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Tensions and dilemmas in clinical psychology's relationship with the service user movement

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Summary

In this article I discuss dilemmas which arise as psychologists and service users work more closely together, in particular when the clinical psychology profession presupposes that its interests and those of service users are synonymous when they may not be.

> *We're not mad, we're angry*
>
> Title of 1986 Channel 4 survivor-led documentary

'Them and us': Challenging boundaries

From the early 1990s I began to have contact with the mental health service user movement through attending conferences organised by the *Hearing Voices Network* (HVN), *Psychology Politics Resistance, Mad Pride, Asylum Associates* and others. At events like these there was more of an equal balance of service users and professionals and meetings between the two were on a different footing than one finds in professionals-only conferences or in clinical settings. Between 2001-2005 I was involved with the London-based Critical Mental Health Forum (CMHF) with current and ex-service users, survivors, academics and critical professionals -- including some who were or had been service users (for more detail, see Harper, 2005 and http://www.critpsynet.freeuk.com/criticalmentalhealth.htm). Having friendly and respectful debates and discussions, going for a drink afterwards and occasionally planning and going on demonstrations against the Mental Health Bill alongside service users provided an opportunity for different kinds of relationships. It was an excellent opportunity to meet thoughtful service users who helped me think about my own practice. These kind of contacts can have a very progressive dynamic -- for example, psychiatrist Marius Romme may not have begun his pioneering work on hearing voices if his patient Patsy Hage had not engaged him in debate, arguing that her hearing of voices was a valid experience.

Prior to experiences like these I had not met many service users who were not clients of mine and these experiences were helpful in challenging the 'us and them' boundary that we imbibe as part of our socialisation as mental health professionals. The notion of professional boundaries originated as a way of protecting vulnerable clients from being abused by professionals -- it was not the aim to protect professionals and yet this is how professional boundaries can function nowadays. An overly rigid view of boundaries can prevent us from being challenged by the user movement . Therapists like the late Michael White have noted that there are other ways of viewing the therapeutic relationship (White, 1997).

Now that service user involvement is a key factor in the NHS policy machinery it can be easy to forget that it is a social movement (Crossley, 2005) which demands recognition of basic rights and needs so often denied in traditional services. Although services have changed a lot in response to the user movement there is still a long way to go. For example, there are hardly any survivor-run crisis houses and the movement remains poorly funded. An idea of how far we still have to travel can be seen in examining the 24 demands made by the Mental Patients Union (MPU) set up in late 1972 following an occupation of the Paddington Day Hospital by patients and staff (Spandler, 2006). Today, only nine of these demands have been met and some of those only partially. The 15 outstanding demands include: the abolition of compulsory treatment and seclusion; the 'abolition of irreversible psychiatric 'treatments'' like ECT, psychosurgery and medication; and that 'all patients should have the right to have any 'treatment' which they believe will help them' (Roberts, 2008).

Viewing the movement as a political one and engaging in campaigning alongside service users means that one has to think about the extent to which one is acting as a professional or as a citizen. At the times I have engaged in more direct political action like attending a rally, participating in a demonstration or a bed-push (e.g. www.bedpush.com) I am acting as a citizen but I am, at those times, a citizen who is also a clinical psychologist. I realise that direct political action is not everyone's cup of tea but I would like to see clinical psychologists both seeing intervention in the political sphere as legitimate and engaging in thoughtful debate about the implications of different interventions. By 'political sphere' I mean intervening in the broader social world through anything from community and neighbourhood initiatives up to intervening in debates about government or international policies (see Hayward *et al*., 2008 for further some examples of socially inclusive practice). I do not see a major contradiction between the role of the citizen in this context and being a psychologist. However, I would be much more wary of mixing these positions up in the service of partisan party politics, and when we act politically as a profession, there are some difficult dilemmas to negotiate.

Dilemmas posed by the profession's engagement in the policy arena

The key question for me when our profession acts politically is to ask in whose interests we are acting? Dating back over the last twenty to thirty years, when we were still a relatively small profession, many psychologists allied themselves with service users. Those involved with groups like the *Psychology and Psychotherapy Association* spoke out about the problems of traditional psychiatric services and sought to develop non-medical alternatives, like psychological therapies. However, I think that this has allowed a dangerous implicit belief to develop: that our profession's interests are synonymous with the interests of service users. This is dangerous because there are occasions when these interests may well diverge. For example, the DCP Policy Unit's account of the Society's work on the Mental Health Act (2007) states:

The Act is now law. Its passage through parliament was a near-unadulterated success for the DCP. The objectives or goals of the BPS/DCP were achieved with only one exception – the omission of an 'impaired judgement' clause. This means that the passage is now open for psychologists and others (mainly nurses) to be given the 'approved clinician/responsible clinician' role.

Division of Clinical Psychology (2007,p.16)

I think it is striking that the main concern here is the extension of professional roles to psychologists – indeed it was the main topic of discussion in the BPS working party (of which I was a member) during the Bill's passage through parliament. Those provisions which were most criticised by service user groups, like community treatment, when the government first tabled Bills in 2002 and 2004 were included in the 2007 Act with only relatively modest changes. The 'impaired judgement' clause would have meant that a person's judgement would need to be impaired before they could be compulsorily treated – this is the case in Scotland but the failure to include this in the 2007 Act means that a much lower threshold prevails in England and Wales. The government lost a vote on this in the House of Lords by a large margin and there was a chance to face the government down but both the Mental Health Alliance and the Mental Health Coalition (of which the Society was a member) decided not to push this in case the government withdrew the Bill altogether. In my view, that would have been preferable and there is a chance that this was an empty threat.

It is in just this kind of case that the conflict between professional and service users' interests comes to the fore. I suspect that the Society's response to the Bill would have been more consistently critical if our own professional interests had not been concerned. I think service users' interests would have been better served by an impaired judgement clause than by widening professional roles.

As we become more politically active we will need to be more transparent in discussing conflicts between the interests of service users and the 'guild interests' of our profession (Hare-Mustin and Maracek, 1997). A useful question to ask of ourselves here is what our long term goal is as a profession. Speaking personally, I think that our long term goal should be to seek to change the things in society which cause people to develop mental health problems and so to remove the need for professions like ours altogether. Consistent with this aim we would therefore need to look at our own actions both interpersonally and professionally. However, the problem is that professions tend to be self-interested and wish to expand rather than do themselves out of a job.

Ways forward

A real, as opposed to a tokenistic, engagement with the user movement requires us to develop skills in working collaboratively with social movements (Paré & Larner, 2004; Prilleltensky & Nelson, 2002). At an interpersonal level we need to listen to concerns without being patronising, we need to see service users' experiences as valid, rather than offering psychological interpretations. This is far from straightforward. For example, from my contacts with the HVN I know that there are tensions around whether psychologists involved with Hearing Voices groups accept a variety of explanations as valid (as the HVN does) or whether only a cognitive model is accepted. I am uneasy with the idea of replacing the dominant ideology of biomedicine, simply to colonise the territory of service users' experiences with a new dominant ideology of psychological explanations (see Harper, 2001).

Even though the user movement may have diverse views (as do professional bodies) there are often bigger differences between professionals and service users – for example in relation to research priorities (e.g. Rose et al., 2008). Professionals are less likely to attempt to advance their disciplinary models and interests when they are not in leadership positions in social movements. Psychologists should engage in collaborative action as allies, with leadership positions going to those who are the targets of social policy (Prilleltensky & Nelson, 2002).

Engaging with service users as a movement rather than only on an individual client basis opens up opportunities for new forms of engagement. For example, a recent project where service users were interviewed identified that many of them remained unaware of the existence of the user movement (Vakili, 2003). This is disappointing as we know from examples like Sue Holland's White City project, that some of the best work comes from helping people to move from individual work to group work and community action (Holland, 1992). We also know that collective action has lots of intrinsic benefits such as the development of solidarity (including between service users and professionals) and a chosen rather than imposed collective identity (Drury et al., 2005; Hopkins et al, 2007). Perhaps mental health professionals focus too much on the services they provide, rather than linking people into the movement and self-help resources like the HVN? As time has gone on I have become more acutely aware of how collective action like this can lead to people developing new identities for themselves and that this, in some ways, can be more powerful than individual therapy. Drawing on Vygotsky's (1978) idea of the zone of proximal development we can see that participants in collective actions, both service users and professionals can be challenged to move out of their comfort zones (Shah-Shuja, 2008). As psychologists we need to take this issue seriously and learn how to be allies.

Acknowledgements

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