work. The  
26 Pounds 600 million cost of the new CBT nationwide service would soon be similarly  
27 recouped.

28 Sounds great? If only life were so simple. The truth is more complicated.

29 CBT is a form of mental hygiene.

30 However filthy the kitchen floor of your mind, CBT soon covers it with a thin veneer of  
31 positive polish. But shiny surfaces tend not to last.

32 Take the example of Mrs B, 32, a mother of three who suffered from panic attacks,  
33 agoraphobia (fear of open spaces) and claustrophobia (fear of enclosed spaces).

34 On one occasion, she had been driving through London and panicked she couldn't find  
35 her way home. She ran out of petrol and the police found her at the side of the road,  
36 sobbing.

37 When she got home, she felt 'trapped' inside. But if she went into the garden it seemed  
38 too big - she feared she would 'disappear into the hugeness of the sky'. Only when her  
39 husband come home did she calm down.

40 Her doctor sent her to a clinical psychologist for ten sessions of CBT.

41 He got her to describe the thoughts that came into her mind during attacks, like that she  
42 was about to have a heart attack or that the room would contract and crush her.

43 THEN he asked her to consider if these thoughts were realistic, and to replace them  
44 with less disturbing ones. He also taught her to think positively.

45 For a few weeks, she felt better.

46 But within six months the symptoms returned. Contrary to Layard's optimism, this is  
47 what usually happens after CBT.

48 At the point when the treatment finished, she would have been rated a success. But as  
49 many researchers have shown, where patients have been examined two years later, at  
50 least half of panicky ones have relapsed or sought further help.

51 Even immediately after the end of a course of CBT, the average patient is still having a  
52 panic attack every ten days.

53 The results for depression are even worse. Two-thirds of those treated for depression  
54 with CBT have relapsed or sought further help within two years. If given no treatment,  
55 most people with depression or anxiety drift in and out of it. After 18 months, those  
56 given CBT have no better mental health than those left untreated.

57 However, in the short-term, CBT does have some effect. It reduces the intensity and  
58 number of symptoms for many people.

59 But even this is of questionable advantage, because CBT is very focused, targeting  
60 specific behaviours in isolation. Will, a workaholic property millionaire, is an example  
61 of how superficial this is.

62 After losing a small fortune (since regained), he became depressed and underwent CBT.

63 He says: ' "What you think is what you feel" is very true. I rigidly and fastidiously try to  
64 prevent myself sitting on negative thoughts. I try to remain active, do lots of sport,  
65 outings, things that keep me occupied.' He lives, thinks and talks at a tremendous pace.

66 It could be argued that this is good for him, except that he is involved in a constant  
67 struggle to control his thoughts, with depression always just around the corner.

68 The CBT patient is taught a story to tell themselves, a relentlessly positive one. If the  
69 therapist is skilled, the patient becomes able to ignore many of their true feelings.

70 When tested at the end of the treatment, like a well- coached pupil taking an exam, they  
71 often regurgitate the positive story.

72 A few months after the teachertherapist is no longer coaching them, their anxieties  
73 gradually force themselves to the surface and they cease telling the positive story.

74 The great majority of the reduction in symptoms that CBT patients achieve happens by  
75 their fifth session.

76 Indeed, in 15 per cent of cases, it happens after the first one. This might be because they  
77 are learning a gloss to put on their emotions, a simple technique that can be learned  
78 easily.

79 Another indication comes from testing the unconscious thoughts of those who have just  
80 finished CBT.

81 When words are flashed subliminally on screens, they react faster to depressive ones.  
82 Their dreams reveal a similar hidden negativity.

83 That brief courses of CBT are not the best answer for the commonest emotional  
84 problems (depression and anxiety) is suggested by the case of Mrs B. I treated her once  
85 a week for two years and by the end she had no symptoms. Many years later, she has  
86 had no relapse.

87 But rather than using CBT, I focused on her childhood. She was one of eight children,  
88 and her mother had been unable to care for her very consistently.

89 This had made her jumpy and insecure.

90 It soon became apparent that her panics were triggered by feelings of abandonment  
91 dating back to early childhood. Living far away from her original family, with a  
92 husband who worked long hours and three small children to care for, she had few close  
93 friends.

94 This isolation reminded her of the many times she had felt uncared for by a mother who  
95 was herself very anxious.

96 Over the two years of her treatment with me, we developed a relationship that seemed  
97 reliable to her. In depending on me and not being let down, she gradually discovered a  
98 feeling of safety.

99 CBT had not worked because it addressed only her symptoms.

100 Perhaps she had been unfortunate in her CBT therapist.

101 At its best, CBT encourages volition, the realisation that we can make choices.

102 But its worst, the method trumpets the power of thought over emotion. In the case of  
103 Samantha, for example, a highly intelligent woman in her thirties, 'the therapist just kept  
104 telling me to say black was white'.

105 Describing her despair at her ugliness and corpulence, the therapist tried to persuade her  
106 she was neither. This was despite her having an unusually unattractive face and being  
107 very overweight.

108 MORE experienced CBT therapists have grasped that this kind of doublethink is not  
109 very helpful. If possible, they will see the patient for many more sessions and even  
110 begin to analyse the childhood origins of the problems. But that is not CBT.

111 Far more helpful are methods that go beyond symptoms. One is Cognitive Analytic  
112 Therapy. Initial treatment is for 16 sessions, of which the first four are devoted to the  
113 childhood causes.

114 Psychoanalytic therapies can be helpful, although it is important to find a practitioner  
115 who grasps the importance of childhood causes.

116 But ultimately, CBT doesn't work because it is un-British. It's an American, glass-half-  
117 full philosophy, while Brits generally have a 'glass half- empty' view, making us  
118 healthily realistic.

119 Studies of Americans show them to be living in a rose-tinted bubble of positive  
120 illusions. They are unrealistically optimistic.

121 When asked to rate how sensitive they are to others, 90 per cent of Americans believe  
122 they are in the top 10 per cent of sensitivity - by definition impossible - and the figures  
123 are similar for their falsely bloated self-esteem.

124 Americans who have accurate perceptions of themselves are deemed to suffer from  
125 'depressive realism'. A dangerous formulation, personally and nationally.

126 For if you do not know that things are going wrong, you cannot put them right.

127 While I know Richard Layard to be a well-intentioned, honourable man, I am suspicious  
128 of the motives of the politicians attracted by the economic advantages of his wheeze.

129 Rather than seeking to send the depressed worker back to work with a false smile on  
130 their face, I agree with a saying beloved of one of my aunts: 'We weren't put on this  
131 Earth to be happy.' Happiness is a brief, chimerical state. Rather than being determined  
132 to Think Positive, we should pursue insight, maturity and authenticity. I find the idea of  
133 250 happiness centres to promote rose-tinted bubbles of positive illusions faintly  
134 sinister.

135 OLIVER JAMES is the author of They F\*\*\* You Up - How To Survive Family Life.  
136 His book Affluenza - How To Be Successful And Stay Sane, will be published in  
137 January.



## Article 10

1 Independent on Sunday (London)

2 September 3, 2006 Sunday

3 Final Edition

4 Leading Articles: Listen to Lord Layard

5 **SECTION:** NEWS; Pg. 33

6 **LENGTH:** 604 words

7 Depression, as a genuine, debilitating medical condition, rarely gets the social  
8 recognition that it warrants. Unfortunately, it has also failed to attract the government  
9 attention and funding that it needs. Earlier this year, there was rejoicing among many of  
10 the people who deal with mental illness at the news that the Secretary of State for  
11 Health, Patricia Hewitt, had officially accepted that people who suffered from  
12 depression should be offered a variety of treatments by the National Health Service -  
13 cognitive behavioural therapy as well as Prozac. This paper, which has campaigned  
14 over the past four years for mental illness to be treated with greater humanity and  
15 effectiveness within the NHS, was among the first to welcome Mrs Hewitt's change of  
16 direction. It has not taken long, however, before it became clear that this positive  
17 development is more apparent than real.

18 Back in June Professor Lord Layard, the economist who advises the Government on  
19 ways of advancing the nation's well-being - as opposed to its merely material prosperity  
20 - published research to show that only a quarter of those who suffer from mental illness,  
21 in terms of anxiety and depression, are getting proper treatment. Now, as we report  
22 today, he says they are still neglected. Indeed, people who need help are not even being  
23 put on waiting lists for treatment because those lists are simply too long. The folly of  
24 sidelining this condition within the NHS has been brought home to us in a particularly  
25 tragic fashion by the bleak situation of John Hogan. He is the man who, while on  
26 holiday in Crete, jumped from a hotel balcony after a quarrel with his wife, taking his  
27 two small children with him. His son Liam died and was buried this week' his daughter  
28 survived. Mr Hogan survived too. He suffers from depression, and two of his brothers  
29 committed suicide. His wife said his behaviour was entirely at odds with his normal  
30 loving regard for his children. As Claire Rayner discusses over the page, it was because  
31 of his condition - aggravated by family difficulties - that he killed his own child. Of  
32 course, only a few sufferers behave in this way, but the case demonstrates the dangers  
33 as well as the inhumanity of giving this illness lesser priority within the NHS.

34 What seems clear from Lord Layard's remarks is that the health authorities' undeniable  
35 financial crisis - allied to the Government's obsessive concern with managing its targets  
36 for meeting waiting lists - has undermined ministers' good intentions for treating less

37 serious forms of mental illness. Earlier this year this paper reported that health  
38 authorities were planning to cut as much as pounds 20m from mental healthcare  
39 budgets. Yet it is a problem that continues to worsen: one estimate puts the number of  
40 people suffering from anxiety and depression at one in five. No fewer than nine out of  
41 10 GPs say that they give antidepressants to patients who would benefit more from  
42 talking therapies.

43 More than three million people are dependent on anti-depressants such as Prozac. The  
44 demand for alternative treatments such as cognitive behavioural therapy far outstrips the  
45 rate of recruitment of psychiatrists. Some patients have to wait for two years for access  
46 to a therapist - if they get on the waiting list.

47 Ministers ought also to reflect that a third of people claiming incapacity benefit are  
48 estimated to suffer from depression - a huge cost to the taxpayer. As Lord Layard says  
49 forcibly, the state has a duty to help those suffering from depression. The Government's  
50 failure to live up to its own promises is - forgive the expression - profoundly depressing.

## Article 11

1 The Guardian (London) - Final Edition

2 June 30, 2006 Friday

3 G2: A little more conversation: It is hailed as a quick fix for depression,  
4 schizophrenia, ME - even infertility. Now the government sees it as the  
5 answer to Britain's widespread mental health problem. So what is cognitive  
6 behavioural therapy? And does it really work?

7 **BYLINE:** Helen Pidd

8 **SECTION:** GUARDIAN FEATURES PAGES; Pg. 6

9 **LENGTH:** 3145 words

10 From her early teens, Katie had two nicknames. They were "Fat Sharon", inspired by  
11 Pauline Quirke's character in Birds of a Feather, and the more self-explanatory  
12 "Womble". Though meant in jest, the taunts cut deep, and by the time she was 16 she  
13 desperately wanted a way to make the bullying stop.

14 More than a decade has passed since she first managed to stick two fingers far enough  
15 down her throat to trigger the vomiting reflex. Now 27, the chronic blisters below her  
16 knuckles are testimony to her long struggle with bulimia, formed after more than 3,000  
17 brushes with her upper teeth. She has tried "everything" in order to shake the condition.  
18 "Self-help books, self-help groups, acupuncture, psychiatrists, both the NHS and  
19 private, psychologists, people-centred counsellors, antidepressants," she lists. "And  
20 probably some others I've forgotten."

21 One approach she has tried over the past few years, and continues to be treated with  
22 regularly, is cognitive behavioural therapy (CBT), a "talking" therapy which was largely  
23 ignored until 10 years ago but which, as well as being used as treatment for bulimics, is  
24 suddenly being touted as the best "evidence-based" (ie rigorously scientifically tested)  
25 cure for just about everything, from depression and phobias to schizophrenia, ME,  
26 obsessive compulsive disorder and obesity. In perhaps the most astonishing study yet,  
27 scientists last week from Emory University in Atlanta, Georgia, US, suggested that it  
28 could even combat infertility. In a small pilot study of women who had not had a period  
29 for at least six months, CBT appeared to kick-start ovulation in some 80% of cases.

30 All this, from between five and 20 hours of very structured conversation. No wonder  
31 many people are asking where the catch is with this ostensibly quick "fix", which  
32 undoubtedly appeals to our modern consumer instincts. In a world where everything  
33 from food to weight-loss is delivered in double-quick time, a therapy that can  
34 apparently be knocked off in a matter of months has a definite allure.

35 It is definable, in general terms, as a kind of talking therapy which is based on the belief  
36 that psychological problems are the products of flawed or irrational ways of thinking  
37 about yourself, the world and other people. Its very broad aim is to evaluate realistically  
38 - using a rigid, structured approach, often including the setting of homework - why a  
39 person feels a certain way, in order to modify their negative thoughts and improve not  
40 just their mood but also their behaviour. In fact, CBT works on the assumption that  
41 while it is often easy to talk about doing something, it is much harder actually to do it. It  
42 is a bit like getting a helping hand from a sort of benevolent thought police,  
43 administered one-on-one or in a group by a doctor, nurse, social worker, occupational  
44 therapist, physiotherapist, counsellor, teacher or psychologist. Anyone, in fact, who  
45 decides they want to practise CBT. You can even do it on yourself, with the help of a  
46 CD-rom or self-help book.

47 Every Tuesday, Katie goes to her local community mental health centre in Essex for a  
48 one-on-one session with a psychotherapist trained in CBT. When her name is called, she  
49 goes into the small room, gets out her homework - a food diary, risky situation  
50 worksheet, shifting core beliefs worksheet, thought monitoring worksheet and other  
51 assorted bits of paper - and the therapist asks her to go through everything she has  
52 written down. Where was she when she started to binge? What was she doing? Who  
53 was she with? What may have triggered it? How did she feel before/during and  
54 afterwards?

55 There is no couch, no "tell me about your childhood/dreams/father". Barely any mention  
56 will be made of her past. Instead, the therapist tries to encourage Katie to rationalise her  
57 thoughts now, to see the connection between her feelings and her actions. He tries to  
58 recognise unhelpful patterns of behaviour ("I ate a whole loaf of bread, then made  
59 myself sick because I felt ugly and fat") and replace these with more realistic or helpful  
60 ones ("I don't need to binge. I have other ways of controlling my emotions, like calling a  
61 friend or going kickboxing). This very practical, proactive approach is rather different  
62 from the classic modes of therapy, which one CBT convert describes as "frustratingly  
63 fluffy and meaningless" and "encouraging you to feel you are not responsible for your  
64 own personal wellbeing".

65 Getting people to talk about their problems in a logical, meaningful way is not rocket  
66 science, but it is this sort of therapy that the government, with the help of its "happiness  
67 guru", economist Professor Richard Layard, wants to ramp up and make available for  
68 the one million people receiving incapacity benefit in Britain because of mental illness.  
69 According to the Depression Report, released last week by Layard and a group from the  
70 London School of Economics, mental illness has taken over from unemployment as  
71 today's greatest social problem, costing £17bn a year. It came hot on the heels of the  
72 results of a huge public consultation conducted by the Department of Health last year  
73 for the Our Health Our Care white paper, which showed that the second most popular  
74 thing people wanted from the NHS (after free care for the elderly) was access to more  
75 counselling and therapy.

76 In the face of not-terribly-strong competition from more "traditional" forms of  
77 psychotherapy, which have tended not to be subjected to rigorous clinical trials and are

78 generally far more costly because of the longer time involved, CBT has been pinpointed  
79 as the most economically viable and evidence-based answer to Britain's widespread  
80 mental health problem. Layard and co claim that with fewer than 16 meetings with a  
81 therapist (at a cost of just £750 to the state), at least half of people with depression or  
82 clinical anxiety can be cured completely. It is this kind of hype which has prompted  
83 some to hail the treatment as the new cure-all - or as one rather more sceptical  
84 psychiatrist put it, "the bollocks du jour".

85 It was as recently as 2003, almost 30 years since an American doctor called Aaron T  
86 Beck developed CBT, that Nice, the government body set up to advise on best  
87 treatment, began to recommend CBT as either the first-line treatment or an adjunct  
88 treatment for anxiety, depression, eating disorders, obsessive compulsive disorder, post-  
89 traumatic stress disorder and schizophrenia. Despite - or because of - these  
90 recommendations, demand far outstrips supply. Though the Department of Health says  
91 that there are as many as 60,000 practitioners trained in CBT in the UK (48,553 of  
92 whom are psychiatric nurses), this figure is misleading, because the majority do not  
93 exclusively practice CBT. According to Layard, the waiting list for an NHS referral  
94 through a GP for CBT can be up to 18 months, but if a government-led series of pilots  
95 goes to plan, from 2008 CBT could be offered to millions of Britons.

96 Jennie Bowden, a 29-year-old recruitment administrator from Sheerness, is one  
97 beneficiary. She had been having seizures for three years, unexplained fits that would  
98 put her in a trance for minutes at a time. Initially diagnosed as frontal-lobe epilepsy (a  
99 brain disorder), doctors subsequently decided that the roots of her condition were  
100 psychological and that her seizures were non-epileptic. She started seeing a therapist at  
101 the Maudsley psychiatric hospital in south London for an initial course of 10 one-hour  
102 sessions, and less than a year on, is now having only one fit a day (compared with five,  
103 pre-CBT).

104 "It's like going back to school," she says. "I take notes - it's like taking lessons in how to  
105 retrain your brain." It is, she says, a very pragmatic approach. "One thing I discovered  
106 that sets off my seizures is - and this might sound strange - the cord of a telephone. If I  
107 stared at it for too long, I'd have a seizure. CBT has taught me how to concentrate on  
108 just one tiny detail of the cord, rather than the whole thing, and channel my energy into  
109 that rather than the whole thing. And it works so quickly." The somewhat jaw-dropping  
110 speed at which CBT reaps results is, of course, particularly appealing in today's fast-  
111 moving society, and marks a real cultural shift in the way mental health is treated.  
112 Compare it, for example, to psychoanalysis, which often takes many years to  
113 "complete".

114 There is no doubt that CBT has the weight of scientific evidence behind it when  
115 compared with other forms of psychotherapy, such as the let-them-talk-freely ideas of  
116 Rogerian counselling or psychodynamic therapy, which tend to be much harder to  
117 subject to clinical trials because of their more nebulous nature.

118 But while there are few, if any, mental health specialists prepared to dismiss CBT out of  
119 hand, there are a significant number of experts who feel that CBT is being grossly  
120 oversold. The primary objection seems to be that it doesn't work for everybody (not  
121 even nearly, say some), and that this one-size-fits-all approach may ride roughshod over  
122 more traditional forms of therapy which can be just as - if not more - worthwhile in  
123 many cases. A year ago, there was even a debate at the Institute of Psychiatry entitled:  
124 "CBT is the New Coca-Cola: This house believes that cognitive behavioural therapy is  
125 superficially appealing but overmarketed and has few beneficial ingredients."

126 Phil Richardson, professor of clinical psychology at Essex university, who also heads  
127 the psychotherapy evaluation research unit at the Tavistock clinic in north-west London,  
128 is one voice of dissent. "While I am in no way against putting more money into mental  
129 health, the available empirical evidence does not support many of the claims that are  
130 being made for CBT," he says. "There is a risk that those involved in delivering the  
131 psychological therapies will end up with egg on their face when the wild claims are  
132 shown eventually to have been false."

133 Richardson thinks that Layard's big idea - the notion that it is possible to get depressed  
134 people off incapacity benefit and back into work with up to 16 hours of CBT - is  
135 fundamentally flawed. "While many studies have shown that it is effective for people  
136 with simple, uncomplicated depression, there is no good evidence to suggest that the  
137 kind of depression suffered by people who are signed off work - that is, those who have  
138 been treated with no success at least once - can be helped by CBT," claims Richardson.  
139 He and a colleague have conducted a systematic review of the available evidence and  
140 says that the trials are almost exclusively conducted on patients with mild, first-time  
141 depression - "those who have nothing else wrong with them to complicate things". He  
142 concedes that the logic behind this is reasonably sound: traditionally, good clinical trials  
143 use a clearly defined treatment on a clearly defined group of people because they are  
144 relatively easy to control. But the problem is that in order to be signed off work, the  
145 chances are that your depression has gone past the mild stage.

146 Katie, who is soon to become an in-patient at a London hospital, and whose bulimia  
147 prevents her from holding down a job or having any real structure to her life, agrees.  
148 "It's good that CBT deals with the here-and-now, and I do find it helpful to a certain  
149 extent, but for me it has come too late. My problems were left undiagnosed and  
150 untreated for too long. I had already been bingeing for more than four years when I first  
151 sought treatment."

152 Another woman told the Guardian that she was turned away from one private CBT  
153 therapist for having "too many intertwining problems". Though she went along  
154 ostensibly to address her depression, when she admitted underlying problems with an  
155 eating disorder, the therapist refused to treat her. "CBT is very inflexible," she says.

156 While the jury is out on whether CBT can really help those with serious, complicated  
157 and long-term mental health problems, it is in some way becoming the "acceptable" face

158 of therapy for those with less chronic problems - particularly those who would rather  
159 suffer in silence than lie on a couch and tell strangers about their dreams.

160 Take Stefanie, a 37-year-old primary school teacher. "I'm not an introspective person,"  
161 she says. "I'm not the sort of person who goes to therapy." But she did, last year, for  
162 eight sessions at £45 an hour, after a harrowing experience when her child very nearly  
163 died. "After my son was so gravely ill I started to react out of all proportion at any sign  
164 of illness. Because something so catastrophic had happened, I lost the ability to know  
165 when to fear the worst. CBT taught me how to recognise the difference between rational  
166 and irrational anxiety. After just eight hours I feel that I now have the tools to draw on if  
167 I need to." Karen liked how specific it was. "It's not a huge commitment, like going into  
168 analysis. It can be done relatively quickly."

169 But despite CBT taking a relatively small amount of time, it can be a deceptively large  
170 commitment. "In theory it's fantastic, but in practice it's completely useless unless you  
171 are incredibly self-motivated and have the time and determination to put the effort in,"  
172 says Janice, a 31-year-old advertising executive who had seven hours of private CBT a  
173 few years ago after her GP told her there was a two-year waiting list for NHS treatment.  
174 "If you don't bother doing one, if not two, hours of homework every night - recording  
175 and monitoring your moods and thoughts - it won't help at all." And there is one other  
176 key thing: "You have to already have admitted to yourself that you have a problem."

177 Even CBT's greatest proponents admit readily that the treatment has its limits and  
178 caution against billing it as healthcare's great white hope. "There is the danger that CBT  
179 is being oversold as a cure-all. But no treatment is a cure-all," says Philippa Garety,  
180 professor of clinical psychology at the Institute of Psychiatry and head of psychology at  
181 the South London and Maudsley Trust, who has conducted a lot of research into CBT  
182 and schizophrenia. "What is true, however, is that CBT is useful for quite a number of  
183 problems because so many things are related to how we experience and make meaning  
184 of the world."

185 It seems unbelievable that a condition such as schizophrenia, which is not just "all in the  
186 mind" but, most people now accept, is a brain disease, can be ameliorated by a talking  
187 therapy such as CBT. But, says Garety, it can - not as an exclusive treatment, but  
188 typically as an adjunct to medication. "Medication often helps change people's acute  
189 psychotic experiences, to reduce the over-arousal of the brain, but it doesn't always help  
190 to change how they felt about them at the time. As an example: a schizophrenic man  
191 who, after medication, had stopped seeing things jump out of mirrors at him, was still  
192 acutely troubled by the sense that he was being watched. He thought there were cameras  
193 on every street corner, above his bed, in his flat. Nothing was private any more and he  
194 was very distressed about it. Although the acute episode had been resolved, he couldn't  
195 change the way he felt, and he didn't want to take drugs in the long term. CBT was able  
196 to help him, because we looked at how he was making sense of his experiences, and at  
197 his triggers. We looked at why when a family member phoned up and said, 'Are you ok?  
198 you sound down,' he interpreted that as meaning that they had put a camera in his flat

199 which is how they knew he was having a bad day. We were able to unpack these  
200 thoughts and feelings in the context of his relationships, and discuss what we termed his  
201 'paranoid default'. After 20 hours of CBT spread over a year, this man (who had been  
202 schizophrenic for 10 years) stopped thinking that he was being watched."

203 But while the Department of Health diverts money to CBT, what happens to other  
204 therapists? The psychodynamic therapists? The family counsellors? Perhaps  
205 understandably, they are feeling rather left out. "It's a short-sighted policy," says Keith  
206 Hagenbach, who since 2001 has been a self-employed NHS psychotherapist.  
207 "Therapists should be free to adapt an approach to each particular client rather than  
208 being forced to practice just CBT, which I think is only really effective in 10% of cases  
209 I see." The Royal College of Psychiatrists, however, says that CBT is "the most  
210 effective psychological treatment for moderate and severe depression; as effective as  
211 antidepressants for many types of depression".

212 Hagenbach thinks that the reason CBT is so popular among policy makers is because of  
213 their innately rational and logical bias. "It appeals to people on committees because  
214 those sort of people are likely to take an intellectual, rather than emotional, approach to  
215 an issue." He and others worry that CBT is being seen as a one-size-fits-all treatment,  
216 "when the truth is that different people who have had relatively similar experiences can  
217 respond totally differently to the same treatment." Another worry is that not everyone is  
218 very good at practising CBT - and that the CBT industry is currently unregulated.  
219 Anyone can set themselves up as a therapist despite the existence of an accrediting  
220 body, the British Association for Behavioural and Cognitive Psychotherapies.

221 But despite the grumbles of dissent, one thing is sure: everyone involved appears  
222 delighted that mental health, so often described as the "Cinderella" of healthcare -  
223 underfunded and unappreciated - is finally getting the attention, and cash, it deserves.  
224 "We are often horrified and outraged that not everyone has access to certain cancer  
225 treatments," says Professor Garety, "yet tens of thousands are suffering enormously  
226 from mental health problems, particularly depression and anxiety, and being denied  
227 access to treatments that have been proven to be effective." CBT may not be a cure-all,  
228 but it can cure some. And for many, that's enough \*

229 Some names have been changed Eating disorders Association: [www.edauk.com](http://www.edauk.com) British  
230 Association for Behavioural and Cognitive Psychotherapies: [www.babcp.com](http://www.babcp.com)

231 Just connect . . . how CBT works Practitioners of cognitive behavioural therapy claim it  
232 can help you make sense of overwhelming problems by breaking them down into  
233 smaller parts. This makes it easier to see how they are connected and how they affect  
234 you. In the following example, the same situation leads to two very different results . . .

235 Situation

236 You have had a bad day, feel fed up, so go out shopping. As you walk down the road,  
237 someone you know walks by and, apparently, ignores you



- 238 Unhelpful
- 239 Thoughts He/she ignored me - they don't like me
- 240 Emotional feelings Low, sad and rejected
- 241 Physical feelings Stomach cramps, low energy, feel sick
- 242 Action Go home and avoid them
- 243 Helpful
- 244 Thoughts He/she looks a bit wrapped up in themselves - I wonder if there's something
- 245 wrong
- 246 Emotional feelings Concerned for the other person
- 247 Physical feelings None - feel comfortable
- 248 Action Get in touch to make sure they are OK

## **Appendix J: Statement of researcher orientation and research expectations**

In approaching this piece of work, I recognise my own position as a trainee clinical psychologist who is beginning to explore different theoretical models that inspire clinical working. In particular, I am aware that whilst I often use CBT as a therapeutic approach, I am beginning to show a preference for other ways of working that involve consideration of an individual's social context.

The recent focus by the government on the IAPT agenda leaves me feeling mixed emotions. Whilst I am encouraged that more funding is being given towards the development of psychological provision within the NHS, I am concerned that the increased concentration on CBT means that other approaches are becoming devalued. New IAPT-worker roles are being created and I fear that the opportunity for clinical psychologists roles to be developed may be limited. This feels somewhat threatening and there have been times when I have felt angry and frustrated by what seem to be simplistic claims made regarding recovery by those who have developed IAPT.

It is often hard to know how to respond to these feelings. On some occasions I wonder whether to support the IAPT agenda in the belief that I will secure my professional role. At other times I feel like opposing it, resisting to conform to a purely CBT-approach and waiting to see if the predictions for success prove to be unfounded before stepping in and showing my worth as someone who works in a person-centred manner.

In carrying out this piece of research, I hope to understand something about the way in which CBT is spoken about and consequently how it has become so central in causing emotional responses within the field of psychology. I suspect that findings might suggest CBT to be an easy answer to mental health problems with emotional

experiences reduced to facts and figures that look good on paper. In this respect, CBT might be constructed as a uncomplicated treatment, similar to the giving of medication. I also expect that the methodological difficulties of the original IAPT pilot studies will be absent from CBT's descriptions.

## **Appendix K: Results summary**

Text regarding individuals with mental health difficulties constructs males and females differently. Whilst females who are appropriate candidates for CBT appear to lack common sense, exaggerate difficulties and struggle to maintain emotional stability alone, creating psychological difficulties from within, males are constructed as passive victims of mental health problems, being attacked from external sources and unable to put up a fight. Females are shown to benefit from the back to basics, common-sense approach of CBT which is seen to be essential to their needs, with empowerment being suggested through its use. Alternatively, male clients are suggested to already have a sensible and logical approach to difficulties, reinforced by their ability to utilise CBT easily when they choose to, however this, on occasions, is suggested to be hopeless in dealing with external difficulties. CBT is presented as being potent, scientifically state of the art and trendy in comparison to other approaches and the client is constructed as passive in its use, with CBT becoming personified and the agent of change. Articles which criticise CBT counter the above by questioning the ‘realness’ of the approach, suggesting emotional problems to be more subjective and less easily ‘swept under the carpet’. It could be suggested that the articles frame the hard sell of a cure-all involving such a commonsensical approach as ignorance and deceit on the part of professionals. Throughout the text, polarisation is used to encourage the reader to take a stance, positioning CBT, contemporaneity, fashionableness, empowerment and common sense on one side, with other therapies offering the opposite on the other. Whilst the articles recommend choice for mental health clients, this technique serves to implicitly reduce treatment options.

## Appendix L: Chronology of research process

	<b>Stage of research</b>
January - May 2008	Ideas for research topic gathered and relevant literature considered. Self-contained literature review commenced.
June 2008	Initial research proposal submitted.
July - August 2008	Research proposal revised and final research questions agreed.
September 2008	Research supervisors identified. Research diary commenced.
October 2008 - May 2009	Planning of research completed, including reading of literature relevant to methodology. Introduction section and parts of the Methodology section drafted.
June 2009	Newspaper articles for analysis identified and initial reading of these completed.
July - November 2009	Initial analysis of newspaper articles completed.
December 2009 - January 2010	Results section drafted. Newspaper articles re-visited for further analysis where necessary. Self-contained literature review updated and amended.
February 2010	Discussion section drafted. Newspaper articles re-visited for further analysis where necessary.
March - April 2010	Final writing up of self-contained literature review, research report and critical appraisal.