



**Progress is pleased to bring readers key articles from the charity Primary Care Mental Health and Education (Primhe), which covers issues relating particularly to mental health in the primary care setting. We feel the articles will be of interest to Progress readers in primary care but also to those in secondary care. For more information about Primhe visit the charity's website at [www.primhe.org](http://www.primhe.org)**

## Dangers of diagnostic labels in patients with mental health issues

In this account, Dr Robinson, a GP with a special interest in mental health, describes how her experience with one of her patients led her to re-evaluate her approach to patients with mental health issues.

**A Robinson MB ChB, DRCOG**  
GP with a Special Interest in Mental Health

Stigma has many meanings ranging from a botanical term meaning a receptive apex of a flower pistil on which pollen is deposited at pollination, to the archaic word for a brand mark burned into the skin of a criminal or slave.

Unfortunately sufferers of mental illness in this country usually identify with the latter meaning as today's society often considers it a mark of shame and disgrace – rather than a highly intricate, functional and beautiful part of nature that has evolved through the ages.<sup>1</sup>

I am a full-time GP who cared for Shelley, whose story I describe in this account, for over 13 years. A thorough critique of Shelley's care was painful and difficult to accomplish but ultimately rewarding.<sup>2</sup> The philosopher John Dewey confirmed: 'We learn by doing and seeing what becomes of our actions.'<sup>3</sup> It is possible to learn from mistakes and improve by stepping back and evaluating patient care with the benefit of hindsight. Johns' framework<sup>4</sup> was used to structure a critical examination of Shelley's management. This health report

shows how Shelley changed my views on mental illness.<sup>2</sup>

### Shelley's story

'I'm sorry I'm wasting your time'. This was Shelley's repetitive refrain, a frequent attendee of our practice. Thirteen years ago, Shelley was a shy 21-year-old single parent of two little girls 'who keep me alive'. She was living in a hostel and had recently escaped from an abusive marriage. She suffered anxiety, panic attacks and nightmares. Her anxiety often caused a host of physical symptoms such as headaches and dizziness resulting in unnecessary investigations and increasing doctor frustration as described by Craig and Boardman,<sup>5</sup> Creed and Mayou<sup>6</sup> and Gask.<sup>7</sup>

Shelley usually went to bed at the same time as her girls but resorted to alcohol and a couple of paracetamol. 'I need to sleep to make sure they get to school on time.' Shelley had cut her abdomen superficially with a razor blade in the past but stopped this when one of her daughters spotted the scars. A review of her family history revealed that her mother had suffered from panic attacks and her older brother was in prison for

shoplifting. He was a heroin addict, and usually only visited Shelley when in need of money. Her alcoholic father abandoned the family when Shelley was eight years old but Shelley recalls the relief within the home when he left: 'He was a drunkard and I hate him for what he did to Mum.'

Shelley attended a normal school but left with no qualifications. She confided that she had always wanted to be a carer but it always seemed too complicated and difficult, settling instead for a cleaning job arranged by her mother to bring in money. She had very few close friends and says she was always shy. With hindsight her social phobia was a problem that prevented any treatment benefit for many years.<sup>8</sup>

She had taken several impulsive overdoses of alcohol and painkillers, all precipitated by stressful life events she had been unable to deal with. She had seen several psychiatrists but had never been considered at serious risk of suicide or needed admission to a psychiatric ward. On many occasions she has wept in surgery saying she 'wants to escape but can't leave the girls'.

Her past history included several different diagnoses including anxiety, depression and borderline personality disorder. She was given the latter label after a series of occasions during which she self-harmed and drank to excess. Her distress was precipitated by the death of a friend. The diagnosis of personality disorder augmented her distress, guilt and anxiety as it simply reinforced her low self-esteem and lack of confidence.<sup>8</sup> Unfortunately, this diagnosis stuck

despite several futile attempts by myself to erase it from her medical records.

Quality and outcomes framework requirements<sup>9</sup> have emphasised the need for diagnostic labels in primary care and although the principle is admirable, it may cause diagnostic dilemmas and increase the risk of stigma for some patients.<sup>10</sup>

As a result of her despair, Shelley became even more withdrawn and isolated from the community, which reinforced her paranoid fears of being dubbed an alcoholic, bad mother and her children being taken into care. The Human Givens therapy model<sup>11</sup> emphasises that the label of mental illness may interrupt the recovery process and that the key to success is maintaining hope. Shelley's anxiety and poor coping abilities at times of stress often resulted in frequent doctor appointments and subsequent investigations for a variety of ailments including headaches, tiredness, dizziness, general malaise and abdominal pain as illustrated by Creed and Mayou,<sup>6</sup> Gask<sup>7</sup> and Goldberg and Bridges.<sup>12</sup> GPs see many patients with a diagnostic label of depression and/or anxiety.<sup>13</sup> Although most patients usually receive a prescription for antidepressant medication, individually they are very different people with very different problems ranging from physical illness, abuse, family or work difficulties. I am always concerned by their distress but equally worried that her treatment is not as beneficial as it could be and indeed at times may even cause harm.<sup>14</sup>

### Taking time to reflect

It is all too easy when a patient such as Shelley arrives and bursts into tears, to seize the first opportunity to take control and resolve the problem as speedily as possible. 'Don't worry – I know what the problem is, this is depression – it's not your fault, Churchill had it too! I have the solution.' Thus, a speedy prescription and referral for computerised cognitive behavioural therapy following NICE guideline recommendations<sup>15</sup> ensues, with soothing comments that it is understandable they feel as they do but they will feel better soon. Next please!

Johns<sup>14</sup> advice on reflection showed the necessity of avoiding this Procrustean 'one size fits all' approach and encouraging patient passivity. The process of medical education predisposes doctors to take

on and solve problems,<sup>16</sup> but Gask<sup>7</sup> teaches that patients are often the experts in their own illnesses and also expert in understanding the origins and potential remedies for their distress.

With practice, communication skills may be developed to foster a therapeutic encounter and thereby support the inherent strength of the patient and promote his or her healing powers. Empathy is not a mystical concept only blessed to a few individuals but is accessible to all health professionals through practice and by adopting specific skills.<sup>17</sup> We must be open to all verbal and non-verbal clues the patient may give us.<sup>14</sup>

Dowrick's<sup>18</sup> inspirational concept of a 'detached involvement' is achieved with self-knowledge, emotional intelligence and peace of mind. Also, Stuart and Lieberman's<sup>16</sup> description of a consultative framework for general practice and their advice on developing an effective consultation style within a 15-minute appointment slot is very informative. With practice and experience, Dowrick<sup>18</sup> reassures us that it does become easier to understand the world from the patient's eyes. He also emphasises that labelling and diagnosis are not as important as seeking out more detail in the patient's life in order to offer ideas for change or different ways of thinking. Shelley was taught that it was not realistic or helpful to try to be 'liked' by everyone. She was reassured that some mistakes are normal and may teach us useful lessons for the future.<sup>3</sup>

Dowrick<sup>18</sup> and Greenhalgh and Hurwitz<sup>19</sup> also espouse narrative therapy, which encourages a listening and understanding approach rather than diagnosis and prescription. It may not be appropriate for every patient in surgery because of time constraints, but for some patients such as frequent attenders it is time well spent. There is no doubt that helping patients find better stories to tell about themselves does work. The importance of effective communication encompassing the complexities of language, meaning, linguistics and etymology, cannot be underestimated.<sup>20</sup>

GPs usually excel in the art in communication. An inspirational publication by Lester<sup>21</sup> showed that people with mental illness prefer to be treated by their GP. Interestingly, patients valued continuity of care, listening skills, willingness to learn

and optimism in treatment more than specific knowledge about mental health. This is a great acknowledgement of the good work being done in primary care.

### The therapist/patient relationship

Shelley was referred for computerised cognitive behavioural therapy according to NICE guidelines,<sup>22,23</sup> but found no benefit, 'I hate computers, I can't understand them like my kids can, I feel stupid and panicky.' She was then placed on a 10-month waiting list to see a psychologist.

Often because of waiting lists or fear of stigma, patients resort to seeking help from sources other than the NHS. Shelley saw a counsellor based at her church – a free service, which she understandably took up. This opened painful memories regarding her history of abuse and, unable to cope, Shelley took an overdose of alcohol and paracetamol. She came to casualty with her children, hysterical and screaming for help. This cry for help earned an urgent appointment with the psychologist but sadly also a diagnosis of borderline personality disorder from the duty psychiatrist.

Unfortunately, Shelley had difficulties engaging with the therapist and also could not get to grips with the logical approach of cognitive behavioural therapy. 'I feel stupid, fat and ugly', she wept. Crisis after crisis ensued with her accessing many different agencies in times of need. Then, Penny came on the scene: an energetic cheerful charity worker who befriended Shelley and had the key to curing Shelley. The two met when, after months of my exhortations, Shelley finally plucked up courage to venture into a charity shop to look for clothes.

Penny highlights the importance of the therapist-patient relationship.<sup>24</sup> Norman Cousins<sup>14</sup> underscores the therapeutic value of encouraging confidence in the body's healing potential and the importance of establishing a supportive partnership between patient and therapist.

Penny began to accompany Shelley to appointments and observing the two talk together made me realise I had to try harder to communicate, listen more attentively to Shelley's words and then give advice in words she could comprehend.<sup>3</sup> Shelley didn't understand words such as self-esteem but she did fully understand the concept of worry and this distress it

may cause. The analogy of a rocking horse, 'it doesn't get you anywhere' may even provoke a wry smile from the patient. Humour is excellent to ease tension and enhance communication.<sup>14</sup>

### Identifying the problem

The first step is to help the patient to define accurately the problem that is causing the anxiety or depression.<sup>7</sup> Shelley was helped to link her worry to low self-esteem. Keedwell's<sup>1</sup> theory of the evolutionary basis of anxiety and depression reminds us of the positive aspects such as preventing reckless behaviour, stimulating a desire to achieve and fostering a caring and supportive community. It is vital to explain the physiological symptoms of anxiety such as muscle tension causing headaches.<sup>6</sup> This enabled Shelley to link the onset of a headache to an anxiety-provoking event such as the arrival of her brother.<sup>7,25</sup> Simple relaxation techniques can then be taught to the patient to use when anxious, such as the 7:11 breathing pattern, as described by Stuart and Lieberman.<sup>16</sup>

The final step was to support and encourage Shelley to explore possible solutions to the source of her anxiety and enable her to understand that the key to a cure was within her grasp. Cognitive behavioural therapy<sup>26</sup> and a solutions-based approach<sup>27</sup> emphasises the importance of identifying small manageable changes.<sup>28</sup>

The Kupfer curve concept<sup>29</sup> reassures doctors that our role is to simply help patients as far up the curve as possible. Often unforeseen life events will change a patient's position on the curve and thus recovery process. Doctors can only try to teach patients how to recognise and address early signs of stress. The patient has to be ready to tackle the change – however small. Doctors may assist as much as possible with the use of drugs and psychological therapies but Munthe's inspirational book written in 1930<sup>20</sup> shows that desire, inner strength and thus ability to improve has to come from the patient. Shelley's case also illustrates how vital it is for the doctor not to become disillusioned and cease attempts to engage even if the patient shows no immediate clinical benefit.<sup>3</sup>

Lambert *et al.*<sup>30</sup> showed that simple lifestyle advice such as exercise and relaxation techniques for insomnia are often

more effective than standard GP care. Engel<sup>31</sup> proposed that the biopsychosocial approach enables connections to be made between illness, social environment and lifestyle. Problems are then not viewed as simply residing inside one person but as being connected with a person's surrounding environment. Furthermore, Asen *et al.*<sup>32</sup> suggests that symptoms may be triggered or maintained by stresses from within the family, from work or other social factors.

Patients in primary care rarely come with a referral letter so the biopsychosocial approach is essential. This holistic approach recognises the patient's total life situation and reveals how stress and emotions are contributing to symptoms.<sup>31</sup> Other medical specialities see a filtered, ie referred, population and therefore usually adopt a purely biological approach.<sup>16</sup> Balint<sup>33</sup> asks 'Why did this patient come today and for this reason?' Sometimes the open ended question, 'How is life in general?' may reveal the underlying cause of the symptoms.

### Using supportive psychotherapy

Many different simple psychotherapeutic techniques are appropriate to be used during a GP consultation, as different therapeutic approaches suit different patients. GPs are adept at dealing with a highly complex set of problems within a ten-minute consultation. Lengthy psychotherapy is not helpful or useful but small doses given by a trusted health professional who knows the patient well can be most effective. Stuart and Lieberman<sup>16</sup> describe how GPs use supportive psychotherapy every day to reinforce a patient's defences and relieve symptoms, without probing deep psychological conflicts or altering the basic personality. Lester<sup>21</sup> proves how much patients appreciate this support.

As the many different schools of psychology and psychiatry all view the patient and the patient's problems from a slightly different perspective, together they form an excellent practical armamentarium with which to help individual patients. With a little practice, familiarity may be gained with a whole gamut of therapies such as autogenics training, cognitive behavioural therapy,<sup>26,34</sup> solutions-based therapy,<sup>27</sup> the use of genograms<sup>32,35</sup> and the Human Givens model.<sup>11</sup>

In addition, of course, patients may well require concurrent drug therapy to reduce anxiety and allow them to address the behavioural changes required. Shelley was prescribed an SSRI on a regular basis, propranolol 10mg three-times daily for periods of anxiety and very occasional small supplies of diazepam for emergency use during panic attacks.<sup>36</sup>

### Support from the community

Society used to comprise of cohesive, closely knit communities and extended families. Before Penny arrived, Shelley had no backup support. Gask<sup>7</sup> emphasises the importance of mobilising all sources of support such as personal strengths, family, friends and the community. Back in 1836, Burton<sup>37</sup> also extolled the benefits of friends who provide 'counsel, comfort, good persuasion, witty devices, music of all sorts, mirth and merry company'. Indeed, he was such an engrossing read that Samuel Johnson declared it was the only book that could get him out of bed two hours earlier than usual!<sup>18</sup>

The publications 'Making it Possible'<sup>38</sup> and 'Building Healthy Communities'<sup>39</sup> give invaluable advice on encouraging patient support within the community and show the benefits of tapping into philanthropic hives of activity within a community, and the importance of tackling social phobia.<sup>40</sup> The Human Givens model<sup>11</sup> emphasises the importance of finding a role in society and a worthwhile goal. Maslow's hierarchy of archetypal needs<sup>1</sup> also describes basic human requirements for a fulfilling life. A traumatic life event may cause a patient to lose their sense of purpose and spiral further and further into mental illness. Despite the author's repeated attempts to encourage Shelley to become less withdrawn and be more sociable, it was Penny's enthusiastic support and company to the gym that marked the beginning of Shelley's re-emergence into society and recovery culminating in a college course.

### Mental illness today

World Health Organization research<sup>41</sup> shows that modern life is increasingly stressful, and stress and emotions play a large part in how we cope with daily activities and deal with physical illness. Goldberg and Bridges<sup>12</sup> showed that psychological factors account for 40-50 per cent of GP consultations.

Depression is predicted to be second leading cause of disability by 2020, only topped by ischaemic heart disease,<sup>18</sup> but the recent King's Fund publication 'Paying the Price'<sup>41</sup> reassures that prevalence rates in recent years are broadly stable and estimated to remain so for the next 20 or so years. Also Keedwell<sup>1</sup> confirms the evolutionary explanation for the natural incidence of anxiety and depression in a community. The fact is that absolute numbers of people with depression will rise due to an increasingly ageing population. 'Paying the Price' highlights to all health professionals the urgent need to stop incorrect labelling and instead start reducing stigma and normalising mild symptoms of mental illness. Gask<sup>7</sup> emphasises the importance of the definition of mental illness, as there is a wide spectrum of emotional distress ranging from appropriate sadness induced by a traumatic event to psychosis.

Stuart and Lieberman<sup>16</sup> explain that the course of a disease will relate to the patient's psychological response to a diagnosis or treatment. Women with breast cancer who express anger have a better prognosis than those who passively accept their disease.<sup>42</sup> Another study found that women in support groups not only had a better quality of life but also survived significantly longer than a control group.<sup>43</sup> Bartrop *et al.*<sup>44</sup> studied the immune system of husbands' of women with breast cancer and found a highly significant suppression of lymphocyte function within one month of the spouse's death. Munthe in 1930<sup>20</sup> and Cousins<sup>14</sup> emphasise that health professionals cannot ignore patients' emotional 'baggage' with the excuse that it isn't their responsibility to solve. Indeed Vaillant's<sup>45</sup> observation that mental and physical health are inextricably linked cannot be denied.

Stuart and Lieberman<sup>16</sup> speculate why 25 per cent of people get 75 per cent of disease. The reason may be that we all have different limits at different times in our lives.<sup>46</sup> A healthy individual has adept coping mechanisms to normalise and contain physical symptoms so not everyone seeks medical advice for a simple headache<sup>6</sup> but coping mechanisms fail when we are overwhelmed in some way. Seligman<sup>47</sup> suggests 'learned helplessness' results when people are convinced that events are out of their control and that their behaviour is not

able to affect the outcome of a situation. With hindsight, Shelley was in this state for many years before effective communication and teamwork enabled recovery.

The Human Givens model<sup>11</sup> agrees that all humans have different limits and also postulates that there is a fluid continuum of mental illness. Shakespeare's 'King Lear', who became insane after a host of adverse life events, is a masterly example of this hypothesis.

The problem of frequent attenders and medically unexplained symptoms is a burgeoning economic and social conundrum facing government and health service managers.<sup>41</sup> One of the most efficient ways of signalling for help in our society is to develop a disease. Our population may be more 'healthy' but there are more 'sickness' days taken than ever before.<sup>16</sup> Healthcare professionals are in a key position to prevent endorsing sickness leave and at the same time not neglecting illness. Thus it is an exciting prospect that despite radical changes in the structure and function of primary care, GPs remain in the unique and privileged position of being able to identify these patients and offer an effective management plan.<sup>21</sup> Gask<sup>7</sup> and Dowrick<sup>18</sup> confirm that continuity of care allows this supportive role to continue with vulnerable patients over long periods of time.

## Conclusion

This case teaches the important message that mental illness has to be acknowledged as a bona fide illness by society to help sufferers recover. The Human Givens model<sup>11</sup> questions the need for a label, in particular one such as personality disorder which may exacerbate anxiety and depression as well as giving others the licence to behave badly: 'It's not MY fault I'm sick'.<sup>8</sup> Gask<sup>7</sup> emphasises that personality is notoriously difficult to assess. Shelley's case illustrates that it isn't always useful or helpful to put patients into neat boxes – we are a highly complex species! Diagnostic labels can stick and exacerbate symptoms. Media headlines may increase patients' anxiety that they will be ineligible for and excluded from certain treatments. Waller and Hodgkin<sup>13</sup> discuss the difficult problem of data protection in general practice with increasing computerisation. The transfer of scanned documents between all health professionals must be consid-

ered. Patients have to trust their doctor in order to confide their innermost fears and secrets and trust takes time to develop.<sup>24</sup> All confidential information concerning family members, friends and all other people involved with the patient, needs to be protected.<sup>32</sup>

Critical examination of Shelley's care showed the importance of a partnership approach to patient care instead of the doctor immediately assuming the role of problem solver and controller of disease.<sup>14</sup> An honest critique<sup>4</sup> revealed that at times a failure in communication stymied all therapeutic attempts to engage her. Progress only resumed when doctor and patient began to 'speak the same language' and empathy was restored. Empathy requires enthusiasm, energy, dedication and respect for the patient as an individual. I learnt the importance of being interested and 'with' the patient. Active rather than passive listening is vital. As Shelley's case illustrated: ask enough questions and the patient will find the correct solution.<sup>26,27</sup>

Reflecting on this case emphasised the importance of always continuing attempts to engage with the patient whenever the opportunity presents. Repeated simple messages may achieve results even after many years of seemingly fruitless efforts. Frequent attenders are always a challenge!<sup>7</sup>

This case history has changed my values and beliefs as it is a myth that that psychotherapy is always ominous and difficult.<sup>20</sup> This case illustrates the benefits of having a whole range of different simple psychotherapeutic techniques to dip into and tailor to individual patients.<sup>16</sup> Also I have learned that instead of embarking on a particular therapy and working with the patient to a defined pattern, it is often more productive to simply step back and listen to the patient in order to guide them along a path to recovery.<sup>24</sup>

Shelley has also taught me the benefits of utilising all community resources available as well as encouraging the development of patient groups as described by Bate and Robert<sup>48</sup> and the Department of Health document 'Creating a Patient-led NHS'.<sup>40</sup>

Thus, reflecting on this case stimulated an analysis of therapeutic rapport with patients as well as an honest examination of my own professional and personal capabilities and shortfalls.<sup>3</sup> Johns'

views,<sup>4</sup> Jasper's words<sup>49</sup> and Bolton's work<sup>2</sup> on reflective practice all gave useful advice on this process. It enabled me to alter the way I treat patients as well as challenging my personal need to be liked and be 'helpful'.

Shelley's history is evidence that mental illness may be chronic and cause considerable distress and disability.<sup>50</sup> Sufferers are often unrecognised and untreated in which case they are costly to the patient and to society.<sup>41</sup> This case teaches that all health professionals should aim to reduce stigma and increase society's understanding, knowledge and hence acceptance of mental illness. Mental illness is a treatable disease and certainly not a life sentence. Examination of Shelley's care<sup>3</sup> shows that to give hope and support to these patients is a therapy alone.

Finally, to return to the concept of stigma and Marrel's beautiful seventeenth Century drawing of a bee alighting on a tulip stamen,<sup>51</sup> In the anniversary year of Darwin's theory of evolution, Shelley's message to all health professionals is to remove her brand of disgrace and accept anxiety and depression as bona fide treatable conditions with an evolutionary basis. She asks us to remember that the patient in front of us is human and that there is a reason behind every human behaviour.

## References

1. Keedwell P. *How Sadness Survived: The Evolutionary Basis of Depression*. Oxford: Radcliffe Publishing, 2008.
2. Bolton G. *Reflective Practice: Writing and Professional Development*. London: Sage Publications, 2005.
3. Rolfe G, Freshwater D, Jasper M. *Critical Reflection for Nursing and the Helping Professions: A user's guide*. Basingstoke: Palgrave Macmillan, 2001.
4. Johns C. *Becoming a Reflective Practitioner: A reflective and holistic approach to clinical nursing, practice development and clinical supervision*. Oxford: Blackwell Science, 2000.
5. Craig TK, Boardman AP. Common mental health problems in primary care. *Br Med J* 1997;314:1609-12.
6. Creed F, Mayou R. *Medical Symptoms not Explained by Organic Disease*. London: Royal College of Psychiatrists Publications, 1991.
7. Gask, L. *A Short Introduction to Psychiatry*. London: Sage Publications Ltd, 2004.
8. Newnes C, Holmes G, Dunn C. *This is Madness: A critical look at psychiatry and the future of mental health services*. Ross-on-Wye: PCCS Books, 1999.
9. Department of Health. *The NHS in England: The Operating Framework for 2006/7*. London: DoH, 2006.
10. Newnes C, Holmes G, Dunn C. *This is Madness Too: Critical perspectives on mental health services*. Ross-on-Wye: PCCS Books, 2001.
11. Griffin J, Tyrell I. *Human Givens. A new approach to emotional health and clear thinking*. Cheltenham: HG Publishing, 2004.
12. Goldberg DP, Bridges K. Somatic presentations of psychiatric illness in primary care setting. *J Psychosomatic Res* 1988;32(2):137-44.
13. Waller J, Hodgkin P. *General Practice: Demanding Work*. Abingdon: Radcliffe Medical Press Ltd, 2000.
14. Cousins N. *The Healing Heart: Antidotes to panic and helplessness*. London: Norton, 1983.
15. National Institute for Health and Clinical Excellence. *Clinical Guidelines for the Management of Anxiety*. Clinical Guideline no. 22. London: NICE, 2004.
16. Stuart MR, Lieberman JA. *The Fifteen Minute Hour: Practical therapeutic interventions in primary care*. Philadelphia, USA: Saunders, 2002.
17. Norfolk T, Birdi K, Walsh D. The role of empathy in establishing rapport in the consultation: a new model. *Med Education* 2007;41(7):690-8.
18. Dowrick C. *Beyond Depression: A new approach to understanding and management*. Oxford: Oxford University Press, 2004.
19. Greenhalgh T, Hurwitz B. Narrative based medicine. Why study narrative? *Br Med J* 1999;318:48-50.
20. Munthe A. *The Story of San Michele*. London: John Murray Publications, 1930.
21. Lester H. Patients' and health professionals' views on primary care for people with serious mental illness: focus group study. *Br Med J* 2005;330:1122.
22. National Institute for Health and Clinical Excellence. *Guidance on the use of computerised cognitive behavioural therapy for anxiety and depression*. NICE Technology Appraisal Guidance no.51. London: NICE, 2002.
23. National Institute for Health and Clinical Excellence. *Depression: The management of depression in primary and secondary care*. Clinical Guideline no.23. London: NICE, 2004.
24. Frank JD. The placebo is psychotherapy. *Behavioural Brain Sci* 1983;6:291-2.
25. Tyrell I, Griffin J, Winn D. *How to Master Anxiety: All you need to know to overcome stress, panic attacks, phobias, obsessions and more*. London: HG Publishing, 2006.
26. David L. *Using CBT in General Practice: The 10-minute Consultation*. Bloxham, Oxfordshire: Scion Publishing, 2006.
27. De Shazer S. *Clues: Investigating Solutions in Brief Therapy*. New York: Norton, 1988.
28. Greenberger D, Padesky C. *Mind over Mood: Change how you feel by changing the way you think*. New York: The Guildford Press, 1995.
29. Kupfer DA. Long-term treatment of depression. *J Clin Psychiatry* 1991;52(Suppl. 5):28-34.
30. Lambert RA, Harvey I, Poland F. A pragmatic, unblinded randomised controlled trial comparing an occupational therapy-led lifestyle approach and routine GP care for panic disorder. *J Affective Disorders* 2007;99(1-3):63-71.
31. Engel GL. The need for a new medical model: a challenge for biomedicine. *Science* 1977;196:129-36.
32. Asen E, Tomson D, Young V, Tomson P. *Ten Minutes for the Family: Systematic interventions in primary care*. London: Routledge, 2004.
33. Balint M. *The Doctor, his Patient and the Illness*. London: Pitman Medical, 1957.
34. Williams CJ, Garland A. A cognitive-behavioural assessment model for use in everyday clinical practice. *Advances in Psychiatric Treatment* 2002;8(3):172.
35. George E, Iveson C, Ratner H. *Problem to Solution: Brief therapy with individuals and families*. London: BT Press, 1999.
36. Taylor D, Paton C, Kerwin R. *The South London and Maudsley NHS Trust Prescribing Guidelines*. London: Martin Dunitz, 2003.
37. Burton R. *The Anatomy of Melancholy*. Oxford: Clarendon Press, 1836.
38. Care Services Improvement Partnership (CSIP). *Making it Possible: Improving mental health and well-being in England*. London: National Institute for Mental Health in England, 2008.
39. Dowrick C. *Building Healthy Communities: A proposed model for commissioning for health and not just for illness*. Adapted from The North Mersey Health Improvement Programme Primary Mental Health Care Think Tank, 2005.
40. Department of Health. *Creating a Patient-Led NHS: Delivering the NHS Improvement Plan*. London: DoH, 2005.
41. Mcrone, P, Dhanasiri S, Patel A, et al. Paying the Price. *The Cost of Mental Health Care in England to 2026*. London: The King's Fund Publications, 2008.
42. Greer S, Morris T, Pettingale KW. Psychological response to breast cancer: effects on outcome. *Lancet* 1979;13:785-7.
43. Spiegel D, Bloom J, Karaemer HC, Gottheil E. Effect of psychosocial treatment on the survival of patients with metastatic breast cancer. *Lancet* 1989;2:888-91.
44. Bartrop RV, Lazarus L, Luckherst E, et al. Depressed lymphocyte function after bereavement. *Lancet* 1977;1(8016):834-6.
45. Vaillant GE. Natural history of male psychological health: effects of mental health on physical health. *New Engl J Med* 1979;301(23):1249-54.
46. Johnson S. *Who Moved My Cheese? An amazing way to deal with change in your work and life*. London: Vermilion, 2002.
47. Seligman MEP. *Helplessness: On Depression, Development and Death*. San Francisco: Freeman, 1975.
48. Bate P, Robert G. *Bringing User Experience to Healthcare*. Oxford: Radcliffe, 2007.
49. Jasper M. *Professional Development, Reflection and Decision Making*. Oxford: Blackwell, 2006.
50. Layard R. *Mental Health: Britain's Biggest Social Problem? A paper presented at the No.10 Strategy Unit Seminar on Mental Health, 20 January 2005*.
51. Marrel J. *Details from a tulip book*. Amsterdam: Rijksmuseum, 1657.