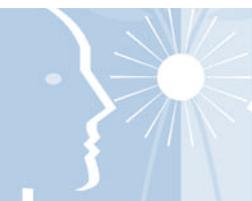


Louise Pembroke continues her series on how we improve relationships between psychiatrists and service users

## Education and training



I am passionate about education. A central way of improving relationships between psychiatrists and service users is to involve us in the training and education of doctors and psychiatrists. Whenever I have given a guest lecture to medical students, the tutor tells me that the discussions are very lively because the experience has been in stark contrast to learning about diagnoses and theories.

However, my contact with medical students has led to me hearing some pretty grim stories about teaching to medical undergraduates; for example, consultants stating that “anyone who self harms has a Borderline Personality Disorder and is generally a horrible person with no hope.” These views may be in the minority, but it still means that some students have graduated with a skewed and narrow approach with damning messages about an entire patient group. How can these negative messages encourage graduates to consider a career in psychiatry, especially since psychiatry is already viewed by some medical students as unscientific and not ‘real medicine’?

I instigated research at an academic unit of psychiatry and found working with psychiatrist Allan House and the research team a productive experience.<sup>1</sup> There was mutual respect for our individual areas of expertise, we worked as equal partners and it was my task to keep the work focused on lived experience. It was successful because we used each person’s specific skills, we were honest and open, and it was okay if I had bad day and needed time before returning an email. I didn’t have to do the Wonder Woman act, which was a relief (bad costume). Indeed, we could *all* be human.

During our discussions about our mutual scepticism of the personality disorder industry, I suggested to Allan that he do some personality disorder tests on himself as an exercise to prove my assertion that *anyone* undertaking it will come out with one. I’ve never been proven wrong on this. Allan came out with a Narcissistic Personality Disorder. His wife said, “Well of course, you’re a psychiatrist,” and I offered a ceiling-to-floor office mirror. He has happily

conveyed his personality disorder diagnosis at a conferences because, like me, Allan sees the diagnosis as a way of labelling characteristics we don’t like in somebody.

It’s the debates and conversations we have with each other, both in working together and over tea, that are enriching and can inform our mutual work as experts by profession and experts by experience.

It would be good to see trainee psychiatrists field-supervised or mentored by users/survivors. I field-supervised a trainee clinical psychologist undertaking her major research project. Jo came to my home and, aside from her study, we talked about lots of things. We looked at her vulnerabilities and experiences in life, and I gave her books to read and recommended things to look at or people to speak to.

I told her about my activism and we did a teaching session together for her colleagues. I gave her an unpleasant piece of homework for this session: the task of deconstructing Dialectical Behaviour Therapy. One of the issues I raised with Jo was the importance of her developing peer support, because often the most difficult aspects of working within mental health services are the structures, prevailing theories and endless ‘objective measures’. Jo got together with like-minded people and started Mad Matters, a group to offer support and challenge thinking.

I gained as much from the experience as she did. There’s something about spending time with people in their lives as opposed to the classroom that is more enriching, and communication and an ability to relate improves more organically. Jo considered her values and outlook, and what kind of practitioner she wanted to be, and I acted as a sounding board. We also did some dog barking and Jo baked a cake. The end result was a practicing clinical psychologist I’m proud to know, and a friend.

1. Bryant, L. and Beckett, J. (2006) ‘The practicality and acceptability of an advocacy service in the emergency department for people attending following self harm’, Academic Unit of Psychiatry and Behavioural Sciences, University of Leeds.