The Philosophical Basis of Effective Care and Treatment in Psychiatry

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Introduction

It is a privilege to be invited to address this conference. As a youth I was enthralled by the story of Thor Heyerdahl's adventures and later learned much from reading Ibsen and studying the paintings of Munch. It is indeed an honour now to visit the land, which fostered these great men, who made such a remarkable contribution to understanding between peoples and also understanding of the human psyche.

My wife and I live on the east coast of Scotland in a small village where the Norwegian Air Force was based during World War II. At our small harbour stand two laburnum trees, erected in 1944 alongside a plaque, which commemorates the alliance between our two countries. This old alliance makes my visit here today doubly meaningful and significant, since collaboration, co-operation and comradeship will be central to the thesis of my paper.

Care And Treatment

The philosophical basis of effective psychiatric care and treatment is a vast subject, especially within the context of the many influences of age, sex, social and cultural factors on the problems of human living, which we call mental illness or psychiatric disorder. Given the theme of this conference I have chosen to focus on issues concerning personhood and implications for the development of personally

appropriate, or person-centred, care and treatment. I hope to illustrate my philosophical position by reference to my work with the Tidal Model of mental health recovery.

People with so-called mental illness or psychiatric disorder are commonly assumed to be in need of 'care and treatment'. However, if there exists general agreement as to the meaning of 'treatment', the exact meaning of the term 'care' remains unclear. Traditionally, nursing has been associated with care, but psychiatric nurses have made only limited attempts to define or explicate the concept of caring (Barker, 1989; 2000a) often choosing instead to follow the fashions of the day, whether this be applying the various technologies of psychiatric medicine or psychology, or – as Clarke has noted – simply 'policing the mad' (Clarke, 1999).

British and North American nurses have been the most prominent voices of the emerging discipline of psychiatric nursing. In the USA, in the 1960s, the humanistic focus of psychiatric nursing (Travelbee, 1969), heralded the emergence of the therapeutic alliance, consumer/user-collaboration and the principle of empowerment, all of which have now become part of the contemporary psychiatric language. Arguably, these all had their origins, at least within nursing, in Peplau's (1952) interpersonal relations theory. However, in recent years this humanistic emphasis has been overshadowed by the focus on professional-ism, which threatens to remould nursing further in the image of medicine, largely to satisfy the demands of economic rationalism required by the healthcare 'business'. In the USA, and more recently in the UK, this takes the form of nurses acquiring specific 'skills': for example in the use of cognitive-behavioural methods, to foster compliance with medication (Kemp et al, 1997) and more generally compliance with the goals of psychiatric treatment or the 'care programme'. Despite the emphasis given to the emerging rhetoric of partnerships and collaboration, in practice much mental health care still stands in the shadow of psychiatric medicine.

Power, Disempowerment and Empowerment

For at least a century psychiatry has promoted the idea that various psychological, social and emotional problems of living are a function of some underlying (but as yet unidentified) biological pathology. This provided a rationale for a huge range of psychiatric treatments - from insulin coma, through electro-convulsive therapy (sic) to neuroleptic medication. Forty years ago Thomas Szasz began his radical critique of what he saw as the medicalisation of 'problems of living'(Szasz, 1961). Although medicine has strenuously resisted such criticisms, by re-framing the various mental 'illnesses' as forms of 'mental disorder' the American Psychiatric Association appears to have accepted that the search for a wholly biological, causal explanation for all forms of mental illness may be impossible. History may suggest that this represents a subtle, but significant, capitulation to Szasz's critique.

Szasz's emphasis of the metaphorical status of mental illness is, however, only one dimension of the movement, loosely called 'critical psychiatry', which challenges mainstream psychiatric thinking on a range of gender, race, culture and scientific issues, all with implications for the practice of mental health care (Newnes et al, 1999).

The social construction of mental illness, especially through the diagnostic process, has long been the subject of debate (e.g Conrad, 1992; Daniels, 1970; Farber, 1987). However, Kirk and Kutchins (1992; 1997) made the original observation that the repeated revisions and additions to the DSM were not initiated by working clinicians, but stemmed from the influence of the census, medical groups, the army or psychiatric researchers. In effect, the 'good clinician' knows that however many diagnostic categories are available, the resolution of the person's problems (of living) must begin with seeking to understand rather than simply classify the 'patient'.

Aside from concerns about the reliability and validity of psychiatric diagnosis (Kirk and Kutchins, 1992) the narrowness of the diagnostic approach is problematic. As Laing (1967) noted: "it is an approach that fails to view persons qua persons, and degrades them to the status of 'objects'". Almost forty years later, psychiatry's failure, in general, to try to understand people and the critical role of the creation of meanings within the therapeutic relationship, remain enduring concerns (Kismayer, 1994; Modrow, 1995).

Such concerns led Grob (1983) to describe psychiatry as a political and professional 'movement' - rather than a scientific enterprise concerned with caring for people who were definably 'ill'. Beverly Hall, the distinguished North American nurse argued that psychiatric diagnosis, and a narrow medical model, served only to disempower people, rather than to help them. Their adverse effects upon nursing practice led Hall (1996) to argue for the recognition of human values over 'objectivity' in mental health care. In a related vein Dumont (1984) exposed the fallacious distinction between illness and wellness in Western thought, suggesting the urgent need for a paradigm shift in the conceptualisation of 'mental illness'.

However, psychiatry has a remarkable capacity to shrug off its many critics, whether philosophical, scientific, social or political. Despite being the butt of many popular jokes, at the beginning of the 21st Century, psychiatry retains its patriarchal power (Barker and Stevenson, 2000). This is illustrated by the number of people around the world who continue to be hospitalised, or required to accept (often dangerous) psychiatric treatment, (many against their will), for an 'illness' or 'disorder' for which there exists no definitive empirical 'test'. Neither should we forget the cruel irony in the fact that:

> "Psychiatrists, of course, do ask for tests such as CT scans on their patients, but these are to exclude the possibility of brain damage. In other words, they are checking to see if there is a real brain problem, evidence of illegal drug use or whatever. Once they have concluded that there is nothing

demonstrably amiss with the patient's brain or biochemistry, they tell the person that they have a condition that results from a biochemical problem. But they don't have a test that could prove a so-called mental illness was actually organic in origin (Newnes, 2002)".

The idea of people taking (or being required to take) powerful drugs, with multiple deleterious 'side-effects', for a physical condition – like cancer or diabetes – in the absence of a diagnostic test, would be seen as ludicrous if not morally suspect. That so many people, in most Western cultures, readily accept this state of affairs, and that so many nurses – traditionally defined as their carers, if not 'advocates' – enable this system, attests to the enduring supremacy of traditional psychiatric treatment in contemporary mental health care.

Colonisation and Power

For over 30 years Szasz has used slavery as the choice psychiatric icon (Szasz, 2002)**.**

> "The psychiatric profession has, of course, a huge stake, both existential and economic, in being socially authorized to rule over mental patients, just as the slave-owning classes did in ruling over slaves. In contemporary psychiatry, indeed, the expert gains superiority not only over members of a specific class of victims, but over the whole of the population, whom he may 'psychiatrically evaluate'.(Szasz, 1974: 135).

In Szasz's view, any form of involuntary hospitalisation is a 'crime against humanity', and the practice of psychiatry echoes the fundamental human rights violation perpetrated by slave-owners, who also justified their practices as being, somehow, in the 'best interests' of the childlike, primitive, or otherwise enfeebled 'negro'. In this sense, Szasz was the first writer to explore psychiatry's colonisation of the self.

Psychiatric power has long been invested in the number of patients held by the psychiatrist and - in descending order of importance - the psychologists, nurses,

support workers and various ancillary staff responsible for 'treating' or 'caring' for the patient. With the advent of de-institutionalisation, people who once were patients have become, at least in principle, citizens again. However, in Szasz's view, for the majority, who were transferred into various forms of state-funded support, all that was achieved was that "they are now maintained like pets rather than being locked up in the zoo" (Szasz, 2000). Those who once were slaves – made to work in hospital laundries, farms and wards for their keep, and who were paraded, and made to undress emotionally, before ogling students, to reinforce the mastery of the doctor – have now escaped and have found their free voice in the community. Or have they? Autonomy remains as elusive as ever.

Foucault (1980) argued that all healthcare workers – whether involved in direct care and treatment or in research – contribute to, and are part of, the dominant discourse, which privileges some experiences, and labels, dismisses, and marginalizes others. Indeed, the emphasis of the dominant discourse of psychiatry on interpreting, labelling, and ultimately silencing, the voices of many of the people in our 'care', is the stock in trade of our practice.

The Potential of Post-psychiatry

Some psychiatrists, like Bracken and Thomas in England, suggest that we are moving to a 'post-psychiatry' position, which acknowledges the relativism inherent in all social constructs – like illness and wellness. However, before we can talk seriously about 'postpsychiatry' (Bracken and Thomas, 2001) we need to give up the use of the empty, but damaging, nosology of the DSM and ICD; we need to stop administering psychoactive medications against a person's expressed wishes; and we need to eschew the use of the detention powers inherent in our Mental Health legislation.

Around the world, most psychiatric nurses now call themselves, mental health nurses. It is axiomatic that if psychiatric nursing wished to enact genuine mental health nursing it would need to begin to dismantle its involvement in detaining, containing and otherwise controlling people in mental distress, and begin to construct a more formal discipline focused on nurturing mental health. Clearly, making an actual, as opposed to cosmetic, change to the practice of psychiatric nursing will be difficult. Indeed, under some social and political restraints, the development of genuine mental health nursing may prove impossible. Nurses may be obliged to be 'keepers' of the mentally ill, as they have been for generations.

These coercive dimensions of contemporary psychiatric practice are linked to the colonising power of 19th Century psychiatry, as Szasz – and historians like Scull – have suggested (Scull, 1979), which generated a more subtle, but no less powerful paradigm of social control(Leifer, 1990; Robitscher, 1980; Schrag, 1978). The colonisation literature in psychiatry remains limited, focusing mainly on the after-effects of colonisation – as a socio-cultural phenomenon – especially featuring the 'mental health' of indigenous peoples, like the Australian Aborigine, the Maori or the Native Americans (Deiter and Otway, 2001; Samuels, 2000). However, the concept of the 'colonisation of the self' also finds an echo in the literature on oppression (Bulham, 1985) or the more specifically in feminism (Hawthorne and Klein, 1999). Szasz challenged psychiatry to confront its failure to address the persecution and exploitation, inherent in its supposedly humanitarian 'care and treatment' programmes (Szasz, 1994). In that sense, he re-located the 'mentally ill' alongside other 'dispossessed' persons, whose core identity had been demeaned or misappropriated: notably women and all non-white/ non-Christian peoples. For all such peoples, self-determination lies at the core of their struggle to recover their full human status (Alves and Cleveland, 1999).

Recovery – the Conspiracy of Hope

This prompts us to ask - how do people, who have been diminished by the

disabling experience of mental ill-health, stigma, and often inappropriate care and treatment, begin to recover their full human status. This question should be the paramount consideration for any mental health professional who aims to develop a quality service. Moreover, without such a focus, any emphasis on productivity and efficiency would surely be worthless.

Dr Patricia Deegan emerged from the experience of seven years of hospitalisation and treatment for schizophrenia, to become a psychologist and, arguably, the leading voice in the recovery movement. She wrote:

> "The goal of the recovery process is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human. The goal is not normalization. The goal is to become the unique, awesome, never to be repeated human being that we are called to be. The philosopher Martin Heidegger said that to be human means to be a question in search of an answer. Those of us who have been labeled with mental illness are not de facto excused from this most fundamental task of becoming human. In fact, because many of us have experienced our lives and dreams shattering in the wake of mental illness, one of the most essential challenges that faces us is to ask, who can I become and why should I say yes to life? (Deegan, 1996a)"

The end of the 20th Century witnessed a rebirth of anxiety over the moral and ethical basis of psychiatry, if not also its scientific validity (Bracken and Thomas, 2001). Some psychiatrists began to acknowledge openly the inherent 'ideology' of psychiatric medicine. Schaeff (1992), an American psychiatrist, described how her training instilled assumptions about 'treatment', which required patients to adjust themselves to fit 'into an addictive, sexist, racist, self-destructing society'. In the UK Double (2002) acknowledged that biomedicine directs psychiatrists away from understanding the patient as a person, reducing her/him 'to a brain that needs its biology cured'. Although George Engels' (1977) original biopsychosocial model has at last found its way into the parlance of contemporary psychiatry, often this is used merely to oil the wheels of the traditional psychiatric process. However, the various

critiques of psychiatric treatment and its fundamental theoretical and philosophical base have stimulated, if only indirectly, the emergence of the recovery movement, which has even begun to influence government health departments like that of England and Wales (e.g. Department of Health, 2001). However, the concept of recovery begs the fundamental question: "what is psychiatry actually needed for?"

In Deegan's view recovery does "not refer to an end product or result" or that "one is 'cured' (or even) that one is simply stabilised or maintained in the community" (Deegan, 1996b). Rather, "recovery often involves a transformation of the self wherein one both accepts one's limitations and discovers a new world of possibility (Deegan, 1996b)" In that sense people do not 'get rehabilitated', since this implies that they are passive objects being manipulated – or at least shaped – by the forces of the rehabilitation programme. This is one particular connotation of the word rehabilitation that Deegan finds "oppressive".

Deegan rejects the view that there can be such a thing as a "hopeless case", acknowledging that 'giving up' is often a way of surviving in environments that are oppressive and which fail to nurture and support the person. When Marie Balter was asked: "Do you think that everybody can get better?" she replied

> "It's not up to us to decide if they can or can't. Just give everybody the chance to get better and let them go at their own pace. And we have to be positive – supporting their desire to live better and not always insisting on their productivity as a measure of their success". (Balter and Katz, 1987: 153)

In Deegan's view Balter was acknowledging the need for a conspiracy of hope - developing the concept of developing 'power with' or 'creating power together', eschewing the traditional power we exercise over people (Miller, 1976). The English word conspiracy derives from the Latin conspirare, meaning to 'breathe the spirit together'. This suggests one arm of the philosophical attitude necessary for enabling the development of the recovery ethos.

The Tidal Model: An alternative paradigm for 'caring with'.

The Tidal Model[®] (Barker, 2002) is a model of mental health recovery, which I developed between 1995-1998, drawing from a series of my research studies, which had focused, initially, on the 'need for psychiatric nursing' (Barker et al, 1999) and the discrete nature of the power-relationship between nurses and the people in their care (Barker et al, 2000). The Tidal Model acknowledges that the various phenomena, which we call ''mental illness,'' can be viewed through different theoretical lenses. However the model asserts the virtue of viewing such phenomena, primarily, as problems of living that can delimit the effective functioning of the person on various intrapersonal, interpersonal, transpersonal levels. The Tidal Model employs a pragmatic and respectful approach to the person recognising, as Alanen and his colleagues in Finland (1991) did in the 1990s, that it is important to help people and their families conceive of their situation "as a consequence of the difficulties the patients (sic) and those close to them have encountered in their lives, rather than as a mysterious illness the patient has developed as an individual(Alanen et al,1991)". By emphasising the centrality of the lived-experience, of the person and her/his significant others, the Tidal Model emphasises the need for mutual understanding between the nurse and the person in care. As a result, the possibilities for a personally-appropriate, contextually-bound form of care, are established.

Originally introduced in to acute care settings (Barker, 1998), the Tidal Model has since developed the concept of a 'care continuum', with sites in hospital, community, rehabilitation and forensic settings. The model emphasises the person's need for three discrete forms of care - 'critical', 'transitional' and 'developmental. These represent different, hypothetical stages of the care process. The care continuum spans the hospital-community divide emphasising that *need* should be the primary focus for care, rather than the setting within which care is delivered.

Although the model may complement the care and treatment offered by other

disciplines, its primary emphasis is the exploration and development of the lived-experience of the person-in-care. Like Deegan, I believe it is essential to begin by trying to find out who is the person who has become the patient, and who might this person become, given the right kind of care and support.

The Tidal Model gives specific emphasis to ways of revealing and clarifying meanings and values, which the person attaches to, or associates with, her or his problems of living. Where appropriate, this exploration extends from the intrapersonal domain, through interpersonal conceptions of Self and Other, to address what might be defined, classically, as the religious, mystical or spiritual dimensions of self-hood (Barker, 2000). In each instance, however, the constructions of the person's experience of personhood are realised through mutual discussion, and all assessments and care plans are acts of co-creation, between the person in care and those supporting her/him. My colleague, Irene Whitehill and I originally called this the process of 'caring with' (Barker and Whitehill ,1997).

The Process of Change

Unlike normative or adaptational psychiatric models, the Tidal Model holds no assumptions about the *proper* course of a person's life. Instead, it focuses on the kind of support that people believe they need now, to take the next step on their recovery journey. The metaphorical language of recovery and journey is emphasised since, as Deegan (1996a) and others (Barker et al, 1999) have illustrated, the process of entering, surviving and recovering from seriously disabling life crises, is invariably expressed in metaphorical terms. This is the language of everyday reality. This is how most people talk of their private experiences – whether of wellness or illness, happiness or sorrow, achievement or loss. This emphasis on the rich metaphors that people use to describe such experiences differs markedly from the often vacuous jargon of psychiatric medicine or nursing diagnosis (Barker, 2000).

The Metaphor of Madness

People experiencing life crises are (metaphorically) in deep water and risk drowning, or feel as if they have been thrown on to the rocks. People who have experienced trauma (such as injury or abuse), or those with more enduring life problems (e.g. repeated breakdowns, hospitalisations, loss of freedom), often report loss of their 'sense of self', akin to the trauma associated with piracy. In such instances, people need a sophisticated form of life-saving (or psychiatric rescue) followed, at an appropriate interval, by the kind of developmental work necessary to engender true recovery. Such 'rescue' may take the form of crisis intervention in community or the 'safe haven' of a crisis house. In nursing terms, once the rescue is complete (psychiatric nursing) the emphasis switches to the kind of help needed to get the person 'back on course', returning to a meaningful life in the community (mental health nursing).

Currently, there exists a vogue for protocols and standardised care packages, which are administered to groups of patients with common diagnoses. By contrast, the templates for assessment and intervention contained within the Tidal Model serve only as a springboard for the creative, conjoint exploration of the person's need for nursing. It is assumed that, although people may share similar needs, a genuinely person-centred approach must begin with the assumption that the person's needs are unique and, as such, require a uniquely focused care plan.

The model also recognises that – like the tides – the person's needs are constantly flowing and changing. Consequently, any care plan needs to be provisional and inherently flexible, in recognition of the inherently chaotic nature of human behaviour, and human experience (Barker, 1996); something that is bounded but infinitely changeable.

Nothing but Stories

Traditional psychiatric practice – whether in medicine or nursing – is characterised by what Buber (1958) called the I-it relationship. The person who becomes the patient is cast as the 'other' and the person who is the professional invariably adopts a powerful position over the 'other'. Oliver Sacks articulated clearly the importance of moving away from such an "I-it" when he wrote:

> "To restore the human subject at the center – the suffering, afflicted, fighting, human subject – we must deepen a case history to a narrative or tale; only then do we have a 'who' as well as a 'what', a real person, a patient, in relation to a disease – in relation to the physical…the study of disease and identity cannot be disjoined…(stories) bring us to the very intersection of mechanism and life, to the relation of physiological processes to biography (Sack, 1970, p.viii).

The Tidal Model assumes that people *are* their narratives (MacIntyre, 1981). All that we have to work with is the ongoing story of the person's life – a story which unfolds, and to which we gradually gain access, as the person acts as the biographer of her or his own life experience. The person's sense of self, and world of experience - including experience of others - is inextricably tied to the life story and the various meanings generated within it (Casey and Long, 2002). The Tidal Model seeks to construct a *narrative-based* form of practice (Barker and Kerr, 2001), which differs markedly from most contemporary forms of *evidence-based practice.* The narrative approach accepts that the person's experience is singular and unique, whereas the evidence-based approach emphasises abstractions from the behaviour of large numbers of anonymous people, within research populations, whose features are merely assumed to be equivalent.

The narrative focus of the Tidal Model is not concerned to unravel the causative course of the person's current problems of living, but rather aims to use the

experience of the person's journey and its associated meanings, to chart the 'next step' - what needs to be done to help the person make progress on the life journey.

In my own voice

As part of this conjoint exploration of the person's lived experience the assessment record is written entirely in the person's own voice, rather than translated into a third person account, or into professional language. The nurse and the person in care co-create a narrative account of the person's immediate world of experience This includes the identification of what the person believes (s)he needs, *at that moment,* in terms of nursing intervention, and what 'needs to happen' to meet that need (Barker, 2002).

In the course of mental health care and treatment it is commonplace for nurses to note that people 'change their stories'. Within the philosophy of the model, this is a reflection of how consideration of the past, in the light of the present (which is changing) serves notice that the person is also involved in creating the future (which is imaginary). Cixious (1993) noted:

"I'll tell you frankly, that I haven't the faintest idea who I am, but at least I know I don't know (p51).

It is folly, therefore, to talk of some putative 'true story' – since this is no more than a pattern of context or agency. Instead, the nurse aims to help the person develop a story, which takes account of how the person is presently making sense of life events (including the process of care) as and when they occur.

Extending the metaphor of the 'script edit' into care planning language, the model proposes that each person should be assessed only once (holistically) during each period of contact with the service. This leads directly to the development of the first

care plan, which is reviewed and revised daily with the person (where the person is in residential care), tailoring and adapting the processes of care, to fit what might be small, but significant, changes in the person's presentation or context. The story recorded at the first holistic assessment, becomes the opening page of this particular chapter of the life story of the current episode of care. This is written conjointly page by page, and is closed only when the person is ready to make the transition to home, or to a new care setting.

The Conspiracy of the Hopeline

The experience of mental ill health is inherently disempowering. Although often described as offering mental *health* care, psychiatric services often focus only on limiting the personal and interpersonal damage resulting from problems of living. In so doing, they often compound the original disempowerment scenario. The Tidal Model attempts to address directly the most common form of disempowerment - the failure to afford a *proper hearing* to the personal story of the experience of problems of living. Traditionally, the person's story is plundered to provide the necessary materials for the psychiatric formulation, and the consequent 'intervention'. Frequently this begins with the requirement that the person abandon his or her own story of human distress, in favour of the professional perspective – especially that framed by diagnosis. Contemporary practices like psychoeducation are examples of how professionals require the person not only to abandon their own story, but to convert (like a religious recruit) to the psychiatric story, complete with its principles, assumptions and language. The parallels with colonisation are apparent.

Drawing on personal experience, Deegan (1996b) described the colonising psychiatric influence at work when:

 "Professionals said we were making progress because we learned to equate our very selves with our illness. They said it was progress because we learned to say "I am a schizophrenic"…and each time we repeated this dehumanising litany our sense of being a person was diminished as 'the disease' loomed as an all powerful

'it', a wholly Other entity, an 'it-itself' that we were taught we were powerless over."

The Tidal Model tries to avoid reducing the person to a 'patient phenomenon', whilst recognising the impossibility of developing anything more than a provisional account of a person's life experiences (which is in constant flux), and the immediate need-for-nursing (which also is subject to change). By incorporating understandings of specific empowering interactions, drawn from empirical research (Barker et al, 2000) the Tidal Model puts the person's experience, and unfolding life-narrative centre stage. Using another metaphor, the person is 'in the driving seat'. The nurse provides the necessary support to ensure the person's emotional and physical safety, (self domain) helps the person explore and identify what needs to change, to facilitate recovery (world domain) and explores the possible roles of professionals, family and friends, in the whole recovery process (others domain). These suggest the presence of a 'hopeline' that might link the person, metaphorically, to the supportive environment where (s)he might begin to feel secure enough to begin the recovery process.

Research and Development

The Tidal Model is presently the subject of a range of evaluations in several countries – Japan, New Zealand, Ireland and Canada as well as the UK. Two extensive evaluations of the implementation of the model, across an Adult Mental health programme in Newcastle, England, have been reported (Fletcher and Stevenson, 2001; Stevenson, Barker and Fletcher, 2002) and a user-focused evaluation of the direct experiences of care by service users, also has been completed (Stevenson, Barker and Fletcher, 2002). Given the pragmatic, collaborative nature of the model, it lends itself best to process evaluation. However, preliminary evaluation has also suggested some of the possible outcome effects of the model, across a range of variables: e.g. length of stay in acute units, use of medication, use of 'containment' procedures, such as special observation and control and restraint procedures, incidence of violence, suicide and self-harm. There are also indications that by emphasising the need to develop care 'in vivo' with the patient, the nurse saves time, which would normally have been spent in the office,

writing up a report on the interaction. In this sense, the emphasis on collaboration has generated some productivity gains for the nursing team.

Conclusion

My friend, Simon Champ, an Australian artist with over 20 years experience of treatment for schizophrenia (2002) described the frustrations felt by consumers of mental health services, at their lack of involvement in research:

> "The colonisation of consumer experience begins with the problem of research agendas that, for the most part, are not determined by the consumers themselves. An example that illustrates this is in the area of recovery from schizophrenia. When consumers are asked what aids recovery, high on their list is 'the need for hope'. This clearly is seen as a key to recovery by consumers but rarely rates in research agendas (p24)".

Arguably, the exclusion of consumers from decision-making within research teams is the least of their problems. Despite the burgeoning rhetoric of social inclusion and partnerships (Meagher, 2002) many users/consumers still are maintained in a dependent position by the psychiatric system (and its social services allies). Indeed, one of the clearest examples of the success of the colonising influence of psychiatry and psychology is the way that people often narrate their difficulties as psychological problems, rather than simply as aspects of their lives. In Rogers' (1995) view psychology and psychiatric medicine continue to represent domineering systems for encoding and treating human beings.

Despite the evidence of independent research, which suggests that users/consumers value nurses more highly than any other mental health discipline (Rogers et al, 1993), nurses appear to have difficulty in accepting such approving statements concerning the value of care. At the same time the recovery literature embraces powerfully the concept of care and the human values associated with

human caring, seeing these as essential environmental prerequisites for the commencement of the recovery journey.

Jean Vanier (1988) talked of the value of "accompaniment" – walking, metaphorically, with people as they make the painful journey necessary to reclaim their lives and, arguably, their human selves. Contemporary psychiatry may be working hard to reform itself but the shadow of psychiatric colonisation still hangs over us all. To foster genuine alliances with people who have been doubly disempowered – by their distress and the psychiatric process – we need to demonstrate our willingness to walk with them, to value and respect their narrative and to learn from them what might need to be done to help further their recovery.

In conclusion, we might remind ourselves of the importance personal experience, for developing our understanding of our selves, and communicating this to others. Ibsen wisely wrote:

"... And what does it mean, then to be a poet? It was a long time before I realized that to be a poet means essentially to see, but mark well, to see in such a way that whatever is seen is perceived by the audience just as the poet saw it. But only what has been lived through can be seen in that way and accepted in that way. And the secret of modern literature lies precisely in this matter of experiences that are lived through. All that I have written these last ten years, I have lived through spiritually

This captures the spiritual essence of the narrative. If we can develop ways of helping people to relate the story of their mental distress, they may not only help us to see more clearly that which they have lived through, spiritually, but this story may also provide them with the beginnings of an attempt to understand their predicament. It may also help them begin to come to terms with, or overcome, the human problems that have blighted their lives.

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