Moving beyond the tyranny of experts

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Harper, D. (2002). Moving beyond the tyranny of experts. *Open Mind, 115*, 20–21.

In a previous article (OM 113) I argued that the kinds of language and concepts available in mental health services had a number of negative consequences. In this article I want to put forward some practical suggestions for change. Because my focus is on expert language, these suggestions are directed mainly at mental health professionals, but I hope others will find them of interest too.

Action needs to occur simultaneously on a number of fronts: from wider political change in the way we order our society down to change in the way mental health services are delivered. This means building alliances. One inspiring alliance for me has been between various groups of survivors and users of psychiatric services and critical professionals. This is most useful when it combines the development of ideas and practical changes in services with political action designed to change the conditions of society that lead to both the current form of and need for mental health services. There is a wide literature directed at workers on what changes need to take place in services,[1] so I'll focus here on two levels that are heard about less often: political and personal action.

Towards a democracy of ideas

We need to embrace diverse ways of conceptualising and responding to emotional distress and move away from professionals having a monopoly on explanation. In recent years there has been an increased recognition of the role service users and survivors can play in researching into, theorising about and responding to their experiences.[2] Workers need to use their influence to support research and services provided by survivors -still thin on the ground - for example, in securing funding. It is here that many new ideas are being born. One example is the notion that we should view what are currently seen as symptoms of pathology as forms of difference,

rather like we see other aspects of our identity (e.g. gender, sexuality and ethnicity).[3] Another example has come from the forging of links with the wider disability movement, leading to a social model of disability aimed at fighting discrimination.'[1] A third, that we need to develop a survivor self-advocacy discourse as opposed to one of psychopathology.[5]

Political action

Current policy initiatives in mental health services are contradictory, pulling in different directions. This continues a long historical pattern. We are supposed to listen to what service users want, yet be persistently assertive in our outreach. We are to put the needs of service users first, yet always be prepared to sacrifice them for moral panics about public safety. How should workers respond? In a post-psychiatry age, as Pat Bracken and Phil Thomas in their 'post psychiatry' columns in previous issues of *Openmind* have argued, we need to expose these contradictions to public debate. Instead, what often happens is that workers and services internalise these contradictions and start to use euphemisms like 'risk' to cover completely different things, like self-harm and violence. We need to challenge the received view about 'mental illness' and show the public that the 'experts' don't always agree and that there are valid criticisms of dominant ideas like 'schizophrenia'.[6] At a time when pharmaceutical companies are bank-rolling anything from research and conferences to in-service training courses, we need, as the Quakers say, to 'speak the truth to power'. This means naming the financial interests that operate under the guise of science in research funded by drug companies.[7] We need to end the fiasco of drug companies having free reign to advertise their products on NHS premises. It also means supporting organisations like Mental Health Media by challenging the misleading images and stereotypes that make for easy headlines. But whilst we are aiming for political change, we also need to offer something different in services as they currently operate.

Personal action in relationships with users of services

At an individual level there needs to be a change in attitude and a development in the skills needed to respond properly to people in distress. Most ordinary people expect that when they are in crisis the first thing they should be offered is a chance to talk to someone. In reality that's probably the last thing to happen on a hard-pressed ward. But talking isn't a panacea and some kinds of talking (e.g. blaming or pathologising) may be unhelpful. So what kind of talk can help? One recent idea is that finding out what has caused people's problems, whether in their biology or in their past, does not necessarily help them to find a solution. Indeed some therapists start off by looking for exceptions to problems (times when the problems don't seem so bad) as pointers to solutions.8 It is important to be respectfully curious about people's lives and not prescriptive. Relentlessly listing positive qualities can seem banal and can also make people feel you are not listening to how difficult things are for them. The key to real help is in being specific; for example, identifying people's qualities and resources but then exploring with them how these might help in their given situation. We also need to create access rather than barriers to the things that are often more helpful than services: enjoyable and supportive relationships; collective action; self-help; decent housing and meaningful employment. It can help to have contact with service users and survivors who are not your 'clients' - for example, at conferences and workshops - and to be open to challenge with a good sense of humour. We need to be joining mental health campaign groups and participating as active citizens alongside service users on issues like the Mental Health Act reforms.

Workers need to free themselves from an 'expert model' approach and the assumption that they must know all the answers. Instead, we need to explain what we're doing and how we think it might help. We need to be honest about the limitations of most forms of help and consider the pros and cons of each with users of services. We need to try to offer choices about what kind of interventions might help (including, with talking treatments, identifying which way of viewing their problems the service user might find most helpful) and negotiate their focus and timing. It is important to learn through trial and error: no solution works for one person all the time. Instead, workers should seek and use feedback from service users about what they find helpful and unhelpful in their work with them. We should see this as an integral part of our work

rather than something tagged on afterwards. We need to avoid either being unrealistically optimistic or unrealistically pessimistic. We need to see problems in ways that don't blame users, their relatives or their friends.

Workers can begin to challenge 'us-and-them thinking', and indeed the courage of survivor-workers who have come out about their experiences is very inspiring in this regard. For those workers who have not experienced more serious distress that has resulted in compulsory hospital admission, it is still important to connect with our own experiences. For example, we can reflect on problems we have encountered in our own lives (e.g. in making certain kinds of changes) and consider what has helped us. Often many are surprised at the variety of non-professional resources they have drawn upon. From this kind of knowledge, we can think about how we might draw upon similar resources in our conversations with service users. We can reflect upon how we have been changed by our work with particular service users. What have we learned from them? Which service users have moved us and why?

There are many dilemmas here. Some would argue that the main change must come from collective action and that trying to develop less harmful forms of therapy could lead to services assimilating radical calls for change. Moreover, critics argue that this can lead to a psychologisation of society, where problems in living come to be seen as the 'psychological problems' of individuals and where we look to ever more professionals for therapy. I have a lot of sympathy for this position. The difficulty is that whilst we agitate for major changes in the current system I think we need to offer something different now too. The only way to try to avoid assimilation is to continually question ourselves and to seek critical feedback from survivors, critical professionals and others.

1. Johnstone, L. (2000) Users *andAbusers of Psychiatry,* second edition, London: Routledge; Newnes, C., Holmes, G. and Dunn, C. (1999) *This is Madness: A Critical Look at Psychiatry and the Future of Mental Health Services,* Ross-on-Wye: PCCS Books.

2.See for example the excellent Mental Health Foundation reports *Strategies for Living, Healing Minds, Knowing Our Own Minds* and *Something Inside So Strong* (The Mental Health Foundation, 7th floor, 83 Victoria Street, London SW1H OHW, tel: 020 7802 0300).

3.Beresford, R and Croft, S. (2001) 'Do people change? From altered states to becoming ourselves', *Clinical Psychology, 1:* 32-35.

4.Sayce, L. (2000) From *Psychiatric Patient to Citizen: Overcoming Discrimination and Exclusion,* London: Macmillan.

5.Wallcraft, J. and Michaelson, J. (2001) 'Developing a survivor discourse to replace the "psychopathology" of breakdown and crisis', in Newnes *et al.*

6.Boyle, M. (2002) *Schizophrenia: A Scientific Delusion?* second edition, London: Routledge.

7.See, for example, Sarah Boseley's excellent articles in the *Guardian:* 'Psychiatric agenda "set by drug firms'" (9 July 2001); 'Drug firms accused of distorting research' (10 September 2001); 'Just say no to drug ads' (10 December 2001); 'Scandal of scientists who take money for papers ghostwritten by drug companies' (7 February 2002).

8.Payne, M. (2001) *NarrativeTherapy,* London: Sage.