The Peregrine Centre Rural Mental Health Podcast

Episode 15. Getting Started with Good Enough Therapy

Speaker Key:

RS Rebecca Sng

CM Caitlin Miller

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Intro Hello. I'm Dr Rebecca Sng, director of The Peregrine Centre. As we begin this episode of The Peregrine Rural Mental Health podcast, please join me in stopping to consider the land beneath your feet. Let's take a moment together to acknowledge the traditional owners of that land. We pay our deepest respects to the elders of the past, those of the present, and the emerging elders of tomorrow. The Peregrine Rural Mental Health podcast is brought to you as part of our rural mental health partnership with New South Wales Health.

RS Well, hello everybody, and welcome to the first of our new series in the Rural Mental Health Podcast. Today's episode is a bit of an introduction to the series. We're going to talk a little bit about why we've selected the topics we have selected and some of the tricky things about extending our clinical or practice repertoire.

With me today is a familiar voice to many of you. Caitlin Miller works with me here at the Peregrine Centre. Caitlin, I'm wondering if you wouldn't mind doing your own introduction and then I will introduce myself after you.

CM Of course, and hello everyone. It's nice to be back on the podcast. My name is Caitlin Miller, I'm a clinical psychologist and work as a research associate for the Peregrine Centre. Over to you, Rebecca.

RS Thanks very much, Caitlin. I am Rebecca Sng, I am the director of the Peregrine Centre and I'm also a clin psych, but I'm also a family therapist as well. And I guess my history is particularly in family violence and trauma.

We are meeting together today just to introduce you to the new series of episodes. Thank you so much to the people who have been watching the last series of episodes and all the wonderful feedback we've had about them.

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But today we are actually thinking about the new series, as I said, and I might start, Caitlin, with a bit of a discussion about how we picked the topics for this particular series. We are calling this series Getting Started With, dot dot dot. And tell the listeners a little bit about why we picked these particular topics.

CM Yes, absolutely. Happy to. As you as listeners might know, every year at the Peregrine Centre on the Rural Mental Health Partnership project, we do what we call a learning survey, which is where all of our amazing local project officers who are based across New South Wales go out and they talk to rural mental

health practitioners in their area about what sort of needs they have for their training.

We know that often training opportunities can be a little bit more limited or a little bit harder to access when you're living in a rural or regional area compared to metro areas. And we really want to know what the top training needs are for people and what people feel like they need to upskill or explore.

And what we've noticed over the past two years is that there are some themes that do continue to come up around what people would like. And our first podcast series really explored some specific topics. And I guess now we're broadening our focus a little bit to explore getting started with different modalities or different treatment choices for you as a practitioner.

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RS I think that raises for me, when you say, hey, there's a lot to learn and you could be upskilling, particularly I like the word upskilling, but there is a part of me that feels stressed when you say the word upskilling. That sounds like a big job, something that I have to put on my very long to do list.

And particularly, I suppose, if I'm working in a rural area and I consider myself a generalist practitioner, and I see a lot of different presentations. Older people and children and all sorts of different issues. Then I think to myself, oh my gosh, there's a lot of upskilling to do. And in fact, I should have skills in 16 different kinds of areas because that is what I see in my practice every week. I think that's a legitimate reaction to that word. What do you think, Caitlin? Do you ever have that reaction?

CM Yes, of course. I'm a human, and so of course I have that reaction. I think as mental health practitioners, we often go into this field wanting to make a meaningful difference and to have some purpose in our work. And we want to help people.

And then if you are practicing as a generalist, you often get into these situations where you see whatever walks through the door and whoever walks through the door. And it can feel really overwhelming. I've certainly been in experiences where the idea of more training or more CPD or development or opportunities for upskilling hasn't felt like a gift and has felt actually like another thing to add to the to-do list.

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And I think at least for me, and hopefully this resonates with some of our listeners, I think it comes from this idea that I have around, or that I have had in the past around what the work is and what my identity is in the work.

And I think for me, there's in the past maybe been a desire to be an expert in lots of different areas, and to know everything and to give clients all that I have. And I think that was often what was driving that feeling of dread when you saw some more training to do.

RS And that idea about, if I know enough, I can fix it. There's a particular presentation. Oh, if I knew the treatment or the, this is a bit of a buzzword, but evidence-based treatment for that particular presentation, I would somehow be able to fix that problem. And if I don't know it, then in fact that person will continue to suffer and it will be my fault because I don't really know exactly what to do with that person.

CM Yes, of course, because I think we often have this idea that it's my job to help someone. And by help, we think fix. It's my job to actually…

RS We never say fix, right?

CM Right.

RS We always just secretly have a shameful little voice in the back of our mind saying, if you were better at this, this person would be doing better.

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CM Yes. The reason that my client didn't improve on their psychometric scores is my fault. It's because I don't know enough. If I just did more training, if I just pushed myself harder and more than maybe then it would be fine. And then I could fix someone.

RS Well, that was a very clin psych answer. If my client isn't improving on their questionnaires, then there'll be some kind of sign. But I think there are a lot of people probably not even taking questionnaires, because they wouldn't be sure what questionnaires to be giving, but also that maybe they're a bit worried about what happens if those numbers don't come out the way that I would hope.

Is that going to threaten my funding? Is that going to make my person that I'm seeing feel like they're not getting anywhere, even though I can see in some ways their quality of life has improved or their understanding of what's going on for them has improved? All sorts of different things that I feel the questionnaires don't measure.

CM Yes, of course. And what happens if there is an outcome on the questionnaires that I might not wish for? How does that threaten my own sense of who I am and what value I bring? What's the point of the work I do if someone's not, quote, getting better?

RS Yes. I think that's a really genuine grey area, isn't it? Because we do want people to feel like, hey, I'm getting feedback from my person that I'm seeing.

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And if the feedback is, hey, I don't think this is helping, we would want people to think, can I do something differently? Is there some other ideas I could be bringing? Whatever.

But there is also another side of it, which is people may or may not be ready for change. Some people may be getting better, but in fact experience a setback in some ways. And that might be a very simple thing like a relationship breakup,

or I've lost my house, or there's a natural disaster. And all those things count in how the person is experiencing the world.

But there's also a sense in which sometimes the gift that we can offer people in terms of… You called it help. The help we can offer people is actually not about getting better, not about feeling better even. And somebody said to me the other day, which I thought was so interesting, why do we have to be happy all the time? Why is that our aim, that a good life is somehow to be joyful and happy all the time? Or is there some level in which the help we can offer is a validation of the difficulty and suffering that a person is experiencing at that time?

CM Yes, and I think that's such an interesting point, because I think you're right in that often we have this preconceived set of ideas about what it means to improve or what it means to make progress or what it means to recover. First of all, I think people don't owe us that. They don't owe us to align with our ideas of what progress means.

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But I also think there's a little bit of a danger in holding on to certain expectations of progress, because I think a lot of the work is sitting in the humanity of the person sitting next to you. And holding that and containing that, and being the person that listens to them. And can feed back to them what they think is going on and help them to potentially see it in a different way.

And of course, therapy in general is not just about listening and not acting, it's also about change and growth. But I think often we have a tendency to jump to the change and growth and miss the part where we ultimately need connection.

RS I think that is a very good point. And that is really the crux of the grey area, isn't it? It should be more than a chat with somebody on the bus, is what I always say. Therapy should be more than just pouring your heart out to a stranger and they listen sympathetically.

There is a place for that. I would maybe term that more like supportive counselling or something like that. And that can be very helpful for some people. But when we do get into the therapy, in inverted commas, we are thinking about growth and change. But different models put that balance at different mixes. That the understanding or the increased reflection is prioritised in some models and less prioritised in other models.

That there is the role of insight or the role of acceptance or the role of different experiences in such as symptom reduction, though all those things are prioritised differently in different models and by different people.

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You can see why it's confusing, for sure.

CM Of course.

RS How do you as somebody who is… You said to me earlier today, you're an early career therapist. How do you as an early career therapist go about trying to make sense of, am I doing good enough therapy? Is my therapy good enough?

CM I think there's a few things. You're going to love my first answer because my first answer is supervision.

RS I am a big fan. It's no secret.

CM Likewise, likewise. I think having quality reflective supervision to reflect on the client experiences and your own experiences and how they relate to each other is incredibly important in terms of developing your sense of identity. I know it's been very important for me.

If I can give a bit of an anecdote, a lot of my experience so far has been working with people with eating disorders. And people often ask me how I can maintain hope when working with clients who have sometimes been really, really struggling with what's going on in their life.

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And I think what has been helpful for me to think about doing good enough therapy is a balance between knowing who you are as a therapist and knowing what you bring to the table, and as well, keeping in mind the things like research evidence and client preferences.

If I were to really think about it, it's about not only emphasising the research evidence, but also thinking about, who is the client in front of me, what do they need, and what can I bring to this table? What is my role as a therapist?

And I think moving from a definite, "my role is to fix you, and if I have not fixed you, I have failed," to a, "maybe my role is to sit alongside you and give space to the things that are really hard to say, and to help you find a better way. But I'm just the passenger seat. I'm in the passenger seat. You're driving. I'm there next to you. I'm there to be a support and a challenger when you need it."

But it's not my life. I don't… And I guess this ties into, people often ask me if I give advice in therapy. And I often say, typically, no. Of course, there are always some exceptions, but I think typically I don't, because I'm not the one that needs to go out and live that life afterwards. I don't know all of the details. I'm not an expert in your life. You are the expert of your life.

I can just offer you a space and a bit of knowledge and a bit of relationship to figure out the things that you need to figure out. And I think knowing if you're doing good therapy is in part about self-identity, and your identity as a therapist. And then, of course, in part having a fair enough grasp on the principles of evidence-based therapy.

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I could certainly not call myself an expert in any particular therapy, but knowing enough to be able to flexibly use different elements of different modalities when needed, I think is important.

RS It's interesting because as you were talking, it reminded me of two models, I suppose, that have gone through my mind. One is the narrative therapy model by, of course, the famous Michael White and the idea about decentred practice.

And the idea that the more central we see ourselves in our consumers lives, then the more burdened we feel as therapists.

And one of the things that comes up again and again in our learning needs survey is that people often feel quite burnt out, quite tired, quite exhausted. That's not to say that that's the only reason they might feel that way. But I do also wonder if there's some conscious decentring of practice, would that be of any help to people who are really feeling like that.

CM I think absolutely, because if you decentre yourself, there's much less pressure to be the person with the magic wand that fixes everything, right? You play a part in your client's life, absolutely. And you might play a really important part. But you're just a part. It's their life and it's their journey, and it's their decisions. And I think it can be so easy to get caught up. And I certainly still get caught up in really taking a lot of the work home or becoming really central in people's lives or feeling like I'm really central.

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And I think often the antidote to that, again, is some supervision. But yes, I guess reframing how you see yourself and what your role is.

RS There is, I guess, an older view about being the one professional, in inverted commas, in a small community and the pressure that that puts on a person. And of course, if you are the only GP or whatever. I think there are some realities about, if I go on holiday, who's going to look after this community? And I wonder if there are some people who particularly feel that way.

And I do know that I was talking to an Aboriginal health worker the other day and they said, it's such a blurred line between being a health worker and being a part of the community that it's so hard to then… Obviously they didn't use this word, but to then decentre yourself or move yourself away from that practice.

I do also think, though, there's a new movement about really recognising the resources that communities and people have within them. And to really be harnessing those kinds of natural networks and resilience that we perhaps have overlooked, or we've tokenly acknowledged in a, tell me about your strengths kind of way. Rather than really making them a really major centrepiece of the intervention that we might be helping a person with.

I think that new movement is an interesting movement. And it may well be that there's something about that that helps people feel a bit released from that, I'm very important in a person's life. And in fact, it's up to me to fix this problem or fix this family.

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I do also think… Can I say two things about that? One is, because I work with families, I feel that the temptation is less, if that makes sense. Because I work with several different people at the same time. And that we always say our intention is to connect people to each other rather than connect them to us. And that is a privilege I guess we enjoy.

But if you work with adults primarily or you work in a different kind of model, maybe having a think about, can I be including support people, a partner or a concerned sister or a really best friend or a flatmate or whatever. Can I be including them in a much more active way in the work that we're doing? Obviously with the consent and permission of that person who's coming to see you. But can we be we be building the support system of that person so it doesn't all fall on us professionals in whatever way?

And then the other thing that as you were talking, Caitlin, I was just thinking, do I feel… I'm in my second decade of practice, we're over 20 years now. Do I feel like I need to know more things? Do I feel lost at times? Absolutely. There are times when I think, oh, I wish I knew more about this particular problem because I happen to know that it's well researched and there probably are lots of ways in which I could be more helpful.

I do think one thing the last 20 years has given me is a confidence to find those answers out, to a professional network of people I can ask.

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And also a bit more familiarity with, for instance, reading peer-reviewed journals or being able to look at things on the internet and judging whether they're reliable sources or not.

The other thing that I think it's really given me is a lot of practice in conceptualisation or formulation or thinking about the story of this person and how they have got to this place. And why what they're doing makes perfect sense in the context that they live in or the context that they used to live in.

Those kinds of things where… And it made me think of, the second model that it reminded me of is the ACC model, Alternate Care Clinic model, which just talks about the first level of intervention with people who have experienced trauma being safety. And what you were talking about, Caitlin, that relational safety is a part of that.

But the next level being reflection. And only when you achieve safety are you able then to move to reflection. And then the third level being improved functioning. There are several levels before we get to, hey, is my client ticking more good boxes on the questionnaire? And are you doing them? Do you feel like, yes, this person is feeling safe, because actually they continue to come or they seem more settled in session, or they're able to share more with me?

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And then, do I feel that their reflection is improving? And it's important to say, obviously, that safety might be a very brief period of time. You might be working on safety for half the session and you get there, and you can move a little bit to reflection. Or you might be over a period of months working away at safety and trying to establish that baseline.

I find that model quite helpful to me in really understanding where we should focus our therapeutic work. But also in communicating to the other people who might be working with that particular client that we're working on this particular

thing now, and you might not see a big shift in functioning at this point in time because we are still establishing safety or we're working on reflection.

What about you, Caitlin? Do you think that that role of really understanding people, do you think that transcends a lot of those models that we talked about?

CM I really do think so, Rebecca. And as you've been talking, there's been something that's been coming up for me that I think almost ties a lot of this together. When you were talking about being comfortable with accessing the research evidence, but also wanting and being interested to access new findings or new things that you haven't talked about before. And when you were talking about formulation and now you're talking about working directly with clients, the thing that's really coming up for me is a sense of curiosity, which I think is really important in this field.

And I think curiosity is also a really nice antidote sometimes to things like burnout or imposter syndrome.

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Of course, it's not, be curious and all will be fixed. But I think it can be nice, because what we know about the mental health field is that it's dynamic. If we feel like we know all the answers, if we feel like we've got a really good grasp of every single thing in the research and in our clients lives, we formulate it perfectly and we have the perfect treatment plan, I actually think we're in a bit of trouble. Because we work with humans.

And I think there's something about maintaining curiosity and approaching the unknown with interest rather than this expectation of ourselves that we should know everything and know it all at once.

RS Well, it's a bit of a chicken in the egg, isn't it? The more burnt out you are, the more hard it is to be curious, I think. And then it's a bit of a vicious cycle where you don't want to necessarily learn, or you don't really have the resources to learn new things. Because you're not learning new things, you become more and more stuck and feel exhausted.

I guess that does segue, Caitlin, very much into the series that we're about to embark on. And I guess I wanted to mention that we've tried to consider that people might be feeling a bit a bit tired, that they might want to have something that is pretty easy to get started with. And so, this particular series, the format is that we've asked a number of experts to bring five resources that they would recommend to very much beginner practitioners in this particular model.

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It's really about trying to make sure that those people who are listening understand, I could learn more about this and here's where I might get started. Because obviously sometimes it's hard to know where to start when it's a very common model or a model which a lot of people have something to say about. Which particular topic do you think you're interested in, Caitlin, in this new series? What's standing out to you?

CM I think something that I'm surprisingly really interested in is the Getting Started with CBT. Which is surprising to me. I would say that I use CBT quite often, but I think my knowledge of the background and the intricacies of it could always be further developed.

And I think the guest that we have for that episode will have a really great explanation of how these core concepts link together, which I think will be really interesting. What about you?

RS Well, I think that really touches on something that I think is so interesting about looking at different models, is that it's not just things that you do in therapy. It's not just exercises you do with your client or worksheets that you give with your client. It's different ways of seeing the world, of seeing people and of seeing the role of the therapist.

And I, like you, I love to hear different people who have really thought deeply about that particular model explain the way that they see the world. I'm actually very interested in things like Getting Started with DBT, which I think is quite a different paradigm.

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I've worked in a DBT format before, and it's a very different way of thinking. And I think it would be really interesting to start to open that up for people rather than just saying, well, here's some exercises or techniques that you can lift from the model. But actually saying, to really understand why those exercises exist in the model, you have to understand a little bit about the model.

CM And the style of thinking that comes from that model.

RS Yes, which I think is quite foreign. I certainly found it very foreign when I started.

CM Yes, of course. DBT is one example of a model that is very different from some of the traditional or older models. But I think there's something really valuable about not just dipping your toe in, but dipping your toe into the framework and the principles rather than just the worksheets or the activities that you can do in session. Because I think that helps us to develop the foundation of who we are as therapists and who we want to be, and how we want to be as therapists in the room with the people that we talk to.

RS Well, I think that we are running out of time, Caitlin, but I think that was a really helpful groundwork for the rest of the series, and hopefully explains to people why we've chosen to structure this particular series this way.

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I will also flag for people that one of the learning needs that came up repeatedly and quite loudly was a bit more training on trauma and how do we meet people who've had traumatic experiences. We will be doing a special three-episode series about that a little bit later on in the year.

But to finish off this episode, I just want to thank Caitlin for joining me today. And I hope everybody has found this episode helpful. And hopefully you're excited, as we are, about listening to some of the episodes in this particular

series. As always, you can find more resources at our website, the Peregrine Portal. Thanks very much for listening today and we hope to see you soon.

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Outro I hope you found today's episode helpful. You'll find specially selected resources on this topic on our digital learning platform. To join the platform for free or to suggest questions or topics for further episodes, please visit our website theperegrinecentre.com.au.