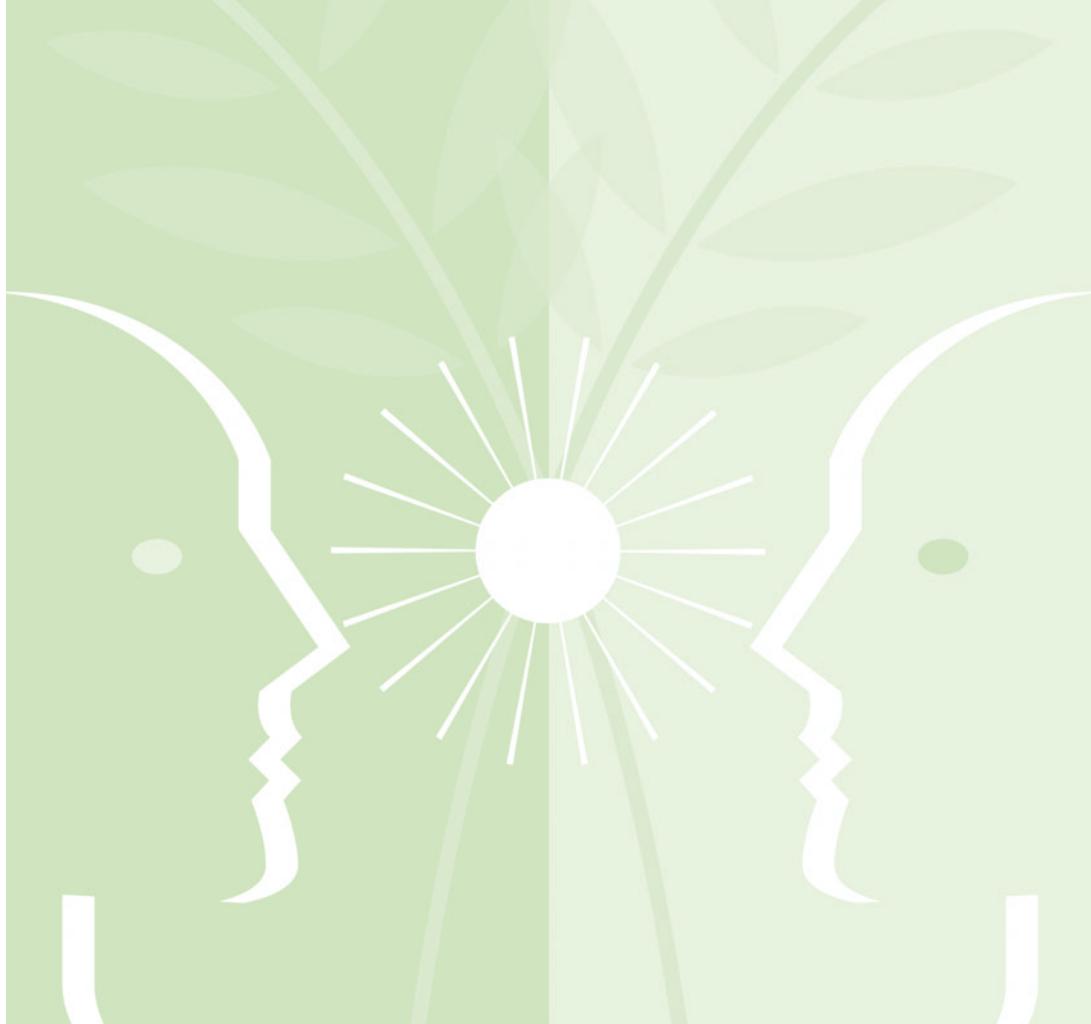


How do we improve relationships between psychiatrists and service users? This question could be put to any service user willing to answer, says Louise Pembroke, and their thoughts would direct psychiatrists towards how best to work with them



Them and us?

What makes a relationship – any relationship? Honesty, trust, reciprocity, warmth, care, humour? It's easy for us to draw up a list of the attributes we look for in a relationship. For me, I would also add the ability to bark with one of my 'inanimate' dogs such as *Patch* who accompanies me in my handbag most of the time, and an ability to tolerate my Star Trek-affective tendencies.

This opening article is the first of a series this year that will explore the diverse ways in which we can improve relationships between service users/survivors and psychiatrists. This series will explore improving relationships through education and mentoring, and communication within the consulting room.

I became involved in mental health activism in the 1980s, at a time when service users and professionals didn't sit together for lunch at events. I was one of the first users locally to sit on a committee while clinicians and managers struggled to adjust their language in my presence. I didn't know what the acronyms meant so spent an entire meeting convinced that 'vol orgs' (voluntary sector organisations) were a kind of sexual aid.

It wasn't easy. I think we were scared of each other. At one meeting I suggested we draw up some medication information leaflets, to which the psychiatrist on the group asked, "Is this subversive?" "No," I replied, "it's informative." I sometimes felt I had to be not only as good as everyone else but better and more efficient in order to be taken seriously – combined with a Terminator/Wonder Woman appearance. But the down side of becoming more articulate and competent was that we suddenly became less 'representative'.

I was viewed as 'anti-psychiatry', even though I hadn't read any books at that time by the 'anti-psychiatrists' such as Laing, Szasz and Cooper. My role models were US and Canadian activists such as Judi Chamberlain and Don Weitz, authors of classic survivor texts *On Our Own* and *Shrink Resistant*.¹ I was greatly influenced by Dutch activists who

Questions I would put to trainee psychiatrists

What does it mean to you to be a psychiatrist?

Would you consider detaining someone *without* forced treatment?

Does diagnosis define a person?

Do current and former service users have expertise and do you consider that expertise equal to yours or that of nurses?

Given all we know about the subjective nature of perception and experience, is objectivity helpful or an obstacle, or even viable?

What kind of practitioner do you want to be?

Some services will tell potential staff that they 'only operate according to NICE guidelines' and 'use objective measures'. Do guidelines and 'objective measures' help you understand a person's needs and the meanings of their distress? What if the 'evidence-based' intervention is not suitable for a person?

How would you like to be treated if you were very distressed?

What matters most to you in your work – for example, your personal outlook, values/underpinning philosophy, ethics, clinical interventions – and why?

Would you work with someone you view as having a psychosis *without* automatically using antipsychotics?

Is a medical model of mental health value free?

You are taught that there are 'real' (*outside* of the head; sounds like the spoken word) and 'pseudo' (*inside* the head; doesn't sound like the spoken word) hallucinations. How do you reconcile this with that fact that voice hearers of *all* diagnoses can hear voices inside *and* outside of their heads? Also that some voices can be different kinds of sounds, not always spoken words; for example, animal sounds or 'white noise'. How would the alleged real/pseudo divide then apply to visual or tactile voices? And do you have a 'hallucin-o-meter' that can tell the difference – like a Star Trek medical tricorder with hand-held scanner?

Is there discrimination and stigma within health services towards its workers with mental distress?

Does it even matter what you believe about the 'reality' of a person's voices, as they are real to the person whatever you believe?

How will forced treatment affect your relationship with a person?

The 'recovery model' has gained some credence over the last few years. Do you see any constraints or contradictions within this model? Is it compatible with a medical model?

helped us set up patients' councils and had a far longer tradition of advocacy than ours. Closer to home, it was people like Peter Campbell – one of the most highly referenced (and diplomatic) of survivor activists – and those I met through direct action group London Alliance for Mental Health Action who helped shape my thinking.

It was sometimes hard speaking publicly at conferences and being attacked personally rather than for the content of what I was saying. For this reason when I came to organise my first conference I didn't support a survivor attacking one

of my speakers, a professor of psychiatry, simply for who he was rather than the content of what he was saying. I knew how that felt and I was in the business of building bridges.

Back on the committees it was sometimes service users on one side of the table and professionals and carer activists on the other, viewing each other with suspicion. We gradually worked on the divide. One of the psychiatrists came to a user group meeting, and although he tried to diagnose me I didn't go for his jugular because I appreciated the effort he had made in coming into 'our domain'.

The 'them' and 'us' fell away for me when I bumped into an approved social worker who had refused to agree to a section 3 on me as a teenager. We sat and drank coffee and talked about what had happened during that time. He was honest with me and explained things I had not been aware of, such as the reason why he had been unable get me into the social service-run day centre.

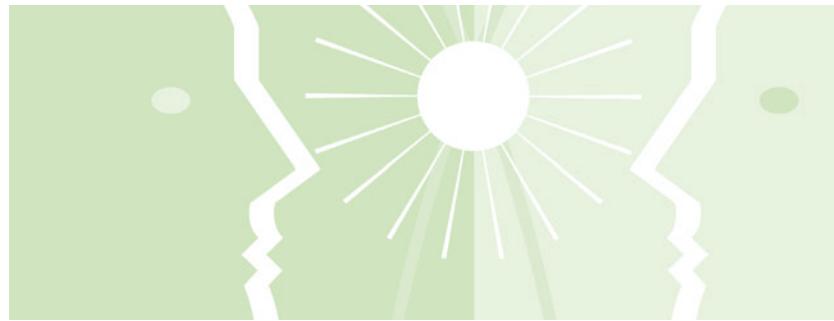
They said they had refused me access on the grounds that I was 'too much of a danger to myself' – ironic, given today's risk-obsessed culture. The real reason had been that the consultant had told every local service to refuse me access if I asked for help because he wanted to make me go back to him.

I appreciated his honesty and it also gave me a chance to convey my gratitude to him because he had been the only professional I had trusted. He had given me permission to arrive unannounced and curl up in his office without speaking, and he would tell his colleagues to just let me be. He understood how alone and unsafe I felt in the world and he made no demands of me. That was about as much as I could take in terms of 'therapeutic interventions' at that point in my life. Sometimes less is more.

The direct action group I belonged to included a psychiatrist, which further melted the boundaries for me because we shared common ground, worked together as equals and socialised with each other. That psychiatrist became my friend. He was Steve to me: a nice, long-haired, bearded hippy bloke who just happened to be a psychiatrist. It was Steve who introduced me to the 'anti-psychiatry' movement, as a former personal assistant to David Cooper who had apprenticed with Laing. On two occasions Steve bust me out of hospital. Then when he had his own 'breakdown' after the death of his partner I was glad to reciprocate support.

During the late 1980s I met Italian psychiatrists in Trieste who had been active in the Psichiatria Democratica movement. I was struck by the informality of their relationships with service users in the community centre. There were no titles; everyone addressed each other by their first names. We had some good arm-waving arguments, disagreement was viewed as an opportunity for growth, and they had no difficulty with direct action against the conference drug reps.

My first experience of a Royal College of Psychiatrists' annual conference was around 1989. I gatecrashed it with a friend because at this point there was little involvement of service users and we really wanted to listen to a debate about community treatment orders with solicitor Lucy Scott-Moncrieff. We slipped past the registration desk and stood quietly outside the main hall handing out leaflets



detailed arguments against community treatment orders. Our intention was to put our ears against the doors and listen to the debate, and hope we were not chucked out. One psychiatrist beckoned us in, informing us she had asked the Chair if we could sit inside and listen, and he had agreed so long as we didn't speak. We nodded and sat down, looking like rabbits caught in the headlights.

Having since presented at two Royal College of Psychiatrists conferences (with their consent) I'm glad to see increased user involvement. But I do think it could be improved. I would like to see user/survivor materials available in the exhibition areas without charge. When I asked if I could leave photocopies of an article I was told it would cost me £200 to do so. It would also be good to see more psychiatrists at non-college conferences, where survivors are more likely to be giving keynote presentations.

I would also like to see users/survivors involved in the debates as well as presentations, and an 'informal afternoon' where psychiatrists could meet activists and groups to discuss topics over tea. I really liked a recent Islamic mela that had a Borrow a Muslim tent, where local Muslims were available to chat about Islam and answer questions. Imagine Borrow a Service User/Survivor!

Illustration by Gary Kempston www.gkimages.com

1. Aitken, K., Banner, N., Pembroke, L., Thomas, P. (2008) 'Is the training of psychiatrists fit for purpose?' *Openmind* 149, pp.16–17
2. Chamberlain, J. (1977) *On Our Own*, Mind Publications [1988].
Weitz, D. and Burstow, B. (1988) *Shrink Resistant*, Vancouver: New Star Books.