A handbook for homeopaths working with patients with mental health problems

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Homeopathy Action Trust is the membership charity that encourages and supports public understanding of homeopathy, for the benefit of patients, practitioners and students. Please visit our website to find out more and consider donating to our funds, to allow us to fund more projects in the future, such as this Handbook.

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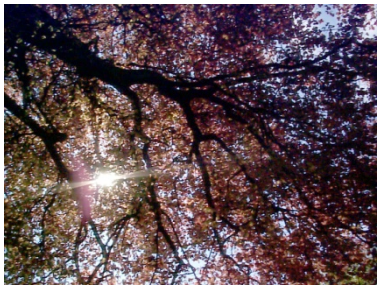
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Preface

This handbook has been developed as a resource for homeopaths, particularly those who are working outside of the conventional healthcare system. The information it contains is drawn from people with expertise in the field of mental healthcare, both conventional, and homeopathic. It is not designed to help improve the quality of your homeopathic prescribing; it is concerned purely with case management issues and will suggest strategies for dealing with challenging situations in practice. This handbook will not help you to become an expert in the field of mental health. Please refer to the information here alongside your professional code of ethics and practice and remember to seek advice whenever you feel out of your depth.

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Chapter 1 Introduction and background

Homeopaths have a well documented history of treating people with mental health problems and current trends indicate that by 2020 mental health problems will contribute to 15% of global disease burden (Murray & Lopez, 1996).

Estimates of the prevalence of mental health problems in the UK vary and several large scale surveys have been conducted to provide data on the prevalence of both treated and untreated psychiatric disorders in the English adult population (aged 16 and over). The Adult Psychiatric Morbidity Survey (APMS) series consists of 3 such surveys conducted in 1993, 2000 and 2007.

The latest survey in the series was conducted by the National Centre for Social Research in collaboration with the University of Leicester for the NHS Information Centre for Health and Social Care (2009). Undertaken in 2007 and published 2009 the main findings are summarised as follows:

- in 2007 nearly one person in four (23.0 per cent) in England had at least one psychiatric disorder and 7.2 per cent had two or more disorders;
- in 2007 5.6 per cent of people aged 16 and over reported having survived unsuccessful suicide attempts; the proportion of women (aged 16-74) reporting suicidal thoughts in the previous year increased from 4.2 per cent in 2000 to 5.5 per cent in 2007;
- people aged over 75 were included in the survey for the first time in 2007. In this age group, common mental disorders (CMD) were higher in women than men (12.2 per cent of women compared to 6.3 per cent of men).

According to the mental health charity MIND, around 300 people out of every 1,000 will experience mental health problems in Britain each year. The types of treatments sought and used can be broken down as follows:

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- 230 of these will visit a GP
- 102 of these will be diagnosed as having a mental health problem
- 24 of these will be referred to a specialist psychiatric service
- 6 will become inpatients in psychiatric hospitals.

(Hatloy, 2011)

By far the most commonly experienced mental health problem is mixed anxiety and depression with an estimated prevalence figure of 9.2 per cent of adults. This is followed by general anxiety at 4.7 per cent and depression (without the symptoms of anxiety) at 2.8 per cent. These figures show an increase in the prevalence of mixed anxiety with depression compared with the 1993 survey by 1.4 per cent. (The Office for National Statistics, 2000)

1.1. Homeopathy and mental health care

"I can confidently assert, from great experience, that the vast superiority of the homoeopathic system over all other conceivable methods of the treatment is nowhere displayed in a more triumphant light than in mental and emotional diseases of long standing," (Hahnemann, Organon of Medicine, § 230)

Historically homeopathy has been used in the treatment of psychiatric conditions since its inception in the eighteenth century, and over 200 years of homeopathic literature suggests that patients with a broad spectrum of mental health concerns seek homeopathic treatment. Many prominent homeopaths beginning with the founder Samuel Hahnemann to more current day practitioners (Bailey 2010; Reichenberg-Ullman &Ullman, 2002; Saine, 1999; Shalts, 2010; van der Zee, 2010; Whitmont, 1980) have written extensively about the treatment of people with mental health conditions.

There is limited available data to describe the full range of conditions treated by homeopaths, how commonly they are seen, or how effective treatment is. It is apparent however that many patients seek help for anxiety and depression and a study involving over 6,500 patients at the Bristol Homeopathic Hospital demonstrated that they are in the top 10 most commonly referred conditions to this NHS provision (Spence et al., 2005). A survey of French homeopathic general practitioners had earlier demonstrated that stress and anxiety

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was one of the most common complaints that clients presented with (Trichard et al., 2003). A more recent service evaluation of members of the Society of Homeopaths concluded that the most commonly cited reasons for seeking treatment fell within the category of mental and emotional problems (Relton et al., 2007).

A survey of 200 UK homeopaths (Chatfield & Duxbury 2010) suggested that a substantial number of people with mental health concerns are choosing homeopathic treatment. The most commonly treated conditions fall into the categories of anxiety and mood disorders, reflecting known prevalence of these disorders. It is apparent however that homeopaths are treating people with a full spectrum of mental health disorders including psychoses.

The same survey suggested that whilst it is widely accepted that homeopaths, working in a holistic and individualised manner, aim their treatment at the whole person and not specific allopathic diagnoses, respondents from the survey identified some case management issues that may be peculiar to this particular field of work.

Mental health care workers in the conventional medical world work predominantly as part of a team. They have particular expertise in the treatment of patients with mental health problems and training in how to deal with challenging situations. In comparison there are few examples of homeopaths working within an integrated team of health care professionals for the treatment of patients with mental health problems. Consequently it is likely that the majority of homeopaths are practising outside of the conventional healthcare system and therefore without access to standard support networks available to mental health care professionals.

This handbook has been developed as a resource for homeopaths, particularly those who are working outside of the conventional healthcare system. The information it contains is drawn from people with expertise in the field of mental healthcare, both conventional, and homeopathic. It is not designed to help improve the quality of your homeopathic prescribing; it is concerned purely with case management issues and will suggest strategies for dealing with challenging situations in practice. This handbook will not help you to become an expert in the field of mental health. Please refer to the information here alongside your professional code of ethics and practice and remember to seek advice whenever you feel out of your depth.

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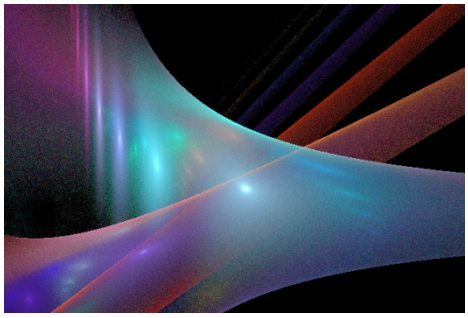
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Chapter 2 Classification of mental health conditions

"A classification is a way of seeing the world at a point in time."
(Norman Sartorius, Director, Division of Mental Health, World Health Organization)

This chapter provides an overview of the classification of mental health conditions, an outline of the main presenting and diagnostic features, and conventional approach to treatment of common mental disorders.

2.1. The purpose of classification

Homeopathic philosophy teaches that the person is an integrated whole of mind and body and as such no part should be treated in isolation. Disease labels are widely considered as unimportant to the homeopathic diagnosis and identification of a suitable remedy. Furthermore it is not within the scope of the professional homeopath to diagnose in a conventional medical sense, either in terms of competence or ethics. However, it is becoming more widely acknowledged that certain groups of patients require more specialised knowledge and competence, particularly with respect to case management. As naturopaths Robert Ullman and Judyth Reichenberg-Ullman, who have extensive experience of working with in the field of mental health, comment:
"There are many potential pitfalls, however. Just having the right homeopathic medicine without correct management and follow through is not sufficient for success", (Ullman & Reichenberg-Ullman, n.d.).
Practising in the field of mental health care can be a particularly demanding area. It is a specialist field and calls for an awareness of the complex needs of the clients and an

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understanding of the type of issues which are likely to be encountered. Having an understanding of disease terminology is important for responsible case management and may be of great importance to the patient.

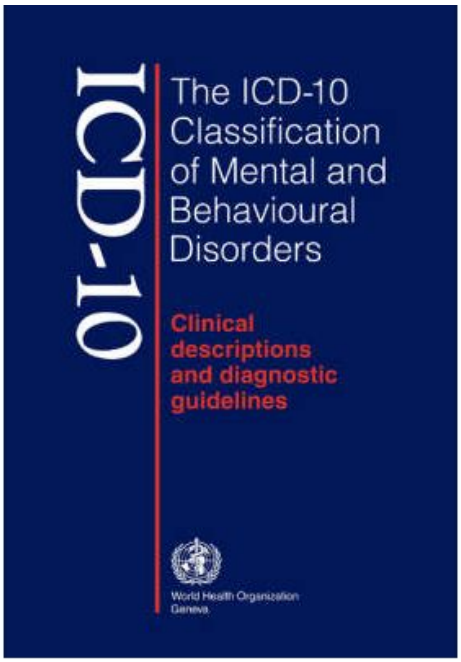
Classification systems of the natural world, in any respect, are invariably imperfect and open to question as they attempt to sort individual entities into common groups. Through the process of categorisation subtle individual differences may be overlooked in favour of the selected unifying factors. However, in practise, classification systems can be very useful as they allow us to organise information into more accessible forms. Indeed in homeopathy we can see the direct impact of classification upon prescribing in the work of Rajan Sankaran and Jan Scholten.

In medicine the classification of disease allows for easier communication between individuals: professional to patient, professional to professional, and so on. Classification of disease provides a common vocabulary and may also be useful for both assessment of patient needs and the natural progression of disease and prognosis.

In mental healthcare the classification of disease has proven to be particularly challenging. Early classification systems had poor diagnostic reliability and there was a great deal of disagreement between specialists from different educational and cultural backgrounds. In addition it should be remembered that most diagnoses of mental health problems are based upon subjective judgement rather than objective tests and as such are open to question. Currently there are two dominant classification systems for mental disorders that you may come across: The International Classification of Diseases (ICD-10) published by the World Health Organization (WHO), and the classification system of the American Psychiatric Association (APA), the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). In this handbook we will focus only upon the ICD-10 classification as it is the more widely used of the two systems.

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2.2. World Health Organisation ICD-10



The International Classification of Diseases (ICD) is an international standard diagnostic classification for all general epidemiological and many health management purposes. It is now in its tenth revision and hence the name ICD-10. Chapter V is the chapter relevant to mental and behavioural disorders. With over 300 individual conditions listed ICD-10 is quite difficult to access and hence a more user friendly primary care version of the mental disorders classification was designed by an international group of general practitioners, family physicians, mental health workers, public health experts, social workers, psychiatrists and psychologists with a special interest in mental health problems in primary care.
A full version of the WHO ICD-10 classification produced for primary care practitioners can be found at this web address:
http://whqlibdoc.who.int/publications/1996/0889371482_eng.pdf
This publication is very useful for those who work in mental health care because as well as describing diagnostic criteria, it also contains management guidelines for each condition including essential information for patient and family, specific counselling advice for patient and family, and strategies concerning the management of the condition (how to cope, what to do, etc.).

The ICD-10-classification for mental disorders consists of 10 main groups:

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F0 Organic, including symptomatic, mental disorders

F1 Mental and behavioural disorders due to use of psychoactive substances

F2 Schizophrenia, schizotypal and delusional disorders

F3 Mood [affective] disorders

F4 Neurotic, stress-related and somatoform disorders

F5 Behavioural syndromes associated with physiological disturbances and physical factors

F6 Disorders of personality and behaviour in adult persons

F7 Intellectual disabilities

F8 Disorders of psychological development

F9 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

In addition, there is a group of "unspecified mental disorders".

This section of the handbook presents an outline of the main presenting and diagnostic features, and conventional approach to treatment of the most common mental disorders in each group. It is necessarily a simplified outline of ICD-10 classification for mental disorders but hopefully will aid understanding of how mental and behavioural disorders are classified and treated. For more detailed descriptions it is recommended that you access the previously mentioned full version of the WHO ICD-10 classification at this web address: http://whqlibdoc.who.int/publications/1996/0889371482_eng.pdf
In addition, further detailed information about conventional medications can be found in Chapter 6 'Medication Matters'.

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F0 Organic, including symptomatic, mental disorders

Examples: Dementia & Delerium

Dementia

Frequent in old age, memory loss from dementia needs to be differentiated from other causes of memory loss such as drug abuse and depression. The patients may themselves not notice that there is a problem and it may be the family who ask for help.

The diagnostic features include:

- decline in recent memory, thinking and judgement, orientation, language.
- patients often appear apathetic or disinterested, but may appear alert and appropriate despite poor memory.
- decline in everyday functioning (dressing, washing, cooking).
- loss of emotional control - patients may be easily upset, tearful or irritable.

Conventionally antipsychotic medication may be prescribed in low doses to control agitation, psychotic symptoms or aggression and patients may be admitted to hospital or nursing home if agitation is extreme.

Delirium

Acute onset of confusion or clouded awareness that can be induced by a variety of causes such as head trauma, infections, metabolic changes or drug intoxication (and withdrawal).

Hospitalisation may be required to treat the underlying cause.

F1 Mental and behavioural disorders due to use of psychoactive substances

Examples: Alcohol use disorders, drug use disorders

Alcohol use disorders

Alcohol abuse is considered an illness with potentially serious consequences. It is not always easy to spot because patients may deny abuse but presenting complaints may include

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depressed mood, nervousness and insomnia as well as physical complications such as ulcers, gastritis and liver disease. In addition there may be related social problems.

Heavy alcohol use in the UK is defined as consumption of over 21 units of alcohol per week for men and over 14 units per week for women.

Withdrawal symptoms can include anxiety, tremors, and sweating. Conventionally, short-term use of benzodiazepines are often employed as well as outpatient monitoring of the patient. Patients with severe alcohol withdrawal (with hallucinations and autonomic instability) may be hospitalised and prescribed higher doses of benzodiazepines.

Drug use disorders

Persons with drug use disorders often also suffer from alcohol use disorders and symptoms may mirror those of alcohol abuse with nervousness, insomnia and depression but there may also be signs of abuse of a specific drug. For example:

- *Opiates:* nausea, sweating, tremors
- *Sedatives:* anxiety, tremors, hallucinations
- *Stimulants:* depression, moodiness.

Similarly to alcohol abuse there may also be harmful social consequences as well as physical complaints. Withdrawal may cause tremors, anxiety and pain and relapse is common. Benzodiazepines are often prescribed for the withdrawal of sedatives and severe sedative withdrawal (with hallucinations and autonomic instability) may require hospitalization. Withdrawal from stimulants, cocaine or opiates is distressing and may require medical supervision.

Withdrawal from opiates is sometimes managed with a 10-14 day tapering dose of methadone or naltrexone.

Specialised counselling programmes and self-help groups are often recommended for drug dependence.

F2 Schizophrenia, schizotypal and delusional disorders

Examples: Chronic psychotic disorders (schizophrenia and persistent delusional disorders), acute psychotic disorders

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Chronic psychotic disorders

The range of presenting complaints is wide but normally includes one or more of the following:

- difficulties with thinking or concentration
- reports of hearing voices
- strange beliefs (e. g., having supernatural powers, being persecuted)
- extraordinary physical complaints (e. g. having an unusual object inside one's body).

Often it is the family rather than the patient themselves who seek help because they have noticed some kind of strange behaviour. There may also be self-neglect, social withdrawal and periods of agitation or restlessness. Acute episodes often resolve though they may recur. The long-term course of the illness is difficult to predict

Conventionally treatment with antipsychotic medication is used to reduce agitation, hallucinations and delusions (e.g., haloperidol or chlorpromazine). However there are common motor side-effects of medications including:

- Acute dystonias or spasms, normally managed with injectable benzodiazepines or antiparkinsonian drugs;
- Akathisia (severe motor restlessness) normally managed with dosage reduction or betablockers;
- Parkinsonian symptoms (tremor, akinesia) normally managed with oral antiparkinsonian drugs.

Family support is considered essential for compliance with treatment and effective rehabilitation

F3 Mood [affective] disorders

Examples: Depression, bipolar disorder

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Depression

The patient may present initially with one or more physical symptoms (fatigue, headache, pain) but further enquiry reveals depression or loss of interest.

The diagnostic features include:

- low or sad mood.
- loss of interest in usual activities (withdrawal or inactivity).
- disturbed sleep
- poor concentration
- guilt or low self-worth
- disturbed appetite
- fatigue or loss of energy
- change in weight
- suicidal thoughts or acts
- decreased libido
- agitation or slowing of activity
- symptoms of anxiety or nervousness are also frequently present.

Conventionally, antidepressant drugs may be prescribed if sad mood or loss of interest is prominent for at least two weeks, the most widely prescribed type being selective serotonin reuptake inhibitors (SSRIs). SSRIs are usually preferred over other antidepressants as they are thought to cause fewer side effects and overdose is less likely to be fatal. The best known SSRI is Fluoxetine (sold under the brand name Prozac) but there are others such as: citalopram (Cipramil), paroxetine (Seroxat) and sertraline (Lustral).

Other types of antidepressants include:

Serotonin-norepinephrine reuptake inhibitors (SNRIs) which work in a similar way to SSRIs, including: duloxetine (Cymbalta and Yentreve) and venlafaxine (Efexor).

Tricyclic antidepressants (TCAs) are an older type of antidepressants and no longer usually recommended as a first-line treatment for depression. They include: amitriptyline (Tryptizol), clomipramine (Anafranil) and imipramine (Tofranil)

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If the patient shows significant risk of harm to self or others or, if psychotic symptoms are present, consultation with a specialist (normally psychiatrist or clinical psychologist) is recommended.

Other therapies such as counselling or cognitive behavioural therapy (CBT) may also be considered, especially for treatment of acute cases and prevention of relapse.

Bipolar disorder

If a patient has a history of manic episodes (excitement, elevated mood, rapid speech), in addition to periods of depression, then he/she may have bipolar disorder. This is a major affective disorder marked by severe mood swings (manic or major depressive episodes) and a tendency to remission and recurrence.

The manic phase of bipolar disorder may include:

- feeling very happy, elated or overjoyed
- talking very quickly
- feeling full of energy
- feeling self-important
- feeling full of great new ideas and having important plans
- being easily distracted
- being easily irritated or agitated
- doing things that often have disastrous consequences, such as spending large sums of money on expensive and sometimes unaffordable items
- making decisions or saying things that are out of character and that others see as being risky or harmful.

Between episodes of depression and mania there may be periods of "normal" mood but some people with bipolar disorder can repeatedly swing from a high to low phase quickly without having a "normal" period in between. This is known as rapid cycling.

The extreme nature of the condition means that staying in a job may be difficult and relationships may become strained. There may also be an increased risk of suicide.

Conventionally, medication is used in different ways to treat bipolar disorder. Some people take regular medication on a long-term basis to prevent episodes of mania and depression. These are known as mood stabilisers, the most commonly used being lithium carbonate.

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Others use medication to treat the main symptoms of depression and mania only when they occur. Periods of depression may be treated with antidepressants and periods of mania are often treated with anticonvulsant medicines such as valproate or carbamazepine
In addition people living with bipolar disorder are often referred for other psychological treatments such as counselling or clinical psychology to help deal with depression and/ or other life challenges such as coping with relationships.

F4 Neurotic, stress-related and somatoform disorders

Examples: Anxiety disorders, unexplained somatic complaints, obsessive compulsive disorder.

Anxiety disorders

The patient may present initially with tension-related physical symptoms (e.g., headache or palpitations) but enquiry reveals prominent anxiety.
The diagnostic features include:
Fear, anxiety or worry (exaggerated worry, inability to relax), often accompanied by:

- poor concentration
- fast or pounding heart
- restlessness
- headaches
- tremors
- dizziness
- churning stomach or nausea
- sweating.

Disorders may occur as sudden attacks of anxiety or fear and some patients may have extreme fear of specific situations. Common feared situations include: leaving home, crowds, social events, buses or trains. Patients may be unable to be alone in these situations or may avoid them altogether.

Learning skills to reduce the effects of stress is conventionally considered the most effective relief and patients are normally encouraged to deal with anxiety without medication. If

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panic attacks are frequent or if the patient is also depressed, antidepressants may be prescribed.

For patients with more severe anxiety, short-term use of anti-anxiety medication (e. g., lorazepam) may be used with caution as regular use may lead to dependence with symptoms returning when the medication is discontinued.

Unexplained somatic complaints

Any physical symptom may be present without a physical explanation and symptoms may vary widely across cultures.

Diagnostic factors are impossible to specify for every case but there may be:

- symptoms of depression and anxiety
- dramatic presentations with exaggerated, attention-seeking behaviour
- unusual symptoms not consistent with known disease
- symptoms that vary from minute to minute
- symptoms that may be related to attention from others
- frequent visits to health services although medical examinations show no physical problem
- focus on seeking relief from physical symptoms only
- conviction of the presence of physical illness and inability to believe that no medical condition is present (hypochondriasis).

Conventional treatment approaches vary according to the expression of disease. Referrals to specialists are normally avoided and patients are managed by a primary health care physician. Patients may be offended by psychiatric referral and seek additional medical consultation elsewhere.

F5 Behavioural syndromes associated with physiological disturbances and physical factors

Examples: Eating disorders, sleeping disorders, sexual dysfunction (not associated with physiological problem)

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Eating disorders

The patient may present because of binge eating or extreme weight control measures such as self- induced vomiting, excessive use of diet pills, and laxative abuse. The family may ask for help because of the patient's loss of weight, refusal to eat, vomiting or amenorrhea

Diagnostic features include:

- unreasonable fear of being fat or gaining weight
- extensive efforts to control weight (strict dieting, vomiting, use of purgatives, excessive exercise)
- denial that weight or eating habits are a problem.

Patients with anorexia nervosa typically show:

- severe dieting despite very low weight
- distorted body image (unreasonable belief that one is overweight)
- amenorrhea.

Patients with bulimia typically show:

- binge eating (eating large amounts of food in a few hours)
- purging (attempts to eliminate food by self-induced vomiting, diuretic or laxative use).

A patient may show both anorexic and bulimic patterns at different times.

Conventionally, antidepressants are sometimes prescribed for associated depression but treatment most commonly involves some kind of talking therapy. Referral for psychiatric treatment or to specialist help units is recommended for severe cases and hospitalisation may be needed if there are medical complications.

F6 Disorders of personality and behaviour in adult persons

Examples: Paranoid personality disorder, avoidant personality disorder, borderline personality disorder.

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Mild personality disorders that do not seriously interfere with a person's ability to function socially are thought to be common. Severe disorders are rare and affect less than 2% of the population. With severe disorder the individual may differ significantly in terms of how they think, perceive, feel or relate to others. Distortions in how a person feels and distorted beliefs about other people can lead to odd behaviour.

Diagnostic features include:

- being overwhelmed by negative feelings such as distress, anxiety, worthlessness or anger ;
- avoiding other people and feeling empty and emotionally disconnected;
- difficulty managing negative feelings without self-destructive behaviour (for example, self-harm, abusing drugs and alcohol, or taking overdoses);
- odd behaviour;
- difficulty maintaining stable and close relationships;
- periods of losing contact with reality.

People with personality disorders often have other mental health problems, especially depression and substance misuse. Symptoms typically increase with stress. Personality disorders often emerge in adolescence and continue into adulthood. They may be associated with genetic and family factors or experiences of trauma during childhood, such as neglect or abuse. Many different types of personality disorder are specified in ICD-10. According to National Health Service Choices (2012) these can be broadly grouped into one of three clusters.

Cluster 1 personality disorders

A person with a cluster 1 personality disorder tends to have difficulty relating to others and usually shows patterns of behaviour most people would regard as odd and eccentric. Others may describe them as living in a fantasy world of their own. An example of this type of disorder is paranoid personality disorder, where the person is extremely distrustful and suspicious.

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Cluster 2 personality disorders

A person with a cluster 2 personality disorder struggles to regulate their feelings and often swings between positive and negative views of others. This can lead to patterns of behaviour that others describe as dramatic, unpredictable and disturbing. An example of this type of disorder is borderline personality disorder, where the person is emotionally unstable, has impulses to self-harm, and intense and unstable relationships with others.

Cluster 3 personality disorders

A person with a cluster 3 personality disorder struggles with persistent and overwhelming feelings of anxiety and fear. They may show patterns of behaviour most people would regard as antisocial and withdrawn. An example of this type of disorder is avoidant personality disorder, where the person appears painfully shy, socially inhibited, feels inadequate and is extremely sensitive to rejection. The person may want to be close to others, but lacks confidence to form a close relationship.

Conventionally there is no single approach to treatment and different types of psychological therapies have been shown to help people with different personality disorders. Most people recover or improve over time.
No medication has been licensed for the treatment of any personality disorder but may be prescribed to treat associated problems such as depression, anxiety or psychotic symptoms.

F7 Intellectual disabilities

Presents differently according to age-group.

In children:

- delay in usual development (walking, speaking, toilet training)
- difficulties with school work, as well as with other children, because of learning disabilities
- problems of behaviour.

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In adolescents:

- difficulties with peers
- inappropriate sexual behaviour.

In adults:

- difficulties in everyday functioning (e. g., cooking, cleaning)
- problems with normal social development, (e. g., finding work, marriage, child-rearing).

Diagnostic features are varied but will normally include learning difficulties and social adjustment problems.

The degree of severity may vary widely and is normally categorised as follows:

- severely retarded (usually identified before age 2, requires help with daily tasks, capable of only simple speech)
- moderately retarded (usually identified by age 3-5, able to do simple work with supervision, needs guidance or supervision in daily activities)
- mildly retarded (usually identified during school years, limited in school work, but able to live alone and work at simple jobs).

Malnutrition or chronic medical illness may cause developmental delays but for most causes of intellectual disability there is no conventional medical treatment. For these individuals conventional care is aimed at management rather than treatment.

F8 Disorders of psychological development

Examples: Specific developmental disorders of speech and language, specific developmental disorders of scholastic skills, specific developmental disorders of motor function, pervasive development disorders such as Asperger's syndrome and Autistic disorder.

Pervasive development disorders

In England, it is estimated that 1 in every 100 children has a form of pervasive development disorder. The conditions are more common in boys than girls, with boys being three to four times more likely to be affected.

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Autistic disorder begins in childhood and is marked by the presence of abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interest; manifestations of the disorder vary greatly depending on the developmental level and chronological age of the individual.
Children with autistic disorder usually have significant problems with language, social interaction and behaviour. Many children with autistic disorder also have learning difficulties and below-average intelligence.

Asperger's syndrome also begins in childhood and causes milder symptoms that affect social interaction and behaviour. Language development is not usually affected but children often have problems in certain areas of language, such as understanding humour or figures of speech.
Children with Asperger's syndrome usually have intelligence within the normal range. Some children have particular skills in areas that require logic, memory and creativity, such as maths, computer science and music.

Pervasive developmental disorder – not otherwise specified or PDD-NOS is diagnosed in children who share some, but not all, of the traits of autistic disorder or Asperger's syndrome. Most children with PDD-NOS have milder symptoms than children with autistic disorder, but they do not share the language skills and normal range of intelligence associated with Asperger's syndrome.
There is currently no conventional medical cure for pervasive developmental disorders. However, a wide range of treatments, including specialist education and behavioural programmes, are used to help improve symptoms.

F9 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

Examples: Attention deficit hyperactivity disorders, conduct disorder, enuresis

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Attention deficit hyperactivity disorder

The presenting symptoms are commonly that the child/adult cannot sit still, is always moving, cannot wait for others, will not listen to what others say and has poor concentration. Younger patients are likely to be failing in school work.

Diagnostic features may include:

- severe difficulty in maintaining attention (short attention span, frequent changes of activity)
- abnormal physical restlessness (most evident in classroom or at mealtimes)
- impulsiveness (the patient cannot wait his or her turn, or acts without thinking)
- discipline problems, underachievement in school, proneness to accidents

This pattern occurs in all situations (home, school, play).

Specialist consultation or behavioural treatment is normally considered before drug treatment. If this is unsuccessful, or not available, then stimulant medication (such as methylphenidate or dextroamphetamine) may be used to improve attention and reduce over-activity.

Conduct disorder

Parents or schoolteachers may request help in managing disruptive behaviour in the child.

Diagnostic features may include:

- abnormally aggressive or defiant behaviour
- fighting
- bullying
- truancy
- cruelty
- stealing
- lying
- vandalism.

Conduct must be judged by what is normal for age and culture and may be associated with stress at home or school.

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Counselling of the individual and family is the normal approach to treatment as there is no recommended conventional medicine. Referral to specialist consultant may occur in severe cases.

Enuresis

The presenting complaint will be repeated urination into clothes or bed.

Diagnostic feature:

Delay in ability to control urination (wetting at night is considered normal until the mental age of 5 years)

The urination:

- is usually involuntary
- may be continuous from birth, or may follow a period of continence
- sometimes occurs with more general emotional or behavioural disorder
- may begin after stressful or traumatic events

Enuresis is normally part of a specific delay in development and is often inherited.

Conventional treatment is normally through use of alarm systems, reward systems, exercises to increase bladder control, etc., rather than with medication. Specialist referral is considered if the problem persists beyond the age of 10 years.

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Chapter 3
Don't be alone

In this chapter we will look at what help is available to patients through mental health services and how they can access them. As well as the need for having additional support in place for patients, it can also be very important for the homeopath to feel that they have the necessary support in place for themselves. Hence in this chapter we will also be looking at what support is available for the practitioner and where they can turn to for help should they need it.

One specific piece of advice that came from all practitioners who were consulted for the production of this handbook was that it is unwise, and potentially harmful, for a homeopath to try and work alone with patients who have severe mental health problems. This opinion echoed the same message from previous studies (Chatfield & Duxbury, 2010; Reed, 2007). Some went as far as to say that if a patient does not have a support network in place, and if they are not willing to access mental health services to put this in place, then we must think very carefully about taking them on as patients because we probably do not have the necessary facilities to help them. Of course, in an ideal world, it would be most beneficial for the patient if their homeopathy treatment could form part of a package of care but sadly this is not possible for most. Because of this homeopaths have to be sensitive to the needs of their patients and acutely aware of their own limitations.

3.1. Support for the patient

Most of the information below has been drawn from the website of the mental health charity, Mind (http://www.mind.org.uk). Mind is the largest and most well known mental health charity in the UK and is a valuable source of information for patients and practitioners alike. Check regularly on the Mind website for the most current descriptions of

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available mental health services in the UK because the way that they are delivered changes from time to time.

3.1.i. The mental healthcare system in the UK

There are many different support services available in the UK, delivered through the NHS, social services and voluntary organisations. These can appear as quite a complex array but the first port of call is normally the GP who can make an assessment of needs and advise appropriate courses of action. GPs are able to offer limited care, such as medication and counselling, but for any further needs they will refer the patient to specialist mental healthcare services, normally either a consultant psychiatrist, or to the Community Mental Health Team (CMHT).

The Community Mental Health Team (CMHT)

Support delivered in the community is divided into health care, for which the NHS is responsible, and social care, which is organised and delivered by local authorities. Teams of people work together with each patient to help address their needs, and one member of each team will act as the 'care coordinator' or 'key worker', being the main contact person for that person. The CMHTs vary from place to place, and person to person, but include people like: community psychiatric nurses (CPN), psychologists, occupational therapists, counsellors, community support workers, and social workers.

CMHTs can offer medication, counselling, or other mental health treatments. They can also provide help to deal with social difficulties such as benefits, employment, problems with daily living and relationship problems etc.

Most CMHTs have a team base in an office or a clinic but members can also work in different places, such as the patient's home. Additionally patients will normally be able to reach someone on the telephone outside of standard office hours.

As much as possible the health and social care representatives work together to attend to the all round needs of the individual. In addition, voluntary sector organisations can be a valuable source of support, offering advice, drop-in centres, or just someone who will listen.

Currently in the UK, health and social services, and the voluntary sector, are becoming more intermingled because of the way in which funding occurs. For example, primary care trusts (PCTs) can pay for some social and voluntary sector services, while local authorities can pay

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for nursing care. Anyone can ask for an assessment for health and/or social care, including carers, who may need emotional care and support of their own because they are caring for someone else. Helping carers to cope is an important role of CMHTs. This support can include information, advice, encouragement, education about mental health and being put in contact with local support groups.

Assessment of need does not guarantee that help will be forthcoming, certain eligibility criteria are in place against which each individual is assessed. The National Service Framework for Mental Health (Department of Health, 1999) states that any individual with a 'common mental health problem' should have 24-hour access to local services as necessary to meet their needs. They can also use NHS Direct for advice and referral to specialist help lines or local services.

If you think a patient might need community care services, encourage them to ask their local authority social services department to assess their needs. A carer, friend or relative can also ask for an assessment on someone else's behalf.

3.1.ii. Mental health assessment

Unless in severe crisis, the general practitioner (GP) is the first person to see for an assessment of mental health but if you believe the patient is experiencing severe mental health problems, a mental health crisis or is in danger of harming themselves or others, emergency assessment can be undertaken in the following ways, with or without the patient's consent:

- A visit to the accident and emergency department at a local hospital, if necessary call an ambulance.
- A phone call to the emergency number at the local social services department.
- In extreme cases the police may be called and they will take the person to a safe place to be.

Emergency departments are not always the best places for people in crisis so it may help if the patient is accompanied by a friend, relative or advocate. Here they will probably wait to be assessed by a mental health nurse or psychiatrist and arrangements made for treatment or care. In extreme circumstances, where there is a risk to safety or an immediate need for

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treatment, the patient may be referred to the inpatient psychiatric ward of the nearest hospital. Others may be referred back to their GP or a CMHT.

3.1.iii. Other available services

Crisis resolution teams (CRTs)

CRTs are a fairly new development in mental health services. They provide intensive and rapid support for people who are experiencing a mental health crisis and who, without the team's help, would be admitted to a psychiatric hospital. For people in the community, CRTs aim to arrive quickly and are subsequently available to contact 24 hours a day, seven days a week. Support continues for as long as it is needed or until the person transfers to another service. This is usually just two or three week, although the length of time varies. CRTs can work with the patient by putting together a crisis management plan. This can include different treatments and supports such as medication, practical help, counselling and education in important mental health issues. They will then visit frequently, often each day until the crisis is over.

Most areas now have a CRT; although they sometimes work under different names such as 'home treatment teams' or 'crisis teams'. People who are under the care of a CMHT will be given the number to call for a CRT should they need it. GPs can also refer to a CRT as can the emergency department or psychiatric unit in a hospital. Depending on where the patient lives they may also be referred via social services, voluntary organisations, the police or probation services. In some areas it is possible for the patient to refer him/herself. This is particularly likely if the CRT has been involved in treatment in the past.

Assertive outreach (AO) teams

For those people who do not want, for whatever reason, to use conventional mental health services, AO teams may be preferred as they can be more flexible in the ways in which they work. AO teams are also part of secondary mental health services, and are usually attached to the CMHT, but are able to work in different ways. AOs tend to work with people who have particularly complex needs and require more intensive support to work with services.

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Appointments with AO team members can be made in places chosen by the patient, wherever they feel most comfortable. Like CMHTs, AO teams can be made up of a range of people with different backgrounds and they can help with the same kind of issues. However, unlike CMHTs they can be flexible in the approach taken and aim to build long-lasting and trusting relationships. People who access AO teams often have a range of other problems, such as drug or alcohol misuse, homelessness or may be in trouble with the police. Just as with a CMHT the patients will be assigned a care coordinator who will oversee the support given and they should also be able to telephone a worker outside of standard office hours. To receive AO team help patients normally have to be referred by the CMHT but they are not available in all areas as some have been disbanded.

Advocacy

Sometimes it can be difficult for a person with mental health problems to say what they want, understand their rights and obtain the services that they need and are entitled to. In these circumstances an advocate may help to make sure that a patient's views are heard, respected and acted upon. In the mental health services, advocates can help while a person is in hospital as well as while living in the community.

Advocates are trained and experienced; often they are users or past-users of mental health services. They may work voluntarily or as paid workers. An advocate can help people to find the information they need and can also accompany them to meetings about services.

Citizens Advice, Mind, NHS Direct, local mental health services, and GP surgeries should be able to provide information about local advocacy projects.

NHS Direct

NHS Direct is a telephone advice line for people who are concerned about their physical or mental health. Via the telephone it provides access to round-the-clock clinical information, confidential advice and reassurance. The NHS direct healthcare professionals, including nurses, trained health advisors and dental advisors can deal with a wide range of health queries.

The advisers can send information in the post (available in many different languages), and provide contact details for relevant organisations. They can discuss treatment options,

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medication issues, such as side effects, and what to expect from different services. The NHS Direct website (www.nhsdirect.nhs.uk) also provides information about mental health.

If a patient calls NHS Direct whilst experiencing a mental health crisis they will be put straight through to a nurse. Depending on what is happening, the nurse may call an ambulance, provide details of the local 24-hour CMHT, or call them on the patient's behalf. In the rare cases where there is an immediate risk of harm to the patient or others, the nurse may call the police.

Other telephone help lines

Telephone help lines can provide essential support to someone in a mental health crisis, particularly if they provide 24-hour cover.

The best known helpline for people in an emotional or mental health crisis is that of the Samaritans and this helpline is available to anyone in distress or despair. In addition there are the help lines of national charities like Mind that focus on specific mental health problems.

Several national charities for specific mental health problems operate telephone help lines out of office hours; for example, No Panic (for panic and anxiety-related problems) and b-eat (the Eating Disorders Association) (see Chapter 8, Useful information and contacts).

Some of these help lines link with NHS Direct, which can refer callers with mental health problems to a local helpline of an approved standard.

Most organisations that provide help lines also provide support through other media such as email and text message. This could be important for those who have problems speaking on the phone.

3.1.iv. Other helpful therapies

In addition to those treatments that are offered as a standard part of the mental healthcare system, some patients may also wish to consider accessing one or more of the talking treatments that are available in their area. Often these are offered as part of NHS package of care but in some cases may only be available in the private health sector.

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Some of the most common types of talking treatment are:

- Counselling
- Psychotherapy
- Cognitive behavioural therapy
- Group therapy
- Relationship or family therapy.

For more information on each of these therapies see chapter 8, Useful information and contacts.

In addition to these talking therapies, you may wish to consider other CAM options. These are the CAM therapies that Mind suggest may be helpful:

- Acupuncture
- Aromatherapy
- Arts therapies
- Bowen
- Herbal remedies
- Massage
- Nutritional therapy
- Traditional chinese medicine (TCM)
- Yoga, meditation and relaxation

Further information and links are available on the Mind website here:
http://www.mind.org.uk/mental_health_a-z/8067_complementary_and_alternative_therapy

3.2. Support for the homeopath

In practice unexpected things happen all the time. Practitioners deal with new and challenging situations frequently and skills grow with experience. However, most practitioners, new and experienced, are able to describe situations that left them feeling uncertain about what to do, or how to react, from time to time (Chatfield & Duxbury, 2010). There are several places that practitioners seek advice, help and support, the most obvious of which are described here.

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3.2.i. Your professional body

Practitioners who are registered with a professional body agree to abide by Codes of Ethics, that lay out the basic principles of what is and what is not acceptable in practice. Hence the first place for you to look when seeking guidance is the Code of Ethics from your own professional organisation.

The guiding principles in Codes of Ethics can be extremely helpful but they are necessarily general and it may not always be easy to apply them to particular situations. If you are struggling with a particular issue that has arisen in practice then you can seek help and advice from someone in your professional organisation. If they cannot help you directly they should be able to point you in the direction of someone who can help you to resolve your issue. Give them a call and ask for advice when you need it.

3.2.ii. The value of supervision

Supervision is used routinely in many mental healthcare disciplines, as well as many other professions, in order to promote learning and reflective practice, and thereby improve patient safety and the quality of patient care. There are many different forms of supervision but it is essentially a conversation between professionals, either informal or more formally organised in planned meetings. Professional supervision consists of the practitioner meeting regularly with another professional, not necessarily more senior, but normally with training in the skills of supervision, to discuss casework and other professional issues in a structured way. In many professions supervision is regarded as a vital part of professional (and personal) development.

The practise of homeopathy can be extremely rewarding but can also be challenging, difficult, and draining at times. The work that we do can affect us in many ways and in order for us to do the best for our patients we need to ensure that we are in fit state to treat them. Looking after oneself is essential in order to avoid burn out. Education and training can prepare us to a certain extent and ongoing training can help us keep up to date with new developments. However, on a day to day basis, buttons can be pressed, new challenges arise, new dilemmas posed, and personal life situations affect us. Having a supervisor in place, with whom you can unload and discuss your work, can help in many ways.

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Professional supervision encourages reflection on your professional practice, and through the supervision process the supervisor is able to hold the mirror up to you, reflecting back what they see, in a manner that is akin to the homeopathic process. The objective stance of the supervisor can promote insight as well as offering support.

The kinds of things that professional supervision can be used for include the following:

- to help with challenging practice issues
- to debrief about difficult experiences and problems
- to explore deeply the work that you are doing
- for support when you may feel overwhelmed
- to talk about practice development
- to help you explore your aims and ambitions for your practice
- to manage a process of change
- to help clarify queries about the homeopathic or healing process.

Ultimately good supervision can enhance safety for both patient and practitioner. It can help you to develop your skills in a supportive environment and to ensure that you practice ethically and effectively.

If you are looking for a supervisor in your area ask colleagues who they see. Also ask your professional body if they can recommend anyone who has received supervision training. Although it can help, it is not absolutely necessary that the person from whom you receive supervision is a homeopath so consider looking outside the profession if you need to.

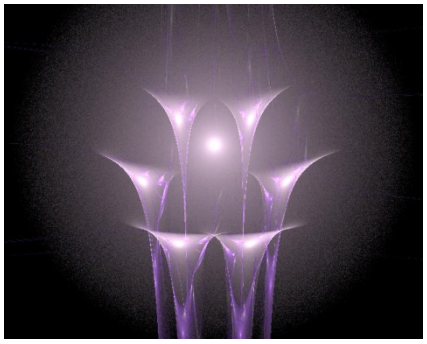
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Chapter 4
Staying safe, protecting your patient and yourself

Primum non nocere (First do no harm)

Concerns about safety for both patients and homeopaths when treating mental healthcare problems have been expressed by practitioners (Reed, 2007; Chatfield & Duxbury, 2010) and many specific examples of challenging situations described. Whilst issues of safety for both patient and homeopath may invoke worrying concerns it should be remembered that they are rare and not experienced by all. In comparison to the number of patients that are treated the number of worrying incidents is probably quite small. Fears may be heightened by feelings of isolation or vulnerability in the workplace. This is particularly relevant given that evidence from professional body registers show that homeopathy in the UK is currently a female dominated profession, a significant proportion of whom state that they work from home. However, even if practice is currently safe in the vast majority of cases, this should not deter us from asking if anything could be done to further enhance safety and minimise the potential for harm in all cases.

4.1. Staying safe, protecting yourself

Mental health care practitioners are often required to carry out a risk assessment exercise for patients. This is used to predict whether the patient is of danger to themselves or others, however the practice is widely challenged for its lack of accuracy and inherent discrimination (Scott & Resnick, 2006). The main problem with the existing risk assessment instruments is that they are not reliable and often greatly overestimate the risk of serious acts of violence. Subsequently many persons are detained in order to prevent one seriously

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violent act. In fact serious acts of violence by persons with mental health problems are rare. Studies examining whether individuals with mental illness are more violent than the non-mentally ill have yielded mixed results (Link, Andrews, & Cullen, 1992; Steadman, Mulvey, & Monahan, 1998; Torrey, 1994). In a study of psychiatric patients released into the community, most were not violent (Monahan, 1997). A weak relationship between mental illness and violence was found but violent behaviour was greater only during periods in which the person was experiencing acute psychiatric symptoms. Contrary to popular belief, a diagnosis of schizophrenia was associated with lower rates of violence than was a diagnosis of depression or of bipolar disorder. In spite of the rarity, acts of violence do undoubtedly occur and, as Poster (1996) pointed out, as many as 75 per cent of mental healthcare workers have been assaulted at some time and awareness of risk factors and increased experience may minimise this risk.

In previous studies homeopaths who work on their own from home have been more likely to express concerns about personal safety than those who work from a clinic. Where personal safety has been perceived as compromised this has largely been due to fears over violence from clients, threatened or implied; or more subtle forms such as a heightened demand for time and attention. This can then lead homeopaths to question the level and suitability of arrangements needed to ensure greater security and safety. Aggressive behaviour is not just about physical attacks. Aggression can also be expressed as:

- physical violence
- verbal or physical abuse, threats or gestures
- discriminatory abuse
- intentional damage to practice premises
- sexual or racial harassment
- stalking.

Staying safe may mean taking some sensible precautions and making small changes to the way that you practice. The following have been suggested as being most helpful:

- When seeing patients with severe mental health problems, work from a clinic rather

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than home.

- If you work from home be extra careful about the patients you take on. Find out what they are coming with and who has referred them.
- If you don't feel comfortable seeing a patient in your home then refer them to a homeopath who works from a clinic.
- If you do work from home always make sure there is another person on the premises when you see a new patient, particularly if they have not been referred by someone that is known to you.
- Consider working in pairs with another homeopath if you are going to be treating a number of people with complex issues.
- If a patient arrives intoxicated explain clearly that that the appointment will not be worthwhile and arrange an alternative.

Aggressive behaviour can occur randomly, but in most cases there will be some advance warning. Look out for agitation, an angry tone of voice, clenched fists and finger pointing or abrupt movements. Take action to remove yourself from the situation if any of these warning signs occur.

If a patient becomes aggressive during the consultation keep in mind that confrontation may aggravate the situation. Never say 'no' to a violent patient. For example, if they are making demands that you cannot meet then say that you will 'look into it for them', or 'investigate the matter further'.

Here are some other helpful tips for dealing with aggressive behaviour that hopefully you will never have to employ:

- Stay calm, speak slowly and politely.
- Keep your voice at a conversational level.
- Maintain eye contact.
- Empathy can help. Show that you can understand the root of the patient's anger, for example, "I understand that you feel angry about your treatment but I'd like to try and

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help you."

- It is possible to regain control of a potentially volatile situation by asking the patient a few questions. Ask them to tell you their story. By identifying the cause of the aggression, you might be able to deal with it.
- Maintain your distance from the patient.
- Never turn your back on a potentially aggressive patient, and position your chair nearest to the door, in case you have to make a quick escape.
- Document all conversations and patient concerns carefully.

Remember that people are choosing to come to you for help so they are not likely to be violent except in acute circumstances when behaviour can be quite unpredictable. If you feel intimidated by a patient it is likely that you will not be able to feel empathy and hence it may be difficult for you to establish a healthy therapeutic relationship.

4.2. Staying safe, protecting your patient

The National Safety Agency warns that mental health service users are vulnerable to a number of potential risks often related to their own behaviour such as self-harm, aggression and violence, and sexually disinhibited behaviour (NPSA, 2006). Issues of safety may rarely arise but it must be recognised that:

when working with patients we accept an obligation to notify appropriate authorities if there is a serious risk of harm to themselves or others.

However, how we determine what is 'serious', as well as whom and how we notify, is a matter that has to be judged on a case by case basis. Hence it can be confusing and worrying, especially if practitioners are working alone. Furthermore practitioners must take care to ensure that the care they provide does not cause unnecessary harm and this can be quite a complex issue when working with vulnerable patients. Consequently it is important that practitioners are able to respond appropriately when they believe their patients are in

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danger of seriously harming themselves and it is also vital that practitioners always work within their bounds of competence.

4.2.i. When patients pose a danger to themselves

Obviously the greatest potential for harm to the self occurs when a patient expresses suicidal thoughts or feelings and, if a patient makes a statement about feeling suicidal to their homeopath, *this must be taken seriously*. Just as with risk assessment for violent behaviour, suicide risk assessment is equally difficult, as some homeopaths have found (Chatfield and Duxbury, 2011). Suicide risk assessment inherently involves an assessment of human emotions, thinking and behaviours, which vary considerably with individuals depending on their age, culture, and personal circumstance (New Zealand Guidelines Group). The diversity of human behaviour and experience precludes accurate, foolproof suicide risk assessment techniques. However, developing a greater awareness of the risk factors and potential antecedents for suicide increases the likelihood that significant risk factors will be spotted during treatment (Boyce et al., 2003).

The risk of suicide in patients with mental disorders is much higher than that for patients without co-existent mental disorders (Raven, 2006) and in Western countries, approximately 90% of people who die from suicide have a mental health disorder. The majority have a depressive disorder but other associations include bipolar disorder, alcohol, drug misuse and schizophrenia (MIND, 2012). For example, suicide is a major cause of death in schizophrenic patients. Studies suggest that patients with schizophrenia have an 8.5 times greater risk of suicide than the general population (Kasckow, J., Felmet, K., & Zisook, S., 2011).

The likelihood of a person taking their own life depends on many factors but these include:

- gender – males are three times as likely to take their own life as females;
- age – people aged 35-49 now have the highest suicide rate;
- mental illness;
- the treatment and care they receive after making a suicide attempt;
- physically disabling or painful illnesses including chronic pain; and
- alcohol and drug misuse.

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Certain groups of people are at higher risk of suicide:

- young and middle-aged men;
- people in the care of mental health services, including inpatients;
- people with a history of self-harm;
- people in contact with the criminal justice system;
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

Stressful life events can also play a part, including:

- the loss of a job;
- debt;
- living alone, becoming socially excluded or isolated;
- bereavement;
- family breakdown and conflict including divorce and family mental health problems; and imprisonment.

(Department of Health, 2012)

The Holmes and Rahe Stress Scale

It is well known and accepted that stressful life events have an impact upon health on all levels and this has been the subject of a great deal of study. As far back as 1967, psychiatrists Thomas Holmes and Richard Rahe produced a ‘stress scale’ to help ascertain the impact of life events of health and well-being. Each event, termed a Life Change Unit (LCU), was given a different "weight" or “score” for stress. Individuals identify the LCUs that are relevant to them and add up the related scores. The higher the final score the more likely the patient was to predicted to become ill.

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This is a simplistic tool that does not take individual susceptibility and resilience into account but it can, nevertheless, be helpful for both practitioners and patients to acknowledge the burden of stress. You can find easy to use versions of this scale on the web, for example here:
http://www.mindtools.com/pages/article/newTCS_82.htm

How to act

If a patient expresses suicidal thoughts or feelings, or tells you of their intent to take their own life, there are certain actions you can take to help keep them safe. *Unless you happen to be a doctor or trained mental health professional, it is likely to be beyond your scope of practice to assess suicide risk.* However, if you are in a room with a patient who expresses suicidal ideation, or whom you think is at risk of suicide, as a health care provider, it is expected that you will act to:

- *Record clearly what the patient says and your response.*
- *Break confidentiality where necessary to ensure protection by contacting their GP or other suitable authority.*

Check with your Code of Ethics and speak with someone from your professional organisation to help clarify your exact obligations should this situation arise. Doing nothing is not an option in this scenario.

Mind offer some general advice for supporting someone who is suicidal that may be helpful (Hatloy 2012) but it should be noted that for some it may be extremely painful for them to speak about their feelings.

What can you do to help?

- be there for them
- talk to them
- look at options for solving their problems
- be accepting of them.

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Don't dismiss expressions of hopelessness as a 'cry for help' or try to 'jolly them out of it'. Talking openly about the possibility of suicide will not make it more likely to happen. But just being there for the person and listening in an accepting way can help the person feel less isolated and frightened.

Even when someone appears to be absolutely determined to take their own life, it is important to talk to them and examine every possible option and source of support. Encourage the person to look at options and explore other ways of resolving their problems.

Encourage them to get help

It is vitally important to encourage a patient who is feeling suicidal to obtain support from someone who is skilled in dealing with these situations. Their GP is a good starting-point as he or she can arrange for the person to get professional help. Organisations such as the Samaritans offer an emergency helpline for people who are feeling suicidal and some organisations may offer ongoing support, self-help groups, general advice and information (see chapter 8, Useful information and contacts')

Discussing strategies for seeking help and creating a 'personal support list' is a useful way of reviewing options with your patient. The list may include the contact details of family and friends, helplines, organisations and professionals available for support. Encourage the person to keep this list by the phone and to agree to call someone when they are feeling suicidal.

Some people may resist sharing their personal feelings and problems. If they are reluctant to seek outside help, helping them make a personal support list may provide some things to think about, allowing them to consider the options when they feel ready.

In an emergency

If you believe someone is in real danger of suicide and they will not approach anyone for help, you may need to break confidentiality and contact social services. Under the Mental Health Act 1983, a person can be treated without their consent.

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If you have reason to believe that an attempt is imminent then it may be appropriate to call for an ambulance.

Either way this is, inevitably, a heavy responsibility and can lead to the person being detained under the Mental Health Act (1983).

To help improve your skills you may consider undertaking some further training like safeTALK. About three hours in duration, this is a training that prepares anyone over the age of 15 to identify persons with thoughts of suicide and connect them to suicide first aid resources. As a safeTALK-trained suicide alert helper, you will be better able to:

- move beyond common tendencies to miss, dismiss or avoid suicide;
- identify people who have thoughts of suicide;
- apply the *TALK* steps *(Tell, Ask, Listen* and *KeepSafe)* to connect a person with suicide thoughts to suicide first aid, and intervention caregivers.

safeTALK training is available in many areas of the country.

For training courses in Scotland:

http://elearning.healthscotland.com/course/view.php?id=205

For training courses in Wales:

http://www.positivechoices-wales.org/en/Training.html

For training courses in Ireland:

http://www.nosp.ie/html/training.html

There is no one website that lists all available training courses in England. To find out what is available near you in England you can either search via the web or contact your local mental health services.

For details of other further training in the UK you can look on the Mind website here:

http://www.mind.org.uk/conferences

Ultimately remember it is vital that patients have others who are working with them. It is unlikely that you can support patients in crisis on your own and you cannot always guarantee to be there at crucial moments.

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4.3. A note about confidentiality

Practitioners must ensure that confidentiality is maintained at all times except when there is a legal requirement to release certain information or when it is deemed necessary in the public interest.

The term 'public interest' describes the exceptional circumstances that justify overruling the right of an individual to confidentiality in order to serve a broader social concern. Under common law, practitioners are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others. Each case must be judged on its merits. Examples could include disclosing information in relation to crimes against the person e.g. rape, child abuse, murder, kidnapping, or as a result of injuries sustained from knife or gunshot wounds. These decisions are complex and must take account of both the public interest in ensuring confidentiality against the public interest in disclosure. Disclosures should be proportionate and limited to relevant details.

Because it may be necessary to justify disclosures to the courts and/or your professional body it is essential that a clear record of the decision making process involved and advice sought is maintained.

If you believe that a patient is at serious risk of harming themselves or others then it will be necessary to act in some way. Where possible it is preferable to discuss your obligation with the patient and let them know what actions you are taking.

The following may help in practice:

- Talk about confidentiality at the first appointment and include it in your information literature.
- Let the patient know the limits of confidentiality by saying something like, 'everything you tell me will remain confidential unless I believe you are in danger of hurting yourself or someone else'.
- Contact your professional organisation for advice if you are uncertain about what

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actions you need to take.

- Where possible discuss your actions with the patient so they are aware of what is happening.
- Where appropriate ask patients who they would like you to contact should you believe they are in danger.

If you have reason to believe that the patient is at risk of harming themselves or another then ultimately you need to act even if this goes against the expressed wishes of the patient. In this circumstance it is advisable to contact an appropriate authority such as their doctor, mental healthcare worker, or the police.

4.4 Child Protection

In practice there are particular issues in relation to child safety that may require you to take action to ensure their protection. Child protection relates to all patients under the age of 18 and also the children of your adult patients where you may have reason to believe they are at risk of harm.

Child abuse can take many forms and the exact numbers of children experiencing abuse are unknown but a survey conducted in England by the National Society for the Prevention of Cruelty to Children (NSPCC) found that:

- 7% of children suffered serious physical abuse.
- 6% of children suffered serious neglect.
- 6% suffered emotional abuse.
- 11% suffered sexual abuse from an unrelated but known person; 4% suffered sexual abuse within the family.

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Any health practitioner who suspects child abuse has a duty to act. If you suspect a child is at risk:

- Record carefully the reasons for your concern, including what is said and observed, and by whom.
- Where appropriate try to get consent to discuss your concerns.
- Contact your professional organisation for advice if you are uncertain about what actions you need to take.

If you believe the child is in danger then you must act in the child's best interests even if consent has not been given. Contact their GP or social services and inform them of your concerns.

The Children Act 1989 puts a legal obligation on Social Services to take action when any information comes in to say that any child may be in danger of being hurt or neglected.

What if I am mistaken and there is no evidence of abuse?
It may be the case that subsequent enquiries show no significant areas of concern for the child and there is no need for any further action to be taken. However it is better to have a situation checked out and find all is well than to ignore possible warning signs and endanger a child.

4.5. Bounds of competence

Of vital importance to patient safety is that practitioners are equipped with appropriate knowledge and skills, and work at all times within their bounds of competence. In order to minimise the risk of harm practitioners need to be able to recognise situations that are beyond their competence and act accordingly. It should not be viewed as a weakness to feel that some situations are beyond competence; rather it should be viewed as good practice,

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for in such circumstances it would be unethical to continue to treat the patient regardless. However, the effective assessment of bounds of competence can pose a challenge for homeopaths who routinely work with many different kinds of patients, different kinds of illness, different approaches to treatment and new remedies.

As many patients will testify, a great strength of homeopathy is that they are treated in a holistic manner and respected as individuals. A conventional diagnosis and disease identification are not normally a necessary requirement for homeopathic prescription. However, it is a normal part of homeopathic treatment to assess the depth of pathology and there are many factors that are known to affect prognosis. Factors such as length of time illness has been evident, family history, extent to which normal life is impacted, concomitant diseases, medication use and vitality levels are examples of indicators that the homeopath routinely uses. Even without conventional diagnosis these indicators can help to assess the complexity of the patient case.

Whilst knowledge of the conventional diagnosis in mental health care may not affect the homeopathic prescription, it can have a great impact upon case management and self-assessment of competence. When working with patients who have chronic and severe mental health problems many demands can be made upon practitioners' expertise and this at times may exceed practitioners' competence. Hence careful consideration needs to be given to the issue of competence before undertaking the treatment of patients with severe or complex illness.

Remember that depth of pathology may not be evident at first but conventional diagnosis together with case history should be enough to reveal a potentially complex case. For example, a patient with a history of psychosis may appear to be functioning very well when you see them, but should they decide to stop their conventional medicine they may quickly relapse into an acute psychotic episode. This happens fairly frequently and patients can end up being hospitalised. There is more detailed information about conventional medication usage in Chapter 6 but it is to be noted here that matters of conventional medication will normally fall outside of the expertise of the homeopath and they may be in direct contravention of their professional code of conduct to give any advice on usage.

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Because of the potential for harm, the patient should be clearly advised that medication withdrawal or reduction be undertaken in consultation with the person who has prescribed the medication (GP or psychiatrist).

When trying to assess your competence you may find it helpful to consider the following:

- Does the patient have support networks in place?
- Are other health professionals actively involved?
- Do you feel confident and comfortable with this case?
- Use self-reflection. Ask yourself can I do this? What else do I need to put in place?
- Are you having regular supervision sessions?
- Who can you ask for help when you need it?

If you find yourself in a position where you feel worried and believe you may not have the necessary skills or support networks for treating a patient then don't treat them. Always act in a professional manner and explain the situation to them. Refer the patient on if possible but remember that you should only refer them to someone who does have the necessary skills and experience. You don't need to treat everyone who comes to you and sometimes refusal to treat is the safer and more ethical choice.

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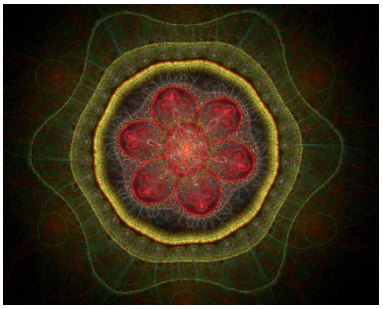
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Chapter 5 Professional boundaries and establishing the limits of your availability

A cause of concern to many healthcare professionals is the problem of establishing and maintaining therapeutic boundaries between themselves and patients which can result in professional conflict and ethical dilemmas. Homeopaths are not the only practitioners who can have problems in maintaining clear therapeutic boundaries but these may be heightened when working outside of conventional healthcare settings, particularly when working from home. In addition the psychotherapeutic nature of the homeopathic intervention can produce a significant power imbalance that facilitates transference and countertransference (Stone, 2008).

These factors make it even more important for the homeopath that great care is paid to the setting and maintaining of clear therapeutic boundaries. It is the responsibility of the homeopath to provide a safe space for patients and ensure that professional boundaries are maintained. The potential for harm to the patient increases when boundaries become blurred (Pepper, 2008).

The maintenance of professional boundaries requires that attention is paid to many issues such as personal self-disclosure, social contact outside of the consultation, equitable treatment of all patients, and all aspects of the relationship. These are extremely important issues for practitioners to be cognisant of with all patients, not just those with mental health problems.

A particular issue for those working in mental health care, and often highlighted when treating patients with acute exacerbation of symptoms such as anxiety, depression or psychosis, is the need for readily available support. It is widely acknowledged that the support needs of this group of patients are greater than those of other patient groups.

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Additionally, the demands of working with patients who have a high level of need both inside and outside the consulting room can be psychologically draining (Reed, 2007).
The increased need for support has been ascribed to various factors, particularly the vulnerability of the patients, many of whom have unstable lifestyles. In addition, the potential for people to develop an acute psychological crisis, requiring immediate attention needs to be understood and managed.
The term crisis was defined by Caplan (1964) as the
"…. psychological disequilibrium in a person who confronts a hazardous circumstance that for him constitutes an important problem which he can for the time being neither escape nor solve with his customary problem-solving resources"(p53)

Individuals in crisis can feel helpless to change and as though they don't have the resources to deal with their situation. Levels of anxiety can rise to the point of the individual becoming non-functional, with obsessional thoughts, and all behaviour aimed at relief of the anxiety that is being experienced. The feeling can be overwhelming and may affect the individual physically as well as mentally. Even when practitioners are very clear about their availability, during a crisis this can be completely overlooked and unexpected situations can arise. In severe crises emergency care or support may be necessary.

Hence there are two main issues for homeopaths to be concerned about in respect to their availability:

How are normal levels of availability established and communicated to the patient?
What measures are in place to cope with unexpected or emergency situations?

5.1. How are normal levels of availability established and communicated to the patient?

Practitioners vary a great deal in what they actually do to establish boundaries, both between and within professions, and there is no one 'right' way of doing things. The levels

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and types of communication between practitioner and patient may also vary from patient to patient according to assessed need. If you make yourself too unavailable then this can send out the message that you don't care or don't want to speak to people. Conversely, if you invite your patients to call at any time then you might find yourself in a situation where people call frequently at inconvenient times. This can intrude upon personal life, create an expectation on the part of the patient that you are always there for them, and ultimately lead to stress or burn out.

As there is no set way for homeopaths to deal with this issue it may be helpful for you to consider some of the options below that have been suggested by people who have significant experience of working in mental healthcare. Obviously you cannot adopt all of these options as many contradict each other. The important thing is to think about what will work best for both you and your patients, adopt what you believe is best practice and communicate this clearly. It is helpful for patients if they understand the parameters before they embark upon treatment.

Setting your availability:

- Remember that you can be in control of the ways in which you are contacted.
- If you work from home consider having a separate phone line or mobile phone.
- Set specific phone in times.
- If you want to vary phone in times then leave a message on your answer machine to say when your next phone in time will be.
- Outside of phone in times always let calls go straight though to answer machine so you can respond in your own time.
- Don't set phone in times, just ask people to leave a message if they need to speak with you and call them back when convenient.
- Use call identifier so you can see who is calling and assess whether it is convenient to respond.
- Try to respond within 24 hours.
- Ask patients to send a text message if they need to speak with you and tell them you will call them back.
- Provide email contact if it suits you both to communicate in this way.

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- If you work from a clinic decide whether you want to give out your home number/ mobile number/ or have all calls go through the clinic.

Communicating availability:

- Provide written information about what can be expected before beginning treatment.
- Ensure contact details/terms are clearly defined.
- Discuss verbally at the first consultation and repeat when necessary.

5.2. What measures are in place to cope with unexpected or emergency situations?

When somebody has an acute mental health problem your previously well established boundaries for contact might be ignored because people behave differently when they are unwell. Even if all seems fine when you first explain your availability at the start of treatment, unexpected things can happen during an acute flare up or crisis. There are decisions to be made about how you deal with patients who are experiencing an acute need for extra support. Unless you are working as part of an integrated health team it is impossible to offer 24 hour care. It is beyond the scope and competence of most professional homeopaths to offer emergency care and hence it is helpful to know how to deal with unexpected situations when they arise.

When patients with an acute exacerbation of symptoms such as anxiety or depression do need additional support there are options you may choose to consider:

- Renegotiate with them over your availability and make it clear how often and when they can contact you during this period.
- Ask them to come in for another appointment.
- See your patient more frequently.

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- Remind them they have an appointment coming up and normally this will help.
- Arrange for them to check in with you once per week at a specified time.
- Make sure you are clear about whether your fee covers additional contact or acute prescriptions.

If there are signs of crisis, patients needing emergency care, or more support than you are able to offer, then consider the following:

- Routinely find out what support systems patients have in place at the start of treatment so you know if they have other people they can contact.
- If they don't have the support in place then think very carefully about taking them on unless they are happy to arrange access to support.
- There are organisations such as the Samaritans that can offer a listening service free of charge (See useful contacts in chapter 8). Find out what is available in your area.
- There is a national standard in the NHS that people should have access to 24 hours care. This may not be the case in all areas but it does exist in most places. Crisis services offer 24 hour care so find out what statutory services are available in your area and encourage your patients to use this service.

Overall remember that it is not advisable to work in isolation with patients who have mental health problems. Your care will generally be far more effective if the patient has a support system in place that extends beyond what you can offer as a homeopath. So be realistic about your availability, be transparent in communicating this and be consistent in your actions. When unexpected things happen, deal with them in a professional manner, and don't panic. Seek help when you need it from your professional body and through supervision. Don't be alone!

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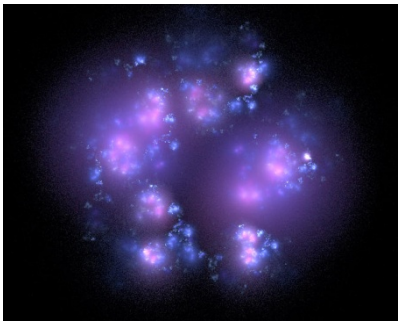
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Chapter 6
Medication matters

The issue of how to work with patients who are taking conventional medications to treat the symptoms of mental health problems invokes many ethical principles. The ability to take a homeopathic case might be affected by the drugs that the person is taking but this can be true for any type of pathology. It is also possible that the conventional medications may interfere with the action of homeopathic treatment but there is disagreement amongst homeopaths about this (Chatfield & Duxbury, 2010).

6.1. The ethical situation

When considering advice to patients about their use of other medications or treatments, the maxim 'first do no harm' is of direct relevance. It has been known for patients to inadvertently develop the idea that they can cease all other medication when they begin homeopathic treatment but it is part of the homeopath's ethical responsibility to ensure that patients understand how homeopathy works and to explain about the possible consequences of changing treatment regimes. Professional homeopaths in the UK can be considered experts in the field of homeopathic interventions, and as such qualified to give advice on this matter. Matters of conventional medication use will normally fall outside of their expertise and hence they may be in contravention of professional codes of conduct to give any advice on usage.

Current ethical guidance in the UK would have us place autonomy of the patient as paramount in cases where the patient is capable of making decisions for him/herself. As with any case that is taken, the right of the patient to self-select the treatment(s) that they believe are right for them must be accepted, even if it makes the job more difficult. This holds true for any treatments or therapies that the person chooses, not just allopathic

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medications. Consequently a homeopath may find him/herself in the position of trying to treat a patient who is concurrently taking a mixture of heavy conventional medications or, on the other hand, trying to treat a patient who wishes to stop conventional medication altogether.

Trying to respect the patient's wishes, whilst at the same time avoiding harm, can be tricky and lead to dilemmas in practice. Where necessary practitioners should seek advice from their professional body or take challenging issues to supervision to help ensure that they are working at all times in the best interests of the patient. The difficulties of navigating through a case that is masked by effects from conventional medication is an example of a challenge that may benefit greatly from supervision and further professional development. The issue of medication withdrawal is perhaps much more sensitive and requires acute awareness of bounds of competence and limits of practice. As can be seen from the information on conventional medications in this chapter, withdrawal from mental health medications can lead to extreme rebound effects and result in significant damage to the patient.

Some patients may refuse to go back to their GP or psychiatrist for help with this and their right to choose must be respected. In such situations it may be helpful to offer to work collaboratively with the GP or psychiatrist if this is what the patient wishes.

Because of the potential for harm, the patient should be clearly advised that medication withdrawal or reduction be undertaken in consultation with the person who has prescribed the medication (GP or psychiatrist).

Whatever the patent decides, it is essential that the homeopath records clearly and accurately in the patient's notes any advice that is given. As well as being in the patient's best interests it should be remembered that complaints can be made against homeopaths and there is perhaps greater potential for patients with mental health problems to become confused about what has been said.

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6.2. Conventional medications used to treat the symptoms of mental health problems

Conventional mental health medications can have many effects upon a patient, both desirable and undesirable. Some can have severe side-effects whilst others are tolerated very well. It is helpful, when treating patients who have mental health problems, to have an understanding of the medications they have been prescribed and what effects they can have.

There are many different kinds of conventional drugs used to treat the symptoms of mental health problems. They may be prescribed individually or combined to target a range of symptoms. Medications can be categorised according to their function with the following being the most common:

- Antipsychotics used to relieve symptoms of psychosis
- Antidepressants used to relieve symptoms of depression
- Mood stabilisers used to moderate extreme mood changes
- Benzodiazepines used for the relief of anxiety.

Within each category of medication, there are also different types of drugs, and they in turn may be available under different brand names.

The following information has been taken from the website of the Royal College of Psychiatrists, http://www.rcpsych.ac.uk/expertadvice/treatments.aspx. It is only a brief description of the different medication groups and is correct at time of going to press. For detailed and updated information it is wise to visit the website directly.

6.2.i. Antipsychotic medications

Antipsychotics are generally used to treat illnesses such as schizophrenia, bipolar disorder, personality disorders, and severe anxiety and depression.

They are prescribed for:

- Hallucinations
- Delusions
- Difficulty in thinking clearly (thought disorder)
- The extreme mood swings of manic depression/bipolar disorder.

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According to the Royal College of Psychiatrists, 4 out of 5 people who take antipsychotics find they are successful in treating their symptoms. They can also be used in smaller doses to help treat anxiety, tension and agitation.

There are different types of antipsychotic medications and several different types may be tried in order to find the one that works best for a patient.

Antipsychotic medications all affect the action of chemicals in the brain called neurotransmitters. There are a number of neurotransmitters in the brain, including two called serotonin and dopamine. These are messenger chemicals involved in thinking, emotions, behaviour and perception. It is believed that in illnesses where psychotic symptoms are experienced, these chemical messengers can be too active or not active enough, and that antipsychotics work by correcting this chemical imbalance. They are normally referred to as either 'typical' or 'first generation' (the older drugs), or 'atypical' (the newer forms).

Older antipsychotics first appeared in the mid-1950s and work by blocking the action of dopamine, some more effectively than others.

Examples of older antipsychotics:

Generic name	Brand name
Chlorpromazine	Largactil
Haloperidol	Haldol
Pimozide	Orap
Trifluoperazine	Stelazine
Sulpiride	Dolmatil

Newer antipsychotics: over the last 10 years, newer medications have appeared which still block dopamine, but much less so than the older drugs. They also work on different chemical messengers in the brain (such as serotonin) and are often called 'atypical' or 'second-generation' antipsychotics. This is misleading - they have many of the same effects as the older drugs.

Examples of newer antipsychotics:

Generic name	Trade Name
Amisulpride	Solian

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Aripiprazole	Abilify
Clozapine	Clozaril
Olanzapine	Zyprexa
Quetiapine	Seroquel
Risperidone	Risperdal
Sertindole	Serdolect

Depot antipsychotics

In addition to the tablet forms of anti-psychotics described above some, known as 'depot' antipsychotics are given by injection every 2 to 4 weeks which releases the medication slowly over this time.

Withdrawal

Antipsychotic medications can produce a wide variety of side-effects and consequently patients may be keen to reduce them or stop taking them altogether. However, sudden stoppage of antipsychotic medications can have severe consequences and hence reduction should be monitored by the psychiatrist over a period of time. Symptoms of antipsychotic medication withdrawal may be physical such as diarrhoea, stomach pain, nausea, vomiting, dizziness and shaking, but it may also exacerbate psychotic symptoms such as hallucinations and delusions.

These withdrawal symptoms do not always improve with time, as they may be symptoms of the underlying disorder.

6.2.ii. Antidepressant medications

There are several types of antidepressants and it is not known for certain how they work. However, it is proposed that they are able to increase the activity of neurotransmitters, with the most commonly involved in depression being thought to be Serotonin (sometimes called 5-HT) and Noradrenaline. Both of these neurotransmitters are important in the areas of the brain that control or regulate mood and thinking and there is some evidence that they are not as effective or active as normal in the brain of someone who is depressed.

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Antidepressants are prescribed for:

- Moderate to severe depressive illness (Not normally mild depression)
- Severe anxiety and panic attacks
- Obsessive compulsive disorders
- Chronic pain
- Eating disorders
- Post-traumatic stress disorder.

The most commonly used forms of antidepressants are tricyclics, selective serotonin re-uptake inhibitors**,** serotonin and noradrenaline reuptake inhibitors, noradrenaline and specific serotonergic antidepressants and mono-amine oxidase inhibitors.

Tricyclic antidepressants (TCAs)

Dating back to the 1950s, TCAs used to be the most commonly prescribed antidepressants. Although they are still considered to be highly effective, they have been increasingly replaced by antidepressants with a better safety and side effect profile.

Selective serotonin re-uptake inhibitors (SSRIs)

The SSRIs are now one of the most commonly prescribed types of antidepressants. Generally, SSRI's are believed to have fewer side-effects than the older drugs and are less likely to cause major damage if taken in large doses.

Serotonin and noradrenaline reuptake inhibitors (SNRIs)

SNRIs act upon, and increase, the levels of two neurotransmitters in the brain, serotonin and norepinephrine. This is in contrast to with the more widely-used SSRIs which act upon serotonin alone.

Noradrenaline and Specific Serotonergic Antidepressants (NASSAs)

NaSSAs work to enhance both noradrenergic and serotonergic transmission while at the same time blocking 5HT2 and 5HT3 receptors. The blocking action permits selective 5H1

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stimulation and, as a consequence, limits the occurrence of troublesome serotonergic side effects.

Mono-amine oxidase inhibitors (MAOIs)

MAOIs are used to treat symptoms of anxiety and a number of other symptoms as well as treating low mood and depression. Most notable about MAOIs is that some foods must be avoided whilst taking these drugs and for that reason they are rarely prescribed now.

Examples of antidepressants:

Medication	**Brand name**	**Group**
Amitriptyline	Tryptizol	Tricyclic
Clomipramine	Anafranil	Tricyclic
Citalopram	Cipramil	SSRI
Dosulepin	Prothiaden	Tricyclic
Doxepin	Sinequan	Tricyclic
Duloxetine	Cymbalta, Yentreve	SNRI
Fluoxetine	Prozac	SSRI
Imipramine	Tofranil	Tricyclic
Lofepramine	Gamanil	Tricyclic
Mirtazapine	Zispin	NaSSA
Moclobemide	Manerix	MAOI
Nortriptyline	Allegron	Tricyclic
Paroxetine	Seroxat	SSRI
Phenelzine	Nardil	MAOI
Reboxetine	Edronax	SNRI
Sertraline	Lustral	SSRI
Tranylcypromine	Parnate	MAOI
Trazodone	Molipaxin	Tricyclic-related
Venlafaxine	Efexor	SNRI

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Withdrawal

Although antidepressants are not described as addictive, withdrawal can cause adverse symptoms in varying degrees. Some antidepressants like Venlafaxine and Paroxetine cause withdrawal symptoms in a high percentage of people, whereas others like Fluoxetine and Mirtazepine are thought to cause symptoms in a much smaller number of people.

The most common withdrawal symptoms from antidepressants are:

- anxiety (70%)
- dizziness (61%)
- vivid dreams (51%)
- electric shocks / head zaps (48%)
- stomach upsets (33%)
- flu like symptoms (32%)
- depression (7%)
- headaches (3%)
- suicidal thoughts (2%)
- insomnia (2%).

The Royal College of Psychiatrists has some very helpful information for people wanting to come off their antidepressants here: http://www.rcpsych.ac.uk/expertadvice/treatments/antidepressants/comingoffantidepressants.aspx

6.2.iii. Mood stabilisers

Mood stabilising medication is often prescribed for people with mood disorders in an attempt to even out the highs and the lows of their moods. There are a number of mood stabilisers used both to reduce mania and depression, and in the long-term stabilise acute mood swings.

- **Lithium** is widely used for the maintenance and treatment of mania. It reduces both the number and severity of relapses.
- **Valproate** is an anti-convulsant medication used in epilepsy**.** It is licensed to treat mania.

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- **Carbamazepine** is an anticonvulsant medication used in epilepsy. In the UK, it is licensed to treat bipolar disorder in people who do not respond to lithium.
- **Lamotrigine** is also an anticonvulsant medication used in epilepsy. In bipolar disorder, it may be used where depression is the main problem. It seems to be effective at preventing depressive relapse, but not so effective at preventing manic relapse.

Some of the newer, atypical antipsychotic medications also have mood stabilising properties such as olanzapine, quetiapine, aripiprazole and risperidone.

Withdrawal

Lithium and other mood stabilisers, such as anticonvulsants, can cause seizures and rebound mania if a patient stops taking them suddenly. This may be characterised by symptoms such as agitation, rapid speech, racing thoughts and mood instability. Mood stabilisers are a very difficult medication to discontinue in patients with a history of mania because of the risk that the medication may be keeping that person stable. Withdrawal should be closely monitored by the psychiatrist for any signs of rebound effect.

6.2.iv. Benzodiazepines

Benzodiazepines are used in the treatment of severe and disabling anxiety, or where people are becoming greatly distressed as a result of their anxiety. They are most commonly prescribed for short term treatment, as they can be very addictive and cause withdrawal symptoms when used for longer durations. These drugs are not usually prescribed for conditions like schizophrenia or manic depression but may be used in emergency situations of acute and severe anxiety.

Benzodiazepines are prescribed for:

- anxiety
- epileptic seizures
- mania
- alcohol withdrawal
- sleeping problems

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Benzodiazepines are sometimes grouped by the length of time over which they act, (called a half-life) with short half-life benzodiazepines known as 'hypnotics' and longer acting benzodiazepines known as 'anxiolytics'.

Hypnotics are used for those experiencing difficulties sleeping (insomnia) and they include:

- Flurazepam (Dalmane)
- Loprazolam
- Lormetazepam
- Nitrazepam (Mogadon)
- Temazepam.

Anxiolytic type benzodiazepines help to reduce anxiety, agitation and tension and they include:

- Diazepam (Valium)
- Alprazolam (Xanax)
- Chlordiazepoxide (Librium)
- Lorazepam (Ativan)
- Oxazepam

Withdrawal

Anyone who has been taking a benzodiazepine continuously for more than 3 weeks should not stop this medication suddenly. Withdrawal needs to be managed slowly to prevent severe reactions. Withdrawal symptoms can include severe sleep disturbance, irritability, increased tension and anxiety, panic attacks, tremors, sweating, difficulty in concentration, confusion and cognitive difficulty, memory problems, nausea, weight loss, palpitations, headache, muscular pain, perceptual changes, hallucinations, seizures, and psychotic episodes.

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Chapter 7
Understanding the therapeutic relationship

In all forms of medicine, care is normally administered via another person and relationships are inevitably formed between practitioners and patients. The impact of the practitioner/patient relationship upon outcomes in healthcare has been the subject of a broad expanse of research and numerous studies have shown that the quality of the relationship between therapist and patient is a consistent and strong predictor of outcome (Martin, Garske, & Davic, 2000). It might seem obvious that a positive therapeutic relationship can indirectly improve outcome, for example through better case taking and adherence to treatment. However, a large body of evidence suggests that a positive practitioner/patient relationship can also have a direct therapeutic effect (Frank & Gunderson, 1990; Hansson & Berglund, 1992; Krupnick et al., 1996; Weiss, Gaston, Propst, Wisebord, & Zicherman, 1997).

In mental healthcare it has been suggested that therapeutic relationships are at the *core* of practice (Muller & Poggenpoel, 1996). In patient surveys about psychiatric care the therapeutic relationship has repeatedly, and in different settings, been reported as the most important component of care (Johansson & Eklund, 2003). The relationship between practitioner and patient is a fundamental element of mental health care (McGuire, McCabe & Priebe, 2001) and has been associated with therapeutic outcomes in the treatment of mental health problems across a range of clinical settings and patient populations (McCabe & Priebe, 2004).

Just as a positive therapeutic relationship can enhance clinical outcomes, so a negative experience can have a detrimental effect upon outcomes. Hence it is vital for the homeopath to pay attention to the impact of the therapeutic relationships they establish with their patients, especially when treating mental healthcare problems.

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The main way that a practitioner influences the therapeutic relationship with a patient is through the way he or she behaves towards the patient. Practitioners who are able to behave and communicate with patients in a way that helps establish good therapeutic relationships are more likely to be effective in helping patients to achieve clinical aims. Numerous people have written extensively about therapeutic relationships and different models have been suggested to aid understanding and practical application. Before we take a closer look at any particular model it may helpful here to understand that there are different schools of thought in clinical psychology, stemming from different perspectives, and there is no one unified approach that is agreed upon by all psychologists. Each approach uses a different conceptual framework to explain behaviour and mental processes and, in turn, each suggests different approaches to treatment of people with mental health problems.

The five most well known perspectives in clinical psychology are:

- Biological: *there is a biological origin for mental disorders*.
- Pyschoanalytic: *emerging from the work of Sigmund Freud, this is the idea is that disorders are caused by unconscious conflicts*.
- Behavioural: *all behavior is learned, nothing is instinctive, and genetics do not influence behaviour in any appreciable way*.
- Cognitive: *what we need to focus on are the thought processes of mentally ill patients because they "think differently"*.
- Humanistic: *free will is a basic aspect of the human condition and, if left to their own devices, humans strive for self-actualisation* (see below).

It is beyond the scope of this handbook to take an in-depth look at each of these perspectives and what they may have to offer. However there are some key concepts, particularly drawn from the Humanistic and the Psychoanalytic perspectives, that are referred to in homeopathic literature as being relevant to the development of a positive therapeutic encounter.

From a Humanistic perspective, the Person-Centred Approach has proven to be highly influential across a range of psychotherapeutic disciplines and beyond. Initially developed by

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Carl Rogers in 1940s, this approach has been likened in many respects to Hahnemann's teaching of the homeopathic process (Townsend 2010).
From a Pschoanalytic perspective the notion of transference and countertransference may help us to understand the complex dynamic of the therapeutic relationship.
What follows is a brief outline of the underlying principles of the Roger's Person-Centred Approach and Freud's concept of transference and countertransference, and how they might be directly applied to the homeopathic case-taking.

7.1. Person-Centred Approach

This approach moved away from the existing dominant expert models of care to one that acknowledges and respects the patient's ability to make the right choices for him or herself, regardless of the therapist's own values, beliefs and ideas. It is based upon the belief that human beings possess a 'self-actualising tendency', an innate tendency to fully realise their own potential. Carl Rogers believed that this tendency should be trusted and valued, and that, in order to create the most effective kind of therapeutic work, a practitioner must respect the patient's feelings in a non-judgemental way (Rogers, 1967, Rogers, 1980).
Rogers describes a therapeutic environment as one in which a patient feels comfortable and free from threat, both physically and psychologically and that this can be achieved when in a relationship with a person who is deeply understanding (empathic), accepting (having unconditional positive regard) and genuine (congruent). When these three 'core conditions' are provided the self-actualising tendency of the patient is nurtured and encouraged.

Congruence
Also termed 'genuineness', or 'authenticity', congruence is achieved when there is willingness to relate to patients without hiding behind a professional facade. According to Rogers (1967) congruence is the most important attribute in establishing the therapeutic relationship. Unlike the practitioner who remains elusive and reveals little of their own personality in therapy, the Rogerian approach allows the patient to experience the practitioner as they really are. Rogers (1967) defined congruence as a state of self-awareness and an integration of feelings and attitudes, requiring the practitioner to

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acknowledge and accept his/her own thoughts and feelings. In a congruent relationship it will be easier for patients to trust and open up (Howe, 1993) and furthermore authenticity in the practitioner can facilitate fundamental acceptance of the patient's own self-worth (Mearns and Thorne, 2000).

Unconditional positive regard

Unconditional positive regard can be described as an acceptance of the patient, as they are, without disapproving feelings or actions. It requires an open willingness to listen without interrupting, judging or giving advice. This acceptance or regard should not be confused with being nice, showing special consideration, lavishing in praise, or colluding with the patient's own opinion of themselves. The concept is similar to that of the unprejudiced observer in homeopathy and hence should be easy for the homeopath to relate to. We are to value the patient as a human being, with all their inherent flaws and difficulties, and receive the case without judgment. It is helpful here to distinguish between the person and the person's actions. Whilst we may not approve of some of the patient's actions we can still respect and value the patient for who they are.

Empathy

Empathy has been described in many ways including: stepping into in another's shoes, putting yourself in their place, entering into another person's frame of reference, or to understand another's emotions. In counselling, empathy is often described as the regard and respect the counsellor holds for the client whose experiences may be quite different from that of the counsellor.

Empathy must be distinguished from sympathy which refers to a feeling of sorrow in oneself in response to another. When we feel sympathy for someone we might view them with pity, and while pity makes a victim of the sufferer, empathy can empower them through the feeling that they are understood.

Rogers (1969) stated the important indicators of empathy are:

- The practitioner understands the client's feelings
- The practitioner's responses reflect the client's mood and the content of what has been said
- The practitioner's tone of voice conveys this understanding.

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We know from studies of patients' views that empathy is experienced in homeopathic consultations (Mercer, 2004). Furthermore it has been suggested that a positive outcome is not possible without sufficient empathy, (Mercer, 2001).

In addition to Roger's 3 core conditions described above there are many other facets of a therapeutic relationship that have been identified as important for effecting a positive outcome. Dziopa and Ahern (2009) deconstructed the therapeutic relationship in mental healthcare into nine main constructs:

- conveying understanding and empathy
- accepting individuality
- providing support
- being there/ being available
- being genuine
- promoting equality
- demonstrating respect
- maintaining clear boundaries
- having self-awareness.

Each of the above can be considered important influences on the quality of the therapeutic relationship and paying attention to them can only be helpful to the patient. However, in addition there are other issues to consider that may arise when working closely with patients.

7.2. Transference and countertransference

Whatever model we look to, or methods we utilise in practice, the end product of our attempt to create a positive therapeutic relationship should end up with just that, *a relationship.* Inevitably relationships are more than a one-way dynamic and there are certain consequences of being engaged in a relationship, some of which are helpful to be aware of especially when dealing with patients.

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First identified by Freud, the classic use of the term *transference* comes from psychoanalysis and is often described as the redirection of feelings and desires, and especially of those unconsciously retained from childhood, toward a new object. Transference occurs all the time as people or situations remind us of a relationship we had in the past. When transference occurs we are reacting to a person in the present in the way that we might have reacted to the relationship we are reminded of from our past.

The process of transference is not conscious, and the patient unwittingly projects a needed aspect of a previously experienced or *wished-for* relationship on to the practitioner. In psychoanalysis a transference projection is considered a communication of a patient's needs that may not be consciously known and cannot be verbally expressed (Hughes & Kerr, 2000). Because it is a relationship that is "transferred", the patient and doctor are expected to take complementary roles. For example, a patient who has extreme anxiety may adopt a needy and child-like role and project a parent-like quality on to the practitioner, who is then expected to take care of them. Dealing with a patient in this state, who is showing signs of dependency, can be challenge and the situation must be handled sensitively. When this situation arises for you the following may help:

- Making and keeping appointments is calming for the patient.
- Do what you say you will do, as unreliability is likely to increase anxiety.
- Adhere firmly to professional boundaries.
- Make the limits of your availability and scope of practice clear to the patient.

Countertransference

Freud realised that transference is universal, and therefore could occur in the psychoanalyst as well as the patient. Both patients and practitioners can experience strong emotional reactions towards each other within a therapeutic situation and, for the practitioner, this is termed countertransference.

Countertransference is a situation in which a practitioner, during the course of treatment, develops feelings toward the patient. These feelings may take many forms; affection, irritation, pity, or sadness for example, and may be the therapist's unconscious feelings that

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are stirred up during therapy and directed towards the patient. The feelings can be quite vague and appear to arise for no reason, for example the practitioner might start feeling uneasy about patient, or unhappy with themselves. Just like transference, this is not an uncommon situation in the therapeutic situation.

In the homeopathic consultation, just as in other therapeutic encounters, an awareness of the potential for transference and countertransference can help the practitioner to understand and cope with the dynamics of the relationship. If the effects of transference and countertransference go unrecognised this may have a detrimental effect upon the therapeutic relationship, interfering with the practitioner's ability to act with congruence, empathy and unconditional positive regard.

Sometimes countertransference will stir up feelings in the practitioner that are challenging. For anyone working closely with patients it may be wise to monitor his or her own feelings that might indicate countertransference. Moreover the assistance of, and discussion with, supervisors and colleagues is useful in regard to countertransference even in experienced practitioners and can lead to unexpected revelations about the self.

For more information and further reading about therapeutic encounters please see the links if chapter 8, 'Useful information and contacts'.

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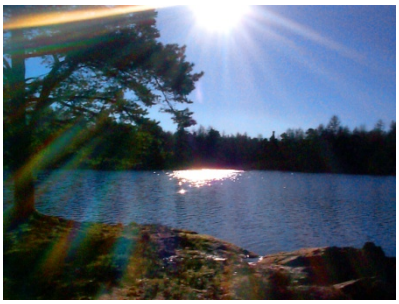
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Chapter 8
Useful information and contacts

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In this chapter you will find links and contact numbers for organisations that may be helpful. The information here is correct at time of going to press but please do contact HAT if any broken links or incorrect numbers are discovered.

8.1. Most useful general websites

BBC Health pages/ mental health

- Information about mental health disorders, treatment options and coping techniques.
- Website: http://www.bbc.co.uk/health/emotional_health/mental_health/

Citizens Advice

- Provides free, independent, confidential and impartial advice to everyone on their rights and responsibilities.
- Website: http://www.citizensadvice.org.uk/

Mind

- Offers many services including helplines, drop-in centres, supported housing, counselling, befriending, advocacy, employment and training schemes.
- Information line: 0300 123 3393
- Email: info@mind.org.uk
- Website: www.mind.org.uk

NHS Choices

- The UK's biggest health website providing a comprehensive health information service.
- Includes around 20,000 regularly updated articles and many directories that can be used to find and choose health services in England.
- Website: http://www.nhs.uk/Pages/HomePage.aspx

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NHS Direct

- Online symptom checkers and mobile apps.
- A single telephone number for people in England gives access to round-the-clock clinical information, confidential advice and reassurance.
- Healthcare professionals, including nurses, trained health advisors and dental advisors can deal with a wide range of health queries.
- Telephone**:** 0845 4647
- Website: http://www.nhsdirect.nhs.uk/

Please note: Over the months following production of this handbook the 0845 4647 service is being replaced by NHS 111 in England. NHS Direct will continue to provide the 0845 4647 helpline in some areas while the local commissioners get ready to publicly launch their NHS 111 service. List of areas available from: http://www.nhsdirect.nhs.uk/About/WhatIsNHSDirect/0845areas

Rethink Mental Illness

- Support and advice for everyone affected by severe mental illness.
- Telephone: 0300 5000 927
- Email: info@rethink.org
- Website: www.rethink.org

8.2. Telephone helplines

Breathing Space Scotland

- Free, confidential phone line for people who are feeling low.
- Helpline: 0800 838 587
- Email: info@breathingspacescotland.co.uk
- Website: www.breathingspacescotland.co.uk

CALL (Community Advice & Listening Line) Helpline Wales

- Emotional support and information on mental health to the people of Wales.
- Tel: 0800 132 737
- Website: www.callhelpline.org.uk

SupportLine

- Offers confidential emotional support for children, young adults and adults.
- Helpline: 01708 765200
- Email: info@supportline.org.uk
- Website: www.supportline.org.uk

PAPYRUS

- Advice for young people at risk of suicide.
- Helpline: 0800 068 41 41
- Website: www.papyrus-uk.org/

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Samaritans

- Emotional support for anyone feeling down, experiencing distress or struggling to cope.
- UK helpline: 0845 790 9090
- Republic of Ireland helpline: 1850 609 090
- Email: jo@samaritans.org
- Website: www.samaritans.org.uk

Sane

- Offers information, crisis care and emotional support.
- Helpline: 0845 767 8000
- Email: info@sane.org.uk
- Website: www.sane.org.uk

8.3. Other general mental health care sites

HandsOnScotland

- An online resource for anybody working with children and young people, providing practical information and techniques on developing positive mental wellbeing.
- Website: www.handsonscotland.co.uk

Hafal

- Welsh charity for those with severe mental illnesses.
- Tel: 01792 816600
- Email: hafal@hafal.org
- Website: www.hafal.org

Maytree

- A sanctuary for the suicidal: a place where, during a brief stay, a person will find the support that can alleviate despair and isolation.
- Tel: 020 7263 7070
- Website: www.maytree.org.uk

Mental Health Care

- Comprehensive information about mental illnesses.
- Website: www.mentalhealthcare.org.uk

Mental Health Foundation

- Uses research and practical projects to help people survive, recover from and avert mental health problems.
- Tel: 020 7803 1100
- Website: www.mentalhealth.org.uk

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Mental Health Foundation Scotland

- Tel: 0141 572 0125 (Glasgow) 0131 243 3800 (Edinburgh)
- Website: www.mentalhealth.org.uk/about-us/scotland/

National Collaborating Centre for Mental Health

- Offers accessible information on NICE mental health guidelines.
- Email: nccmh@org.uk
- Website: www.nccmh.org.uk

Northern Ireland Association for Mental Health

- Provides local support, including housing schemes, home support, advocacy services and information, for those with mental health needs.
- Tel: 028 9032 8474
- Website: www.niamh.co.uk

Scottish Association for Mental Health

- Campaigns and provides services across Scotland for people with mental health problems, homelessness, addictions and other forms of social exclusion.
- Tel: 0141 530 1000
- Email: enquire@samh.org.uk
- Website: www.samh.org.uk

1 in 4 Forum

- UK's largest mental health online forum.
- Website: www.1in4-forum.org

YoungMinds

- Works to promote the mental health and emotional wellbeing of children and young people.
- General enquiries: 020 7089 5050
- Parents Helpline: 0808 802 5544
- Website: www.youngminds.org.uk

8.4. Specific organisations

8.4.i. Alzheimer's

Alzheimer's Society

- Information and support for people with the condition, their families and carers.
- General enquiries: 020 7423 3500
- Helpline: 0300 222 11 22
- Email: enquiries@alzheimers.org.uk
- Website: www.alzheimers.org.uk

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Alzheimer Scotland

- Services for people with the condition, their carers and families.
- Tel: 0131 243 1453
- Helpline: 0808 808 3000
- Email: alzheimer@alzscot.org
- Website: www.alzscot.org

8.4.ii. Anxiety and phobias

No Panic

- Help for people with panic attacks, phobias, obsessive-compulsive disorders and general anxiety disorders.
- Helpline: 0800 138 8889
- Email: ceo@nopanic.org.uk
- Website: www.nopanic.org.uk

AnxietyUK (formerly the National Phobics Society)

- A user-led organisation dealing with anxiety disorders.
- Tel: 08444 775 774
- Email: info@anxietyuk.org.uk
- Website: www.anxietyuk.org.uk

Triumph Over Phobia (TOP UK)

- Structured self-help groups to help with phobia and obsessive-compulsive disorder.
- Tel: 0845 600 9601
- Email: info@topuk.org
- Website: www.triumphoverphobia.com

8.4.iii. Bereavement

Cruse Bereavement Care

- Offers help to anyone who has been bereaved. Free counselling, advice and publications.
- Tel: 020 8939 9530
- Day-by-day helpline: 0844 477 9400
- Email: helpline@cruse.org.uk
- Young persons' helpline: 0808 808 1677
- Email: info@rd4u.org.uk
- Website: www.crusebereavementcare.org.uk

8.4.iv. Bipolar Disorder

Bipolar UK

- Supports people affected by bipolar disorder.
- Telephone: 020 7931 6480
- Website: www.bipolaruk.org.uk

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Bipolar Fellowship Scotland

- Provides information and self-help groups for people in contact with bipolar disorder.
- Tel: 0141 560 2050
- Website: www.bipolarscotland.org.uk

8.4.v. Borderline personality disorder

BPD World

- Focuses on borderline personality disorder.
- Email: mail@bpdworld.org
- Website: www.bpdworld.org

8.4.vi. Depression

Aware Defeat Depression

- Information, advice and support groups for those affected by depression throughout Northern Ireland.
- Helpline: 0845 120 2961
- Email: help@aware-ni.org
- Website: www.aware-ni.org

Depression Alliance

- UK's leading depression charity, with a network of self-help groups.
- Tel: 0845 123 2320
- Email: information@depressionalliance.org
- Website: www.depressionalliance.org

Journeys

- Supporting people to find their own route to recovery from depression.
- Tel: 029 2069 2891
- Email: info@journeysonline.org.uk
- Website: www.journeysonline.org.uk

Depression Alliance Scotland

- A charity based in Scotland working for people with depression living in Scotland.
- Tel: 0845 123 2320
- Email: info@dascot.org
- Website: www.dascot.org

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Depression UK (D-UK)

- A national self-help charity promoting mutual support between individuals affected by depression, through pen/phone friend schemes and newsletters with members' contributions.
- Email: info@depressionuk.org
- Website: www.depressionuk.org

8.4.vii. Drugs

Narcotics Anonymous

- A self-help group running a network of meetings across England, Scotland and Wales.
- Helpline: 0845 373 3366
- Email: NAHelpline@ukna.org
- Website: www.ukna.org

Narcotics Anonymous Northern Ireland

- Helpline: 0300 999 1212
- Email: contact@nanorthernireland.org
- Website: www.nanorthernireland.com

8.4.viii. Eating disorders

B-eat

- Helplines, information and network of self-help groups for those with eating disorders.
- Adult helpline: 0845 634 1414
- Email: help@b-eat.co.uk
- Youth helpline: 0845 634 7650
- Email: fyp@b-eat.co.uk
- Website: www.b-eat.co.uk/Home

8.4.ix. Obsessive compulsive disorder

OCD Action

- For people with obsessive compulsive disorder and related disorders such as body dysmorphic disorder, compulsive skin picking and trichotillomania.
- Helpline 0845 390 6232
- Website: www.ocdaction.org.uk

OCD-UK

- Run by people with obsessive-compulsive disorder for people with OCD.
- Email: admin@ocduk.org
- Website: http://www.ocduk.org/

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8.4.x. Post-natal illness

Association for Post Natal Illness

- Advice and support for mothers experiencing postnatal illness.
- Tel: 020 7386 0868
- Website: www.apni.org

8.4.xi. Schizophrenia

Hearing Voices Network

- A user-led group offering information, support and understanding to people who hear voices, and to those who support them.
- Enquiries: 0114 271 8210
- Email: info@hearing-voices.org
- Website: www.hearing-voices.org

Making Space

- Helping those affected by schizophrenia and other forms of serious and enduring forms of mental illness.
- Tel: 01925 571680
- Website: www.makingspace.co.uk

National Schizophrenia Fellowship Scotland

- Dedicated to the needs of carers of people affected by schizophrenia or other severe mental health problems.
- Tel: 0131 662 4359
- Email: info@nsfscot.org.uk
- Website: http://www.supportinmindscotland.org.uk/

8.4.xii. Self-harm

Equilibrium

- User-led self-injury awareness organisation.
- Email: admin@selfharmony.co.uk
- Website: www.selfharmony.co.uk

National Self-Harm Network

- Supports people who self-harm, providing information, contacts and workshops.
- Email: nshncg@hotmail.co.uk
- Website: www.nshn.co.uk

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8.5. Information for carers

Carers UK

- Information and help for carers.
- Tel: 020 7378 4999
- Carers line: 0808 808 7777
- Email: info@carersuk.org
- Website: www.carersuk.org

Carers Northern Ireland

- Tel: 028 9043 9843
- Email: info@carersni.org
- Website: www.carersni.org

Carers Scotland

- Tel: 0141 445 3070
- Email: info@carerscotland.org
- Website: www.carerscotland.org

Carers Wales

- Tel: 029 2081 1370
- Email: info@carerswales.org
- Website: www.carerswales.org

CAUSE (Carers and Users Support Enterprise)

- Northern Ireland charity providing practical and emotional support to relatives and carers of people with mental illness.
- Tel: 028 9065 0650
- Email: info@cause.org.uk
- Website: www.cause.org.uk

NHS Choices: Carers Direct

- Information from the NHS on support available to carers.
- Tel: 0808 802 0202
- Website: http://www.nhs.uk/carersdirect

The Princess Royal Trust for Carers

- Information, advice and a network of carers' centres.
- Tel: 0844 800 4361
- Website: http://www.carers.org/

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8.6. Advocacy

Advocacy Resource Exchange

- To find a local advocate.
- Tel: 07954 259 230
- Website: http://www.advocacyresource.org.uk/

United Kingdom Advocacy Network (UKAN)

- Tel: 0114 272 8171
- Website: www.u-kan.co.uk/

8.7. Medication information

eMC

- Access to patient information leaflets (PILs) for most medicines licensed in the UK, and Medicines Guides.
- Website: http://www.medicines.org.uk/emc/

The National Institute for Health and Clinical Excellence

- For national guidance on evidence-based treatment of many conditions, including schizophrenia, bipolar disorder and depression.
- Website: www.nice.org.uk/

8.8. Professional organisations

British Association for Behavioural and Cognitive Psychotherapies

- Accredited cognitive behavioural practitioners.
- Telephone: 0161 705 4304
- Email:babcp@babcp.com
- Website: www.babcp.com

British Association for Counselling and Psychotherapy

- For information about counselling and lists of qualified counsellors and psychotherapists.
- General Enquiries: 01455 883300
- Email:babcp@bacp.co.uk
- Website: www.bacp.co.uk

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British Association of Psychotherapists

- Providers of Jungian analytic and psychoanalytic psychotherapy for adults and children.
- Telephone: 020 8452 9823
- Email:mail@bap-psychotherapy.org
- Website: www.bap-psychotherapy.org

British Psychoanalytic Council

- An advisory board made up of representatives from the mental health professions.
- Tel: 020 7561 9240
- Email:mail@psychoanalytic-council.org
- Website: www.psychoanalytic-council.org

British Psychological Society

- The representative body for psychologists and psychology in the UK.
- Tel: 0116 254 9568
- Email:enquiries@bps.org.uk
- Website: www.bps.org.uk

Counselling Directory

- Database of UK counsellors, with information on training, experience and fees.
- Website: www.counselling-directory.org.uk

Institute of Psychiatry

- Website: www.iop.kcl.ac.uk

Royal College of Psychiatrists

- Publishes factsheets, leaflets and books for the public on common mental health problems and psychiatric treatments, some of which are available in other languages.
- National headquarters: 020 7235 2351
- Email:rcpsych@rcpsych.ac.uk
- Website: www.rcpsych.ac.uk

Society of Analytical Psychology

- Provides reduced-fee analysis to members of the public through the work of the CG Jung Clinic.
- Email:clinic@thesap.org.uk
- Website: www.jungian-analysis.org

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UK Council for Psychotherapy

- Publishes the National Register of Psychotherapists, which lists more than 5,000 therapists.
- Tel: 020 7014 9955
- Email:info@ukcp.org.uk
- Website: www.psychotherapy.org.uk

8.9. The therapeutic relationship

The British Association for the Person-Centred Approach
http://www.bapca.org.uk/

Transference and countertransference in communication between doctor and patient
http://apt.rcpsych.org/content/6/1/57.full

Transference and countertransference in clinical psychology
http://www.clinpsy.org.uk/forum/viewtopic.php?t=1979

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