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Pausing to Consider the Impact of Cultural Trends On Mental Health Treatment

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Abstract

The article raises concerns about a focus on efficiency and cost-containment as the main factors in evaluating psychotherapeutic practice. Pausing to consider the impact of cultural trends on therapy can lead to an accent on therapist discretion is an integral ingredient of the therapeutic process that can promote good outcomes for the client and personal satisfaction for the therapist.

Key Words: cultural trends, discretion, efficiency, therapeutic efficacy

Introduction

The above words, written more than forty years ago and introducing a long-playing album by one of rock's more innovative and enduring bands, The Moody Blues, could easily be uttered in our present cultural climate. The impact of our culture's fascination with relentless progress, efficiency and speed in the delivery of mental health care is the focus of this article.

The pressure to remain current, to introduce seemingly innovative and efficacious treatment modalities, to offer integrated behavioural health care, to demonstrate excellence, or to adopt popular trends to remain in the

business of providing mental health care – even at the expense of colleagues and clients, are all potentially troubling yet common developments in the present day. This article endeavours to invite discussion as to how we maintain a balance in our practices: how we make room for brief or manualized treatments while also respecting the benefits offered by longer term or more open-ended approaches to the therapeutic relationship.

When all is said and done, the dilemma in providing mental health services, indeed, in all health care provision, may amount to a question of sacrificing efficiency for quality, or the reverse. "When economic efficiency is the primary driver in all of health care…" (Norcross, et al., 2002, p. 320), the shift to briefer and ostensibly less costly services is amplified, potentially at the risk of quality and a meaningful therapeutic experience for the client. However the evidence and rationales are presented, they can often be distilled to this basic choice. This article is a call to pause, even if only momentarily, to consider the influence that contemporary culture is having on our thinking and practices in the mental health domain and ultimately, to make intentional decisions in how we deliver mental health care.

Contemporary culture

We are not just impacted by our evolving culture. Whether we realize it or not, we are contributing to the culture that is being created in this 21st century. Our imprint on the delivery of mental health services is evolving daily and the risk is that in responding to the pressure to 'keep up' we unwittingly contribute to what is created without actually realizing our contribution to evolving mental health care.

The tremendous fiscal pressure and cost-containment crisis (Cummings, et. al., 2009; Steinberg & Luce, 2005; Anson, 2001; Cummings, 1986) in health care systems throughout the western world and certainly relevant throughout North America, necessitates that we examine our practices carefully, with a view to offering only those services that are effective and efficient. Yet this worthy goal of delivering ever-better services inevitably conflicts with the expectation of doing so cost-effectively. Invariably these principles prompt a compromise too often resulting in a "one size fits all" service model that can be insensitive to the individual and their specific treatment needs.

Mental health treatment has increasingly moved toward a "fast food industry" modality in its fascination with ever-briefer therapeutic interactions and obsession with conformity to manualized approaches. This trend subjects both clients and therapists to performance expectations that are sometimes quite unrealistic. Both clients and therapists hope for profoundly meaningful and lasting transformation, but to achieve it instantly. This emphasis on speed and numbers often occurs at the expense of genuine attention and comprehensive treatment that is imperative when addressing the complex life situations that so many people with mental health concerns bring to our attention. As H.L. Mencken observed, "There is always an easy solution to every human problem —neat, plausible, and wrong" (Mencken, 1920, p.158). At least in the fast food industry there is no pretense of offering a gourmet experience or high nutritional value. There is no confusing the fact that quality and convenience are divergent points on a continuum. "Value for money" can be defined anywhere along that continuum, depending on one's priorities. One may ignore but not escape the constraint, however, that a choice for more of one attribute necessarily entails a sacrifice of the other.

There is a penchant in our culture to set people against one another in the pressure to survive and thrive. Notions of intentional collaboration and honouring people for the particular contributions they have to make to what is invariably a shared enterprise are often minimized or disregarded. This is also true in mental health, where there can be a curious disconnect between therapists in a clinic, or between programs delivering services in a similar domain. We all develop skills and knowledge by first learning from people and programs that precede us. This fundamental idea is frequently disregarded, and more emphasis is placed on our differences. Oftentimes, the vehicle to communicate differences or to jockey for power or market share as a therapist will in-

clude the mode of treatment offered by an individual or a program. Not being conversant or proficient with a particular therapeutic approach can lead to patronizing interactions, or worse, and can contribute to elitist or exclusive groupings that fail to emphasize our commonalities (Cowan-Jensenn & Goodison, 2008). How such practices fit with our claims in mental health to work for the betterment of people, generally, remains to be explained.

The explosion of information available through technology, along with the ability to access information or communicate around the world instantaneously, offers dilemmas as well as benefits. Our culture's relentless determination to be current and attuned to social media non-stop can leave people without a break from work. There is merit in pausing to think about the implications of such cultural trends. Yet, we live in an age that eschews questioning assumptions, instead demanding ready answers to life's problems. Our capacity to reflect, crucial to people contemplating change and the therapists who seek to help them, is being eroded.

There is not wholesale infatuation with our new technology and hard-wired culture. Anecdotally, veteran therapists in mental health will talk about their discomfort with the use of email, blackberry, Iphones and Ipads for communication, preferring the old fashioned personal face-to-face contact with colleagues. Younger staff will occasionally joke about this penchant to rely on personal interactions instead of the more ubiquitous and time-saving, but impersonal devices aforementioned. Mitch Albom tells the story of a Rabbi who shunned shorthand communication devices that might allow him to communicate with hundreds of people daily, out of a concern that in an email "how can I tell if something is wrong?" (Albom, 2009, p.64). Albom's Rabbi might be alarmed by the increasing trend to provide psychotherapy remotely by telephone, or over the computer using "virtual" face-to-face platforms (e.g., Skype, Face Time), or type-written by way of "instant-messaging."

This anecdote illustrates an ongoing dilemma in our culture – as much as technological advances are meant to offer efficiency, are they unwittingly contributing to the loss of human contact, connection and being present in the moment, that are essential for healthy relating? Can we pause to consider and discuss the implications of some of the trends in our culture and how these are having a real effect on the provision of mental health services in this second decade of the new millennium?

The penchant for brevity and efficiency

For the past three or four decades there has been a steady promotion of short-term therapy, brief solution-focused therapy, single session therapy and now the emergence of telephone and on-line therapy sessions, with no need to ever actually see the individual you are working with 'in person'. There are times when a time-limited approach to treatment can galvanize the client into action and that brief interventions do trigger change (Miller & Rollnick, 2002). However, their effective utilization is undermined when they are deployed without regard to where they are effective and where they are not. The esteemed psychiatrist David Burns describes brief therapy as relevant with clients experiencing "… straightforward problems that can be dealt with in a fairly short time – say, fifteen to twenty-five sessions" (Burns, 1999, p. 31). If Burns' guideline is reasonable for circumscribed problems, it raises a question about what can realistically be accomplished in four to six sessions (often only 15 to 30 minutes long) especially when the majority of clients rarely present with straightforward problems?

Where the emphasis is increasingly placed on ever-briefer methods as the standard, the options for many tested and proven therapeutic alternatives are diminished. The pressure to move clients through a program or hospital quickly can prompt losing sight of numerous clinical studies that "… rather consistently show a positive correlation of retention in treatment with better outcomes" (Miller, et. al., 2005, p.269). Similarly, with chronic, lifelong illnesses such as depression a continued use of psychological maintenance treatment has been shown to significantly improve survival time following recovery from depression (Teasdale, et. al., 2000).

A National Institute of Mental Health (NIMH) review in the mid-1990's (Blatt et. al., 1996) determined, in a study of therapist effectiveness treating depression, that the more effective therapists expected treatment to take longer than did less effective therapists. In recent years, motivational interviewing has emerged as an important therapeutic skill. The principal authors underline that ambivalence is a common feature of a client considering change and that an action-oriented approach, is not effective when ambivalence is emerging. The main guiding principles of motivational interviewing include expressing empathy, developing discrepancy and rolling with resistance (Miller & Rollnick, 2002, p.36), all practices that take time and which cannot easily be accommodated in the frameworks of brief, manualized therapy models. Where ambivalence as a normal component of human change emerges, a more explorative and reflective approach is recommended, with an emphasis on listening carefully to the client (Rollnick, et. al., (2008), then elucidating ideas with the individual about steps toward goals they might be prepared to initiate.

The idea that significant aspects of our lives can be analyzed, managed and mastered in brief segments of time is questionable. Brief therapies lose their lustre when applied uniformly and rigorously in all situations and with all people. Does the shift to briefer therapy approaches allow for a discussion about the merits of reserving judgment in some instances, so that a brief approach is not the sole tool in the therapists' kit?

Replicating the Primary Care Culture

There are some suggestions that in the future psychotherapy will be more akin to a medical model, aspiring to diagnose and treat patients in fifteen minute blocks (Thomason, 2010). Further, that third-party payers, such as health insurers, will balk at compensating treatments that are not demonstrably medical in nature, such as therapy for self-esteem or other vague or abstract goals. The model of brief therapy does lend itself quite well to recent trends toward integration of mental and behavioural health services with primary care (Hunter, et. al., 2010; Cummings, 2006). The addition of mental health clinicians, among other specialists, to support the primary care physician, is meant to offer education and support to the physician, while also contributing to high-quality care for the patient. This approach is being replicated with success in many areas of primary health care, with dieticians, specialists in cardiac care, diabetes and a variety of other chronic illnesses, being enlisted to work alongside the primary care physician to augment and hone the treatment and care of patients.

The pressures experienced in primary care demand a sharply focused attention to a specific issue and involve moving rapidly and efficiently from office to office in the interest of seeing three, four, possibly half-a-dozen patients in a one hour block. Some primary care physicians embrace a brief therapy approach, marvelling at how much information can be elicited, and treatment interventions delivered, in such a compressed time frame. In some instances, the physician may lambaste the unwitting therapist who does not deliver a complete assessment and intervention in short order. However, in other instances, primary care physicians will lament that their patients often return from referrals for brief or targeted therapy complaining of "being rushed out the door", having no sense of being listened to, or their circumstances being adequately understood. Is it possible that our approach in mental health is replicating the primary care model in ways that are not always conducive to supporting the primary care physician and their patient?

Many mental health concerns, to do with homelessness, addictions, depression, grief, abuse or trauma are neither vague nor ambiguous. Whether or not client symptoms and experiences can be codified according to Axis I – DSM-IV criteria, they constitute real dilemmas having real effects on individuals and their loved ones. A front page article in the Calgary Herald (Kirkey, 2010) lamenting the increasing dilemma of child obesity noted that pediatricians and family physicians lack the time needed to adequately address childhood obesity. The article quoted family physicians as reporting, "… spending, on average, 13 minutes for initial, and 10 minutes for follow-up consultations." The article added that half of those surveyed complained of being limited by billing codes in having any kind of meaningful discussions with children and their families about obesity.

When the integration of a mental health clinician to a primary care setting calls for a high-volume, rapid turnover model without accounting for the patient's presenting concerns and context of their life, concerns invariably arise - one size that "fits all," but suits none. The primary care physician's patient will not typically self-exclude due to circumstances that might prompt us to contemplate longer term treatment, such as the individual with recurring depression over a number of years and limited benefit from trials of anti-depressant medication, post-traumatic stress disorder or grief following the death of a loved one. In fact, where the patient has a long-standing relationship with the physician, one of the most relevant curative factors might arise from the nuanced communication of care and concern provided by the physician who refers their patient for mental health care. Neither the patient nor the physician may be inclined to feel rushed through the therapeutic encounter, and a more traditional therapeutic hour can offer great benefit and relief to the patient, thereby also offering sustenance to the physician who has extended their commitment to the patient.

Are we sure about what constitutes efficacy?

How to define and assess effective service delivery and what factors to consider as components of quality care is a topic that has prompted discussion for more than two decades (Donabedian, 1988). Similarly, a lament about the erosion of health care delivery has endured since the mid-80's (Cummings, 1986). Cost-containment strategies and the growth of managed care approaches in mental health care are dominating the landscape and can be critical to our maintaining our employment. The risk is that we abandon discussion about our direction as therapists and in programs that employ therapists. For example, you can go into a sports medicine clinic for treatment with a skilled physiotherapist and find four or five people receiving direct treatment at the same time. While this may be efficient and fiscally rewarding for the clinic, and presumably will reflect well on the clinician providing service delivery to multiple clients within the same hour, the individual client may have a less salubrious experience. As with patient feedback to primary care physicians about feeling "rushed" the client in this instance may feel unable to ask for or receive adequate attention related to their rehabilitation.

There can be an assembly-line feel to our practice, especially in public agencies where constantly measuring and statistically accounting for all time and activities as a way to measure performance has become ubiquitous. Certainly, accountability is warranted. However, pushing people through the health care system does not impress as constituting effective treatment or care. Can we pause to ask if this is the long-term design of health care that we want to embrace, especially when client-centered care is compromised? Again, to compare with the fast food industry, when McDonalds boastfully advertises "over 120 billion served," the implication is that many are repeat customers, coming back over and over for exactly the same thing, time and again. This success in the food industry would reflect a resounding failure in the mental health industry, yet we certainly appear smitten with this business model.

The multidimensional factors to consider when providing high-quality services, in addition to the crucial element of client engagement in the therapeutic process, call for judicious consideration and an ongoing sensitivity to the process (Megivern, et al., 2007). How to measure so many dimensions and the nuances of the evolving therapeutic relationship remains elusive, but deserving of our attention. The plethora of techniques, strategies and interventions that continually emerge adds to the difficulty in determining a coherent and spare approach in psychotherapeutic treatment. When considering the complexities of human relationships and the inevitable tearing of the social fabric that occurs as time goes on, it can be paralyzing to the therapist to master sufficient techniques or modes of treatment that they can have 'at their fingertips' and can benefit most clients with some certainty. There are so many creative and persuasively presented therapies, strategies and interventions, many replete with evaluative measures to confirm their efficacy, that it can be intimidating, if not overwhelming for the clinician trying to find a framework to guide their practice.

Evidence-based practice

For purposes of this discussion no distinctions will be made between practice guidelines and treatment guidelines (Reed, 2002). A discussion about the distinctions is relevant as detailed examination of treatment protocols in a particular program or primary care network emerges. More generally, there is a concern that the trend toward evidence-based practice and empirically supported treatments is having an inevitable affect on evolving psychotherapeutic practices (Thomason, 2010).

There has been a proliferation of practice guidelines throughout medicine as a result of the promotion of evidence-based practice (Torrey et al., 2001). The adequacy of the guidelines recommended depend on the adequacy of the scientific evidence that provides the basis for the proposed guidelines (Stricker, et. al., 1999). Even when this criterion is met, concerns persist as to how uniformly and effectively particular clinicians are educated and trained in implementing specific practice guidelines. It goes without saying that the education and training requires constant updating and opportunities to rehearse the new practice will be necessary to reinforce implementation (Torrey, et. al., 2001). Specific strategies will assist in the dissemination of innovations in practice and treatment guidelines to reduce the tendency to dilute the innovations (Berwick, 2003). Even so, there is an added risk that the emphasis on best practices can lead to "micromanaging", as clinicians are expected to meet treatment standards regardless of their training or agreement with such methods (Megivern et. al., 2007).

An emerging concern is that treatment guidelines are proliferating to the point of creating more confusion than clarity. Two challenges emerge, related to the sheer volume and the inconsistencies that are reported as to what guidelines to adhere to in providing best practice services (Clay, 2000). For example, in treating an illness such as depression, what comes first? Attention to vegetative shifts? Review of extended family history of mood disorder to consider biological vulnerability? Determining the most effective medicine? Exercise? Emphasis on return to work? An assessment of the client's motivation to start treatment? Recruitment of family and social support? A support group and community activity for interest? All at once? No doubt, many clinicians can offer an immediate and confident reply, while others will hesitate or wish to consult the person with the depression to determine treatment steps. All of this takes time and then adjustment to the treatment protocol depending on follow-up feedback from the client.

Within the best practice guidelines there are invariably multiple factors to consider and a range of choices available to the clinician. For example, in the treatment of PTSD, whether to introduce exposure and flooding, or stress-reducing mindfulness practice, visualization for further relaxation or discussion of a safety plan (if ongoing risk is a factor) and whether or not to seek legal recourse (related to abuse or assault) are all relevant and endorsed as practice guidelines. However, the presentation and intentions of the client, in combination with the strengths and inclinations of the therapist, will be critical to the treatment steps taken, and in what order. And, without sufficient engagement, there is a risk that none of these steps will be taken.

Time-honoured therapeutic factors

"…'therapeutic alliance' is the single best predictor of benefit" (Department of Health, 2001, p. 35). "… psychotherapy research has repeatedly demonstrated that the success of counselling and therapy depends less on the particular method than on the "common factors" shared by virtually all therapists – support, empathic understanding, positive regard, genuineness and the ability to establish a strong emotional bond with clients" (Simon, 2007, p.37). There are many therapeutic factors which can be listed and it makes for a stimulating training exercise for clinicians to identify those factors that are most relevant in their experience. The quality of the therapeutic relationship, and appreciating the client's agency in change, are strongly noted to be important factors in what makes therapy effective (Bohart, et. al., 1998). It may be possible, though likely less common, to establish the hallowed therapeutic relationship in a brief encounter or in the first minute of an interview. However, it is more likely that a meaningful alliance will be fashioned as the therapeutic encounter unfolds and as the therapist allows the client sufficient time to provide context and substance to whatever circum-

stances are troubling them. Sufficient understanding of the client's narrative, values and hopes will allow for the development of a focused treatment plan that can account for ambivalence and missteps along the therapeutic journey. All of these features of the meeting between client and therapist will take time and will involve the client having the experience of another human sitting with them, listening, reflecting and working to understand them.

A therapeutic alliance can pave the way for a corrective emotional experience, another feature of effective therapy. Such an experience cannot be predicted by formula, or imposed along arbitrary time lines. A corrective emotional experience evolves over the course of treatment and depends on an exquisite appreciation of the client's experience.

It is in the details of the lived experience that the client can bring to life and express what matters to them in a dignified manner. To first hear and then understand the meaning of the details to the client, will also take time. Open-ended questions are more likely to facilitate a client-centered approach to therapy that will support the individual in articulating their dilemmas, their fears, their hopes and their goals.

Several key components of a helping interaction were identified more than fifty years ago by Carl Rogers, and in most instances, remain true today. It is now routinely accepted that the therapeutic relationship is critical to outcome, with empirical research and clinical experience affirming this seminal idea (Goldfried, M., 2007). Accurate empathy, positive regard and genuineness are foundational aspects of the clinician's skilfulness that few would deny. Many authors note their "… heavy reliance on and indebtedness" to Carl Rogers (Miller & Rollnick, 2002, p. 25) for his contributions to a client-centered approach to therapy that has found renewed interest in the current health care climate. Client-centered, if we are true to the phrase, implies that the therapist will not have an agenda or time frame that they bring into the therapy encounter with the intention of imposing on the client.

It is hard to overstate the significance of Rogers' contribution in emphasizing the importance of attention to vital elements of the therapeutic relationship. In a survey (Cook, et al., 2009) which partly replicated a study more than twenty-five years previously (Smith, 1982), psychotherapists from a variety of training disciplines in North America were asked to identify which prominent people had most influenced their practice. In both surveys, a quarter of a century apart, Carl Rogers was named the most influential. Can there be any stronger endorsement than this?

Empathy, the elephant in the room of effective therapeutic factors

For many years the evidence supporting the significance of therapist variables such as empathy has been acknowledged (Patterson, 1984). Empathy has a central role in creating a therapeutic conversation that supports meaningful and mutual understanding between therapist and client (Snyder, 1995). Such experience evolves out of the shared appreciation of one another – client and therapist – an appreciation which is forged not by formula but is co-created via time and effort. There is a risk that empathy will be compromised in a time compressed or pre-determined method that priorizes efficiency and presumes to predict a treatment course before a client is even met.

"Empathy, for Rogers, was a way of being, not merely a way of listening…" (Cissna & Anderson, 1990, p. 139). Empathy remains perhaps the single most significant therapeutic factor that is recognized and claimed by all in the helping professions. However, the concept of empathy, related to therapy, is not always understood in the manner that Rogers intended. It is not a matter of repeating in rote the words of the client, nor is it a claim to mind-read or to understand the client experience on the basis of the therapist having a similar lived experience. It calls for an appreciation of the individual engaged in the therapeutic encounter with the clinician as an

'other' person, and asks the clinician to recognize the other-ness of the individual they are encountering.

Rogers described the concept of being understood empathically as to experience being accepted and "fully received" (Rogers, 1958, p.143) by the therapist. "… an accurate, empathic understanding of the client's awareness of his own experience… as if it were your own…" (Rogers, 1957, p.99) are further guidelines offered by Rogers in delineating empathy as a fifth condition of change. Achieving such experience in dialogue between two or more people requires time and an effort to focus on the nuances of conversation. It calls for a willingness to reflect and ask for clarification as to meaning and intention. Such effort to understand human dialogue is illustrated in the description of one meeting between Carl Rogers and the eminent philosopher Martin Buber (Cissna, K. 1994), the analysis of which suggests the painstaking effort people must be prepared to engage in if a meaningful conversation is to take place. The analysis of the conversation and reflections on what constitutes empathy remind us that rote or prescribed responses to a client are foreign to some of our most hallowed teaching. Reflection on this discussion of the Rogers-Buber dialogue is a humbling reminder of how difficult it is to be present and engaged with another. Creating the conditions for such encounters call for pausing and reflecting, attributes not encouraged in this culture.

Risks to therapists of ever-faster, briefer trends

Burnout, compassion fatigue, vicarious traumatisation and countertransference are all heightened risks to therapists in the normal course of their vocation, even more so when our culture demands efficiency as defined as cost-containment and resolution of client difficulties (as evidenced by termination or referral to other resources) in a timely (prescribed by duration and number of sessions) manner. When such parameters are laid out before the client is even seen, the challenges and expectations for the therapist multiply. The stigma that can attach to the therapist who acknowledges any of the above stresses further complicates efforts to respond individually and as a program to ensure that staff maintains a dynamic engagement with clients and one another.

For the purposes of this paper a comprehensive review of the above risks will not be undertaken. The terms noted, though not all-encompassing, highlight some of the more common risks to the therapist in mental health. Burnout is a term uttered often in the larger culture and certainly has a long-standing place in reviews of occupational hazards for the therapist. Burnout encompasses physical and emotional exhaustion resulting from a negative self-concept and loss of concern for clients (Rosenberg & Pace, 2006; Karger, 1981). The chronic wounding of the therapist and the inability to see clear progress in a rapid turnover environment can contribute to burnout. The challenge of work with seemingly intractable problems and challenging clients is that the therapist may search for less emotionally demanding techniques in their work (Horner, 1993).

Burnout rates may be lower in programs and agencies where active expression, processing and sharing of personal feelings with colleagues is supported (Martin & Schinke, 1998). There will likely be little objection to such a recommendation in the helping professions, yet to bring such ideas to life is an entirely different matter. Still, making a commitment to just such a staff process can offer the further benefit of attempting to live what we purport to teach clients. The time required creating an atmosphere of trust and openness to sharing in a busy work milieu should not become a rationale to not reach for such an inspiring work atmosphere. Creating a healthy work environment and building a sense of strong team camaraderie can reduce the risk of burnout and optimize wellness across the staff complement (Witmer & Young, 1996).

Whereas burnout refers to broad risk to the individual therapist, compassion fatigue and vicarious traumatization are terms with more specific qualities. Perhaps the leading proponent of the concept of compassion fatigue, Charles Figley, describes compassion fatigue as a form of burnout distinguished by a multi-factored result of caring (Figley, 2002). Figley describes the cost of caring as increasing "… as there is a realization that clients will never fully recover." (Figley, 2002, p. 1433). Figley goes on to talk about the emotional energy re-

quired to work directly with the suffering client, noting that the expenditure of so much emotional energy is one of the reasons some people choose to seek supervisory or administrative positions, as this will offer them a buffer from exposure to such a demanding therapist role. In the context of our culture's shift to ever-faster and ever-shorter sessions, with an expectation that the therapist offer efficient and effective service in reduced time blocks, it is not difficult to surmise that Figley's concerns for compassion fatigue risk being accentuated.

Vicarious traumatisation refers to the risk to "… the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequelae." (Pearlman & Mac Ian, 1995, p. 558). While not all clients being seen in therapy have traumatic experience as a precipitating factor, some substantial number will inevitably suffer so, given the exigencies of daily life and the aggression and array of interactions that all people are exposed to in the modern world. Here again, the advent of technology and the speed at which our culture is moving raises the spectre of increased risk of trauma, through direct or indirect exposure. We are recognizing that many events in life can traumatize. Clients may only be coming to terms with these events as an adult. We are challenged as therapists to witness the client's suffering and to shepherd them to a new understanding of what they have experienced and ideally a life transformation. Contending with these multiple steps in a prescribed format and limited time frame risks further stretching or overwhelming the therapist. Newer therapists and those with a personal history of trauma are at heightened risk of vicarious traumatisation. Protective measures include support for staff, education, a milieu that encourages the processing of traumatic experiences, supervision that nurtures rather than pressures individuals to disregard their own experience and the recognition that client care and self-care are enhanced by flexibility rather than rigidity.

Countertransference involves the total sum of the therapist's reactions to the client, not solely related to personal idiosyncrasies of the therapist, but also arising as a result of the context and the interactions that must evolve from a therapeutic encounter (Kernberg, 1965; Racker, 1957). Further, that countertransference is central to the therapeutic encounter and therapist awareness of their feelings toward the client can serve as a window into the client experience.

Our personal experiences and interactions with the vast array of clients will undoubtedly lead to some countertransference and it is the responsibility of the therapist to engage in self-examination and seek counsel when such feelings are prominent and endanger therapy. However, countertransference reactions risk being increased as a result of cultural trends in how we deliver mental health services. There is a risk that countertransference feelings will increase when the therapist is required in short order to contend with the complex context and potentially demanding expectations of a series of clients through the day. When the client does not respond readily to the therapist working within a prescribed treatment mode there can be additional pressure as to how this will be explained. Familiar responses, which may actually be defenses, are to proclaim that the client is "treatment resistant", "not psychologically minded" or "not ready to change". The client may already have interpreted the therapist's focus on length of sessions and duration of treatment as evidence that "I'm not going to be listened to" or "they were too busy hurrying me out the door for anything useful to happen" when they return to their primary care physician, for example, to report on the outcome of the referral for mental health treatment. When such feedback is delivered to the therapist there is a risk that the need to defend oneself will mask any fruitful discussion about the client experience and how to deliver service in a way that incorporates mandate, expectations of the referral source and needs of the client to have a therapeutic experience that can facilitate change.

Creating Conditions for Resilience

Whichever of the above risks outlined are prominent for the therapist, there are remarkably coherent responses recommended through the literature to support resilience. Prominent in our culture are concepts such as "life balance" and self-care. The particular aspects of these two qualities that appeal to the individual therapist and

which contribute to resilience will be left for individual reflection. In addition, there are a number of recommendations that are suggested to promote a healthy and congruent work environment that can respond to pressure experienced by therapists. The bias of the authors is that the health and vitality of a particular program or agency will reflect the health and vitality of the staff. Hence, the merit in paying attention to these ideas and shifting from saying the words to conducting practices toward one another in a manner that genuinely brings these ideas to life.

In other words, it is not enough to say our program or agency supports self-care, life balance, open communication, , a formal support group to debrief and process challenging interactions, mutual respect, continuing education and a client-centered approach to practice. Within the context of the program or agency mandate and the real working conditions that staff experience, reflection, discussion and specific steps to bring these ideas to life in our daily interactions will be required. Such a mission will take time, developing real trust in one another and a willingness to think through quite carefully how we choose to speak and act toward one another. It is via this commitment that we can create a culture in our mental health milieu that can sustain staff through challenges and disappointments and honour contributions and accomplishments that advance our work. Through such deliberate ways of being with one another resiliency can be fostered.

In recent years there has been a proliferation of ideas related to meditative and mindfulness practices (Kabat-Zinn, 1990) and how important mindful practices are in contending with the pace of our current culture. The interest in such practices and the acknowledgment that their origins are many centuries old suggest the merit in considering an approach to life that invites a distinct departure from the current culture's promotion of speed, efficiency and multi-tasking. In fact, ideas promoted by such eminent figures as Jon Kabat-Zinn contradict the emphasis on multi-tasking and being in perpetual motion. It may be in our haste to demonstrate efficiency and prowess that we unwittingly interact with insensitivity to the other. The idea that we can only attend to one matter at a time and that it takes practice to truly bring our full attention to a subject stands in sharp contrast. Being in the moment seems more consistent with the idea of being deliberate and reflective in how we speak and act toward one another.

Inspiration promoted by reflections on Kabat-Zinn can be joined to the hallowed principles of empathy, genuineness and positive regard underlined by Carl Rogers and further elaborated in the dialogue between Rogers and Buber. The effort and concentration required to develop such skills cannot be underestimated, nor their potential to promote health and constructive human interactions. Such developments can enrich the quality of the therapeutic encounter and enhance collegial relationships as we search for ways to maintain the ideals and aspirations that led us to our vocation.

Discretion, a hallmark of therapist experience and wisdom

However much scientific evidence and evidence-based practices are enjoying a privileged status in contemporary health care, clinical practice in medicine and psychotherapy is a healing art which involves ongoing adjustments to the individual (Zeldow, 2009). It is the clinician's ability to respond to the nuances of the therapeutic interaction as the session evolves, that can best lead to healthy therapeutic outcomes.

Even within the emphasis on guidelines there is a notion that guidelines not be treated as "absolute directives". Rather, there is "… room for the judgment of the individual practitioner to lead to a reasoned exception" (Strickler, et. al., 1999, p. 71). The risk of rigid application of guidelines or a treatment protocol that does not allow for variation in clinical practice according to the needs of the client and their responses in therapy is that the care being provided is detrimental (Reed, 2002). As well, the therapist may experience a rigid or micromanaged setting as constraining them from the emotional flexibility called for in addressing an array of complex predicaments that bring the client to therapy, thereby leading to a negative work environment (Negash & Sahin, 2011).

The individual suffering from chronic trauma, or a seemingly intractable depression, may benefit from an arrangement that allowed for a greater number of sessions, as well as individual sessions of greater duration. In other instances, where lifestyle changes are being contemplated or introduced, where, for example, smoking cessation is the identified issue, a briefer treatment regimen makes good sense. In each example, a focus on treatment goals and a specific time frame for treatment could be negotiated, with adjustments in the proposed therapeutic plan ongoing.

The clinician, in consultation with the client, would make a determination as to which treatment track to follow in the particular circumstance, as opposed to some of the emerging trends in mental health treatment which dictate the length and number of sessions that can be engaged in, regardless of the presenting concerns or context. The therapist, in consultation with the client, would use their discretion to offer a treatment service in keeping with the context and presenting concerns.

In the present climate of many work environments, such an arrangement is not formally contemplated, and it is only by default that clinicians find themselves offering sessions of longer duration, or appointments that extend beyond a dictated and limited number of sessions. This complication interferes with a focus on the therapeutic relationship, as the clinician may, consciously or not, refrain from an unfettered engagement with a client to whom they can only offer limited service. The client may be sensitive to such nuances, thereby having a potentially unsatisfactory therapeutic engagement. Alternately, the clinician may be marshalling a defence for their decisions about extending the length or number of sessions when they submit a statistical analysis of their work day and must explain to a supervisor or manager their departure from a defined protocol. The need to justify and defend an approach not consistent with a mandate can detract from the creativity and engagement of the therapist in their craft.

In the present economic and health care climate it is not realistic to offer open-ended or unending treatment services to all clients who pass through the doors of the program or agency. However, allowing the clinician latitude as to which clients will be offered more than a mandated and time-limited approach can be a balancing step meant to continue offering high quality service to clients, with the acknowledgment that context will invariably be a factor in the decisions that are made about treatment.

Wherever the clinician can be satisfied that their experience and training is leading to judicious use of discretion in providing treatment services, the hope that effective services are being delivered to clients is enhanced. As such, there are additional benefits of job satisfaction for the clinician and a sense of receiving individualized treatment for the client, as the therapeutic encounter is not dictated by prescribed methods or time frame, but by the judicious collaboration of the respective people.

Conclusion

The toll for all of us cannot be estimated if we do not pause to reflect on cultural trends and their impact on mental health treatment.

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