

Silence, power, evidence and a debate with no clear answers

We were interested to read Dr Roger Lindsay's letter on mental health revelations in the February edition of *The Psychologist*. A thoughtful letter demands a reflective response, and we hope that some of the questions we pose here can contribute to a useful debate, and one which moves the discussion forwards.

With no intent to accuse of Dr Lindsay being 'unfeeling or lacking in empathy', we would question why he would like people to stop publishing their lived experience in *The Psychologist*. It is encouraging to hear his acknowledgement that clinical psychologists may also experience mental health difficulties; however, we suspect that it may still be a novel idea to many others. In suggesting that professionals ought not to publish their personal accounts, are we re-enacting the silencing that we are already often guilty of as a profession?

As clinical psychologists, we agree that it is important not to assume that one is a good therapist purely because one has experience of adversity, though research in this area appears to be lacking. Although some studies do exist (e.g. Poal & Weisz, 1989), such work is generally notable for its absence. We are aware, however, of an ongoing study investigating empathy in mental health professionals with a history of mental health problems, which readers of *The Psychologist* may wish to participate in [see tinyurl.com/hfrkh4j]. Do we need more good-quality research into potential links between therapist adversity and therapist competence with the understanding that, as with many parts of the discipline, we may not like what we find?

Do personal disclosures actually help to reduce stigma? The overall picture from campaigns such as Time to Change is mixed (Smith, 2013) and shows that any initial decreases in stigma are not maintained over time. Whilst personal disclosures may be



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initially helpful to both the person disclosing and others who may read them, do they help us to tackle stigma in the long-term?

There are moves to be more inclusive across the profession of clinical psychology, with many examples of this evident at the recent Division of Clinical Psychology conference. We would question in more detail why this is, and what the agenda behind this may be – that there is a power differential in clinical psychology is evident, and in attempting to minimise this are we genuinely helping those less privileged than ourselves, or merely repeating narratives of oppression? And, if we are genuinely concerned about stigma and discriminatory attitudes within the profession, would it not be more useful to formulate an evidence-based and service-user led anti-stigma campaign?

Dr Lindsay questions whether *The Psychologist* is the place for such disclosures, and suggests a 'personal confessions website' as an alternative. Given that the British

Psychological Society is a learned body, this does raise questions about the remit of *The Psychologist*, and whether a letters page necessarily needs to be an evidence-based, scientific forum. A 'confessions website' would, in our opinion, serve as an echo-chamber where little change would occur. Balancing the needs of clinical psychology as a profession with the needs of the 50,000+ people who receive *The Psychologist* magazine is, perhaps, an ongoing debate with no clear answers.

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I am writing in response to the letter, 'Mental health revelations: Enough is enough?' (February 2017), in which the writer comments on the ongoing discussions in the pages of *The Psychologist* on the importance of healthcare psychologists being open about their psychological situation. This exchange has been gathering momentum over the past several months and the openness with which a number of psychologists have described their experiences, and how they draw on them in their work, has received near universal appreciation and acclaim.

Sadly, the writer appears entirely to have missed the point in a letter, which is not only ill-informed but which could also, tragically, be perceived to be extremely stigmatising.

The disclosure of psychological history in the letters to which the writer refers is nothing whatsoever to do with catharsis. Rather, its purpose is to demonstrate that whilst psychological distress may be both disturbing and painful, it can, as with most other conditions, be treated, lived with and overcome, and that most of those so affected can go on to have productive and full careers. As such, it is a much-needed challenge to the widespread prejudice in society, and to the belief held by many, including sadly some of those personally affected, that psychological distress only affects the 'vulnerable' and is something to be ashamed of. This message needs to be promulgated loudly, robustly and widely until such time as psychological distress is viewed in exactly the same way as any other type of distress, where there is no stigma attached to revealing a psychological history, and where a person's psychological history does not de facto affect that person's training, recruitment, selection, preferment and advancement, either in the profession of psychology or elsewhere.

The experience of psychological distress, and the accompanying experience of 'occupying the other chair' as client or patient, are also extremely valuable ones, and ones that should never be trivialised or minimised. They can be a rich source of knowledge and empathy in the delicate human undertaking that is psychological practice; indeed, the latter is compulsory in some branches of applied psychology.

It is clearly apparent that the writer is at least partially conversant with mythological literature. Hence it should come as no surprise to him whatsoever that the reversal of cultural stigma and its effects on society (financial, moral, social and, of course, psychological) is, has been, and will continue to be, for the immediate future at least, a Herculean task. Hence it is that so many of us are engaged, in many complementary ways, in seeking to reverse it and its effects.

And it is for this reason that it is more important than ever to state that, despite the apparent irritation of the writer, the voices of which he complains will not be silenced, either within the pages of *The Psychologist* or anywhere else, until stigma is banished.

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The Minorities in Clinical Psychology Pre Qualification Group welcomes the recent set of letters from psychologists talking about their lived experience of mental health issues. The clearing house figures states that 1 per cent of people applying to training disclose a mental health difficulty, yet recent research suggests that these figures are significantly higher.

With several of our members having completed the doctoral form and having faced the issue of whether or not to disclose and, if so, then choosing how much to share. We have found that the one thing that we all have in common is the sheer mix of information and advice we have received from those higher up the profession. This ranges from the supportive (e.g. it will be seen as an asset or a positive) to the cautious (e.g. maybe don't go into

detail or you are 'brave') to those actively opposed (e.g. do not rock the boat or maybe leave it till you are on training/when you are qualified). This mix of messages has left us feeling confused and wondering quite how big a risk we are taking by being open.

We are hopeful that this situation will change and feel that the more people at the top are open, the more that this will filter down and hopefully one day we will be in a situation where there is no choice to make and disclosing will become routine. We will not then have members worried about contributing to discussions and subsequently articles on these topics for fear of what this may mean for their career.

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The long misanthropic attack by Roger Lindsay on psychologists who talk publicly about their experience of mental health problems contains a flawed logic about the role of empirical knowledge in human science. His conclusion is that the pages of *The Psychologist* should be limited to 'information based upon solid evidence and likely to be of interest and value to a greater proportion of the readership'. However, the majority of the readership of any publication will be personally touched in some way biographically, and often profoundly, by mental health problems; either their own, their friends or their relatives.

Moreover, personal experience is central to these problems because of the high risk of invalidation. This is a social-existential matter: one has a broken leg but one is mentally ill and to lose one's reason is a highly risky business in a society dominated ideologically by forms of (contestable) rationality (Pilgrim & Tomasini, 2012). Because a diagnosis of a mental health problem is both an experiential attribution by medicine and a source of stigma and social rejection in the lay arena, then professionals speaking out about their own difficulties are providing a useful role. They are exposing that experience to fuller public understanding and reducing the probability of the 'othering' of psychiatric patients. Some psychiatrists have offered such accounts productively (e.g. Gask, 2015) and there is no case at all that psychologists should demur.

Finally, empirical knowledge about functional psychiatric diagnoses ipso facto is predicated wholly on what people do and what they say. There is no objective disease state to study; that is why the more humble term 'mental illness' (not 'disease') is used, even within

a medical model, to signal the centrality of subjectivity of both the patient and the professional. Where those subjectivities intersect surely is of both psychological and social importance to us all.

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I'm sometimes frightened about writing letters this in response to such as Dr Lindsay's in case I write something so glaringly obvious that everyone regards me as being silly. Also, of course, nothing is black or white. This letter might turn out to be one of those black and white letters that's glaringly obvious.

There is an underlying difference between medical and psychological practice – medical tries to deal with certainty (technical) whilst psychology deals with uncertainty (adaptive). It's easy to understand what an ingrowing toenail is and what needs to be done about it; it's an adventure to find out why you feel uncomfortable and panicky in different situations and what can be done about it.

Medical practitioners have power over their patients, largely because of the threat that ill health poses to individual survival. Whatever their behaviour the technical processes will lead to some kind of result. Psychological practitioners don't have similar power. The threat of psychological challenges is perceived not to be as strong. Therefore the behaviour of psychologists plays a huge part in influencing how far their client will progress in revealing and in restoration, as there isn't the same threatening imperative to reveal in order to survive.

Patients and clients both suffer fear. Patients with a physical condition are fearful of the threat their condition poses to their lives. Clients with a psychological challenge are fearful of the consequences of revelation on their reception by society – communities, neighbours, friends, family, institutions.

Medical practitioners use the strategy of imposition with their



patients. It's a choice but the choice is often take it or leave it. Psychological practitioners use the strategy of conviction – they need to convince their clients about their authenticity to intervene with their client. Their clients are not recipients of an imposed solution; they are participants in their own discovery and restoration. Clients have to, somehow, abandon their fear and open their mind.

There are two sub-strategies to the strategy of conviction – the rational/empirical strategy based on reasoned argument, and the normative/re-educative strategy based on example. These can be used separately or in combination.

For clients to abandon fear and have an open mind they need to trust their psychologist. Trust is the absence of second guessing the motivation of others, to a point when you accept at face value what the other person says and does, without question. Medical practitioners tend to be trusted by patients, largely because they deal with a subject that is far removed from our normal understanding and want the threat to our survival lifted. They are accepted experts, hence their power and ability to use the strategy of imposition. Not so with psychology. Everyone believes they are a psychologist. Clients only believe you have expertise when you reveal something they regard as

insightful. If you don't achieve this, clients will view you like they view their doctor, as a technician.

A key attribute and behaviour in this process is attentiveness. Psychologists want to provoke the strong reciprocity properties that attentiveness possesses, so that the interaction can optimise its chances of a successful outcome. One of the triggers of attentiveness is asking or sharing something unique between the parties. In other words – to provide an example of an experience that is unique to both.

Jamie Hacker Hughes and Peter Kinderman are highly respected leaders and clinicians in their field. The fact they have revealed, rather than concealed, events in their lives that are examples of experiences relevant to their clients only serves to help the process of a successful outcome. They have revealed in a public space because they are leaders, hoping to inspire followers to do the same.

Of course, there is the bigger picture. The element of fear that those with psychological challenges face is currently justified by the general reaction to revelation. Dr Lindsay's reaction is an illustration. The antidote is more revelation, not less.

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As clinical psychologists who have a diagnosis of autism, we are grateful for Dr Roger Lindsay's sceptical letter in February's edition. As he suspects, we have found it personally beneficial to disclose our own diagnoses, and are encouraged by colleagues' recent disclosures of their mental health challenges. We also see such disclosures as having more a general purpose, which would not be adequately served by hiding them on a dedicated website, tempting as that may be. After all, the hole into which King Midas's barber whispered the secret of the king's asses ears failed as a confidential confessional, because the secret echoed through the land until everyone knew it. In a modern retelling of the myth Dr Lindsay cited (Maddern, 2004) the shameful secret lost its stigma once it was no longer secret.

And the problem is that disabilities still hold stigma. Like others, we at times have asserted that our autism make us better clinicians. In doing so, we have not intended to claim that we are better at our jobs than colleagues without a developmental disorder. Rather, the main purpose of disclosure is to challenge the prevailing assumption that a diagnosis makes us worse at our jobs or even disqualifies us from them. It is good to know that Dr Lindsay for one has never made such an assumption. We have met it at various stages in our careers. We also know numerous colleagues with developmental disorders who, because of their disabilities, have had to overcome more than the usual barriers to further qualification and training in caring professions, or who still repeatedly face such barriers, or who fear the barriers they would face were they to disclose. We regret that some potentially good practitioners are being lost to psychology and related professions.

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president's letter



The political world is vast in its scope, unimaginably complex, but also inescapably human. Psychology has a vital place in politics – and I would argue at the centre of politics. Psychology is a discipline and profession that

spans the whole range of human experience. That gives us a responsibility to act as well as speak out.

When I took up the role of President I called upon the Society to live up to its charitable obligation to make psychology relevant to citizens and the real world. Over the last nine months we have supported and been a driving force behind numerous initiatives, including a statement repudiating 'gay conversion' therapies, a charter on perinatal mental health, a moratorium on the use of psychiatric drugs for people with intellectual disabilities, the call for a helpline for people struggling with prescription drug dependence, a charter on workplace wellbeing for mental health professions, and the report of the All Party Parliamentary Health Group into public health and mental health. We've played our part in developing the NHS mental health Five Year Forward View. We've led discussions in parliaments and assemblies on issues such as acquired brain injury and offending, dementia and refugees and asylum seekers. We've issued assertive press releases (and supplied spokespeople) on issues as broad as human rights, child abuse, funding of health and social care, social justice and Brexit. We've been active and influential on the joint DoH and DWP group on work and health and influenced the content of the green paper on benefits reform.

It is abundantly clear to me that the Society, its Members and staff are indeed refusing merely to be bystanders; they are speaking up, and acting. I am proud of what the British Psychological Society is doing. But I occasionally worry that sometimes our internal debates are framed in terms of what's in the best interests of psychology and psychologists, rather than the general public and citizens.

We need, I think, to move away from simple, binary, choices. We should not contrast the important role for the Society in promoting psychology and the valuable work of psychologists against – in opposition to – standing up for the rights and best interests of our clients or the general public. Shouldn't we, by employing psychology in its truest extent, be able to do both?

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