



Relating with professionals

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This paper addresses my difficulties as a carer in engaging with many professionals in mental health, both locally associated with my son's acute inpatient care, and nationally where policies are being developed and their implementation is pursued. All of us are affected by The Department of Health (DoH) Mental Health policies and their implementation by professionals has formed the way in which professionals relate with my son and myself. The way in which my son is impacted inextricably affects the way I relate to professionals. I think my difficulty in engaging lies in the relationships we all have with each other. In focusing on the process within our relationships, I attempt to raise professionals' awareness of what constitutes a relationship when we dialogue. As it takes two to engage in a dialogue, I perceive my difficulty is also the difficulty of the professionals. Carers are becoming increasingly involved in the training of mental health professionals and our combined difficulty needs to be resolved, so that we all benefit. In order to achieve positive progression, there needs to be a radical change within our relationship to provide ease of engagement from all parties. In this paper I tentatively suggest how this process can be achieved.

Keywords: attitudes, balanced relationships, humanistic, iatrogenic, self awareness

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My intention in writing this paper is to raise an awareness of 'what' and 'how' people are in relation with the other, and much of the following will impact readers differently as each person responds uniquely according to 'how' and 'where' he or she is at this point in time. I am aware some people might identify with the situations I describe, others may agree, some may feel offended, others defensive. If it is possible, I ask only to place yourself, a professional, as a carer in relation with someone you love, in the following situations I describe. At the end of this paper if you, *as a person*, are able to be touched by your own feelings which arise from within, then I will know that I have achieved my purpose. It is only when people come into contact with raw emotions a person can be moved and change to move forward positively in relation with another person.

When I entered the world of the mental health system in January 2000, it hadn't occurred to me that professionals had entered into a relationship with me and I with them. It was in 2002 when the National Collaborating Centre for

Mental Health responding to my issues concerning the Medical Model, by providing me with a short quote from the National Institute for Health and Clinical Excellence Guidelines (NICE) – 'Relationships with Carers': I then understood and recognized that my many difficulties with professionals stemmed from *our* relationship together and specifically the relationship professionals were having with my son.

Honesty and clear communication are essential for quality relationships. The ability to be a receptive listener, respond empathically and to be accountable for attitudes and behaviour fosters dialogue. Having an existential phenomenological attitude is imperative, as this shows an enquiring disposition. When both persons are fully functioning, being able to communicate thoughts and feelings in meaningful ways to the other (Clarke 2005b), the relationship is reciprocal, balanced, healthy and respectful.

Professional knowledge over client ignorance has the potential of creating an imbalance of power within a rela-

tionship. I am a practising chiropodist and have a professional relationship with my clients. However, I choose to reduce my power by sharing my knowledge with my clients to the best of my ability. From the start some clients want to know all the nuances, intricacies of their problem and treatment. Other clients say, 'You are the professional – you know best – I will leave treatment up to you'. This serves to maintain their vulnerability within our relationship and it is these clients whom I actively encourage to be an active and responsible participant in our relationship. I take a degree of responsibility for equalizing our roles.

In mental health, the professional person too often has maintained their long-established position of being 'all knowledgeable' about treatments and assumes the dominant role in the patient–carer relationship. When my son was first admitted, we both fell into subservient roles – myself as a carer, and my son a vulnerable patient. Even though the relationships here were relatively harmonious, they were in fact extremely unbalanced – one side exhibiting power and dominance, and the other unwittingly accepting a subservient role, which had been so easy to fall into because of the professionals' approach.

At the time I didn't realize that I was being compliant towards my sons' treatment, or I had succumbed to the dominant professional attitude. That became clearer to me when I began to approach professionals with information highly pertinent to my son's treatment. Often the information would challenge 'received medical wisdom' and accepted mental health practices and it seemed immaterial whether my research was positive, or negative. In changing my role towards the professional, in being proactive, not reactive, engaging with professionals became difficult and acrimonious. The balance of 'power' was moving, and so was the harmonious nature of all interactions.

As I began to engage with professionals, I experienced reactions which I have not experienced in the world outside mental health. When my son began to suffer with iatrogenic conditions of tardive dyskinesia (TD), of super sensitivity psychosis (Miller & Chouinard 1993), tardive psychosis (Tranter & Healy 1998), neuroleptic induced deficit syndrome (Lewander 1994) and neuroleptic dependency, I gradually began to introduce relevant research. Their response indicated that this line of discussion was not conducive towards my son's 'best interest', it was as though I had no right as a carer to enter into dialogue about the effects of their treatment towards my vulnerable son. Some professionals were dismissive; others were in denial, and others showed their superiority, claiming their expertise due to many years of experience.

I am impacted considerably by these attitudes. It's as though I am not credited with the slightest intelligence or considered a person of worth in assessing how their treat-

ment has impacted on my son. What ever happens to my son affects me deeply. He is my flesh and blood.

Denial of iatrogenic conditions has resulted in my son being held responsible for these physical and psychological changes. Within the schizophrenia label, he is further labelled in being 'treatment resistance', blamed with 'lacking insight' and having behaviour associated with 'negative symptomology'. Professionals appear to be projecting my son's deteriorating condition back onto him; thus ameliorating accountability for their behaviour within treatment. The blame continues at conferences as I listen to professionals stating the 'chronicity of schizophrenia' and 'catastrophic crises' results from patients failing to take treatment. I need professionals to be up front about the consequences of their treatment and own responsibility for their actions.

I am sure many professionals are unaware of the attitudes I have described in our relationship. On one occasion a nurse told me to leave the room after I had requested him to check the 'meds' with me. Even though I eventually explained how I had felt pushed out, the nurse repeatedly denied this. I then explained that no one, no matter how much authority he had, could deny what I was experiencing. Half apologetic he replied it wasn't his intention to push me out. Through my persistence in engaging with him, I received a satisfactory response.

Attitudes, words and behaviour play an important role in developing trust in relationships especially the therapeutic relationship between staff and my son. When I hear about my son being threatened with police, in order to modify aggression and with sectioning for treatment coercion and compliance, he has felt intimidated and scared. In these sectioning situations my own vulnerability comes steeply to the fore; I am exceedingly helpless feeling the ultimate power from professionals. Not only does threatening behaviour annihilate trust I think it is unprofessional and disrespectful.

My distrust is accentuated on the occasions when professionals are selective about factual information in association with neuroleptic drugs. Memory loss in connection with TD, impairment of cognitive functioning, dementia, sterility, cardio vascular disease, Parkinson's disease and death from respiratory disease (Jackson 2005) are all issues which have never been discussed by professionals responsible for my son's treatment. The deception I feel is ongoing especially when keynote speakers at conferences minimize iatrogenic disease while behind the scenes acknowledge many issues.

Despite recent and progressive intentions to involve carers in mental health education, it has been noted by The Ten Shared Essential Capabilities (ESC) (Hope 2004), carers continue to report 'not being listened to'. Dismissive

behaviour in 'not being listened to' is illustrated through my experience of sectioning situations. I thought my son was going to die under treatment under section, as he exhibited neuroleptic malignant syndrome symptoms, which the nurse had failed to act on. My son's deteriorating condition was averted because staff listened to a nurse external to the unit who recommended a reduction dose; I, a mother of my son was 'not listened to'.

On challenging a keynote speakers' content both speaker and professional delegates were silent. Then delegates applauded as a service user gave positive feedback. It appears easier for professionals to listen when current practice is endorsed as compared with professionals' difficulty in listening to my carer's reality and radical evaluation of practice. I am well aware my challenges may be uncomfortable for some professionals to hear, however, basking in comfort zones will not bring about progressive change.

I have experienced non-response, silence and failure to dialogue in multidisciplinary team meetings and in correspondence. These situations have left me at a loss as to 'what' is going on with the professionals to present themselves in this manner. All of these situations are unsatisfactory and are frustrating. I need each professional to engage in responsible dialogue. At one conference where I felt disrespected by one speaker's failure to acknowledge my comments, I took the responsibility by engaging and challenging his abdication of responsible behaviour.

In theory, a care trust independent review gives users and carers an opportunity to have concerns addressed. This independent review comprises a panel of health and lay professionals external to the Care Trust. The panel examines issues surrounding a patient case by taking 'evidence' from Trust staff and service users and carers, making recommendations for the future. Our experience with the panel was fruitless as our issues were incompatible with the fixated belief of the medical model regime. Despite our request for my son to receive humanistic care, nothing changed, neither treatment nor behaviour. I felt totally disillusioned. In my professional practice, I am required to be proactive when faced with complaints or otherwise clients would desert me.

At one workshop I delivered, a supporting lecturer deliberately omitted the term 'carer' from the advertising flyer. Apparently carers are notorious for complaints and professionals instinctively shun input from carers. The reality is that people will complain if services are unsatisfactory, and if nothing changes, grievances only increase. My situation in mental health is compounded by the fact I do not have a choice of moving to a more satisfying service.

Trying to engage within my ongoing distress in these situations I find difficult. Generally I am blamed, for it is I, the carer, who is perceived as being belligerent, having high

Emotional Expression and in need of psychosocial guidance. It appears inconceivable to professionals their behaviour in relation with me and within their rigid treatment in relation with my son is provocative and psychologically abusive. I find the whole situation very sad. Recently I was encouraged when a professional person shared with me the overall difficulty professionals have in engaging with carers. Such openness is very rare.

There is considerable pressure for mental health workers to follow 'good practice' from NICE Guidelines, compounded by the pressure from carers' complaints. I can only imagine the enormous difficulties experienced by ground floor workers in this almost intolerable working juxtaposition. The time and energy consumed by professionals keeping up to date with all policies leaves little space to sit down and listen proactively to carers' expertise and concerns.

I am greatly concerned by the regimented NICE Guidelines policy and I am sure the majority of professionals entering mental health were unaware they would be subtly coerced into compliance with the authority of these policies. The predominant focus on neuroleptic drugs and cognitive behavioural therapy advocated for patient compliance is restrictive: practitioners appear to be virtually being stripped of independent thought and common sense, being disempowered with no choice of being innovative towards alternative approaches to psychosis. This is a strange paradox as my son, through DoH recommended treatment and coercive sectioning, has no choice of treatment and is disempowered for life.

At one conference professionals laughed when a fellow colleague spoke about patients' feelings towards neuroleptics – patients aren't meant to have feelings – one of the neuroleptics' goals is to smother people's feelings and emotions so they become treatment compliant. This too is a paradox as most professionals also appear not to have feelings and their manner comes across as stiff and starchy. This is perhaps a result of being trained not to become personally involved with patients. This is replicated when interacting with carers. Feelings are hidden either because a deliberate front is presented – professional façade – or professionals are unable psychologically to relate *as a person*.

Personality development theories are described by humanistic psychotherapists such as Rogers and Yontef (Rogers 1951, 1967, Kirschenbaum & Henderson 1989, Yontef 1993). People's ability to engage *as a person* stems from birth. Babies are born with their inner sense of self-knowledge and instinctively know what makes them content and angry and they know their needs. Provided caregivers respect babies in relation with their needs, their self-awareness increasingly develops, becoming secure within their own unique independent sense of self. This

leads to a state of congruence where feelings are available to awareness in relation with the unique self, people being able to live these feelings, be them, and able to communicate them. (Brazier 1993). People are able to engage *as a person* being upfront, honest and sincere. This state is synchronous with experiencing strong personal boundaries where personal involvement enhances relationships.

On the other hand, babies who are shown disrespect by caregivers become insecure and adopt unknowingly the conditioned role dictated by their caregivers. Self-awareness becomes distorted; people experience incongruence being unaware of their feelings in relation with their unique self.

This conditioned role suppresses the unique sense of self, and these people show a 'front' or defence by exhibiting the attitudes and manner of control, power, denial, threatening behaviour, arrogance and deceit. These attitudes and behaviour are indicative of fragile personal boundaries, which I have predominantly experienced in the mental health system. Needs and feeling are projected onto others; people lack accountability for their own behaviour, which results in apportioning blame elsewhere. The loss of humanity occurs simply because of the inability to engage *as a person*.

I have tried to search for professionals' humanity in our relationship and by reaching through their protective professional barrier; I often manage to entice their humanity *as a person* to the fore.

For instance, one nurse curtly responded to my concern over my son's extrapyramidal symptoms and TD by stating that it was her duty to give my son neuroleptic medication: her quick response came from her professional position. I replied that her response was professionally orientated and I needed to know her own personal opinion about side effects. She looked away from me and became thoughtful. After a moment she looked at me again, this time with more compassion and warmth replying slowly she would not like to be in my position as a mother seeing her son suffering with side effects. She had melted – I had touched her humanity and she began engaging with me on the same level, *as a person* (Clarke 2005a).

Another time, on a closed unit, my son became agitated with the staff and the charge nurse grabbed hold of him and physically forced him into the isolation room. I thought his reaction excessive and I sensed the nurse was exhibiting his power specifically for my benefit. I explained to him I thought his behaviour was excessive and that my son's annoyance could have been reduced less aggressively; the nurse denied his physical manhandling. Eventually he acknowledged his heavy handedness towards my son and apologized. This nurse in showing accountability for his behaviour gradually mellowed from his cold hard profes-

sional manner and connected with his unique feelings by engaging with me on the same level on a one to one (Clarke 2005a).

In standing my ground and dialoguing with him *as a person* within my own right, I was respecting myself and so received respect in return. From that day our relationship became healthier and I experienced no further difficulties in engaging with him. I call my process 'being relational'.

There are occasions when I am unsuccessful and I think this is associated with the individuals' greater personal fragility. For instance, I confronted one nurse's behaviour after she had put the phone down on me. Despite involving myself *as a person*, she told me her behaviour was exemplary and using her authority commanded me to leave the room, threatening to have me thrown off the unit. Many people with fragile boundaries perceive feedback as criticism even when no criticism was intended and become increasingly defensive.

And yet I do meet professionals who are different and who stand out significantly from their colleagues. Within their professional capacity they are able to engage with me *as a person* with a heart and with a soul; they are curious and intrigued with my experiences; they are warm, compassionate, understanding and spontaneous. I sense their genuineness and I instinctively trust them. These are the people who are at ease with me. They are indeed rare gems and I enjoy engaging with them. I feel respected in their presence and I have no doubt that my son would feel respected if he was in their care. These are the professionals who have a heightened degree of self-awareness and strong personal boundaries.

Partnership is a frequently used term in mental health having recently been extended to policies involving carers: the ESC (Hope 2004) refers to 'partnership' in four out of the 10 capabilities; the combined campaign of the RCP and The Princess Royal Trust used 'Partners in Care' as their slogan. According to Collins English Dictionary (1992), partnership is defined as a 'contractual relationship', involving 'persons associated in such a relationship'. The use of partnership seems to distance itself from the concept of relationships. The result is a framework where 'partnership' replaces the concept of a relationship (Barker & Buchanan-Barker 2004). It is this distancing which appears to prohibit the fundamental personal involvement of professionals '*as persons*' in their own right. Even though training for professionals in psychiatry is mandatory, for those professionals experiencing fragile boundaries, such training would accomplish very little. Throughout all disciplines, professionals need to experience personal development with the objective of developing strong personal boundaries with increased self-awareness.

I truly think an assessment of psychological self-awareness (APSA) would be beneficial in the mental health system. I have various thoughts on this highly relevant issue and would welcome input from interested parties. I speculate that APSA needs to be part of interviews, maintained throughout training and a prerequisite for employment. I recognize the need for assessment to be undertaken experientially in 'live' relational situations: ticking off psychological boxes is inappropriate as those experiencing fragile boundaries have the potential of unintentional bluffing. In one training area where I have an input, the professional lecturer assesses students' attitudes and manner while I lecture from my carer's perspective. APSA needs to be applicable to current professional personnel and managers working in mental health to achieve the true ethos of 'Working together makes a real difference' (Partners in Care Campaign 2004).

The Royal College of Psychiatrists hopes that the Carers in Partnership Training Recourse (Partners in Care Training Recourse 2005), 'will ensure that current and future generations of mental health professionals work in true partnership with carers and the people they care for.' (RCP Press Release 2005). With ASPA, I think this will eventually become a reality and the roles of practitioners, carers and patients will become equalized. The partnership would be truly a partnership because relationships between all people will be healthy and reciprocal.

I am very aware I have written about a very unbalanced set of positive and negative experiences. However, this is my reality. And I wish my reality was different. I feel this situation in mental health is difficult, prolonged and a painful struggle. There is however, some brief respite, because of those few professionals where I have received genuine support, which I cherish deeply.

I have taken responsibility in relating with professionals. However, I think the responsibility of relating also lies with you – it is part of your job of being a professional. and it is

my job for as long as it takes to achieve a more satisfying service for my son to experience.

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