

NOT rocket science

Being human When service users talk about a 'good' doctor they are not referring to clinical interventions; they are referring to human qualities. One of my friends, a former psychiatrist, I observed always to be the same person with service users in an acute setting as he was with family and friends. There was no professional distancing.

Humour I know I need to laugh at myself and psychiatrists should be able to do so too. Once I screened a clip of myself in a Star Trek cyborg costume 'assimilating' a psychiatrist. I just wanted to get away from drugs and CBT for a moment and demonstrate that what is a 'therapeutic intervention' might be quite random. Everyone in the room was laughing bar the single psychiatrist present. Conversely, service users have smarted at psychiatrists giving a presentation laughing at diagnostic groups with the "You can tell the X by the way they park their car" line. Humour should not be about laughing at people.

Non-verbal responses Non-verbal responses have a value as much as what is said. My friends have sometimes 'pulled off' visual voices I can see attached to my body because they know that sometimes it can help where words will not. It's been a discovery for some medical students to hear me say that small things like a smile or basic human comfort gestures do make a difference.

Humility Humility is key. I really respect someone who can say sorry or let me disagree with them because it means they respect me enough to do so. This also cultivates trust.

Reciprocity If a service user asks their psychiatrist whether they had a nice holiday is it a state secret to answer? The importance of reciprocity is underestimated. When I worked with service users in a high-secure hospital they wanted to buy us soft drinks. I was acutely conscious of how much money that took from their extremely low incomes so I wanted to decline. It was gently pointed out to me that they needed to be able to reciprocate, so I accepted the drinks. I know I find it easier to take support from others if I can reciprocate in some way.

Don't be a politician Think how pissed off Jeremy Paxman gets when politicians persistently answer questions with questions. Service users get pissed off with this too. Have a view. Answer the question – even if it's to say you don't know. You don't have to have all the answers. Equally, don't be a Paxman and fire questions.

Pathologising emotions Expression of painful emotion can be pathologised or feared, and sometimes service users will learn to not show emotion for fear of over-reaction. It's like when someone falls over in the street and everyone rushes over to help them stand up again, when maybe the person just needs to sit for a minute before brushing themselves down.

Find something positive A nurse once praised me for finding a creative dressing for a wound that she would never have thought of, and said I'd made a good job of it. She managed to find one positive thing about me in negative circumstances. In doing so she returned to me a shred of dignity.

Go where you are wanted Psychiatrists should meet people wherever they feel most comfortable: in a café, at home or at a Star Trek convention. That way they will get a more relaxed service user because clinical settings distort people through anxiety. I find A&E so frightening I can reach a monosyllabic state through anxiety, and I've seen others sectioned because the environment and the waiting has driven them mad. On a cautionary note, psychiatrists need to ensure they are going where they are wanted. I once observed service users in a residential setting having their deeply feared consultant invited around for dinner by the service manager without them being asked first.

Proactive enquiry I'd like to see psychiatrists ask questions like, "How do you want me to respond to you when you have hurt yourself?" and to enquire actively about what helps or hinders. If a service user can't say what helps because they don't know, then ask what doesn't help because that's an equally valid starting point.

Put yourself in service users' shoes Philip Thomas once accompanied a service user to A&E for repair of self

harm without informing staff he was her consultant. He wanted to witness first hand what it was like for her. I think all trainee psychiatrists should have to undergo a 'mock' section, where they have their belongings taken and are put through standard assessments with a predetermined set of 'symptoms' decided for them. Then they are treated according to their diagnosis. Those brave enough would sample medication, and they would be placed under close observation, including in the bathroom.

Being ordinary It can help connections if psychiatrists talk about ordinary things as well as 'symptoms', and bring something of themselves into the conversation too. Service users do appreciate that psychiatrists are people with lives. Imagine trainees spending time simply being with service users and doing whatever is required – and that might be the washing up. A former community psychiatric nurse told me that some of his service users preferred his dog to him, so he would take his dog along to visit them and just let the dog get on with the session.

Talking about hearing voices Acknowledging the reality of a person's voices, even if you don't believe it, helps to ameliorate the isolation a voice hearer can feel. The denial or dismissal of their experiences creates additional desolation for them. Imagine if a friend was saying to your face repeatedly, "You're a bastard!" How would you feel? Then imagine you told another friend about this person persistently calling you a bastard and the reply was, "Oh, that's just what you think of yourself."

Common sense Communicating with people with a sensory impairment is an area where the obvious is missed to a degree I find shocking. One of my friends is deaf, and I've seen registrars so wrapped up in his

'disorder' they fail to join up the obvious dots: profound loss of hearing... isolation... loss of socialising... distress. It's always worth looking for the common-sense explanation first. For instance, a deaf person needs to sit near to someone talking to them so they can see the other person's lips. Yet my friend has experienced a consultant not allowing him to sit near him.

Attitude Attitude counts for everything. If it is good, the actual 'intervention' might not matter very much. The pathway is more likely to follow because the relationship has a human connection. A good attitude is about acceptance, respect, belief in and hope. It means working with someone at their own pace to define their own frame of reference, meanings, functions and goals, with recognition of the service user's own expertise. It's also about developing individual strategies for coping and living that reflect the individual's definitions and experiences. Often what service users perceive as helpful is not rocket science; it can be about the smaller things.

The greatest challenge for psychiatrists is to work within service users' frame of reference. This means getting outside of the comfort zone. Romme and Escher's¹ work on accepting and understanding voices laid the groundwork in this area, and Tamasin Knight's² seminal text on working within people's beliefs systems exemplifies it and should be required reading for all trainee psychiatrists. Research needs to further explore communication between clinicians and service users, with interventions, such as McCabe's³ recent work, focused on process. This is crucial because while the politically hijacked and sometimes lucrative 'recovery' industry pours out bland rhetoric about how we must 'choose' recovery – with endless lists of therapies most of us can't access and a limited view of what recovery actually means (despite protestations of "Whatever you want!") – the nuts and bolts of relationships where service users are not listened to by psychiatrists continue.

1. Romme, M. and Escher, S. (1993) *Accepting Voices*, Mind
2. Romme, M. and Escher, S. (2000) *Making Sense of Voices*, Mind.
3. Knight, T. (2006) *Beyond Belief: Alternative Ways of Working with Delusions, Obsessions and Unusual Experiences*, Peter Lehmann Publishing.
4. McCabe, R. and Priebe, S. (2008) 'Communication and psychosis: it's good to talk, but how?' *British Journal of Psychiatry* 192: 404–5.