Conflict with patients in hospital psychiatry, and addressing this with ReCreate Psychiatry.

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Good morning, my name is Khaldoon Ahmed and I'm glad to be here to discuss an issue which i've been thinking about since I first started training in psychiatry a decade ago. I work as a consultant psychiatrist for people with severe and long standing psychosis in London. I'm currently based in the community but until recently I was responsible for a 23 bed mixed adult inpatient ward.

I'd like to talk about some of the issues that come up from my clinical work. I'm going to draw from ethnographic research I did as part of my MSc in medical anthropology at UCL, and tell you about the Recreate Psychiatry project.

The reason I'm here today is that I have collaborated with Edward Harcourt and Neil Armstrong on a project called ReCreate Psychiatry. This is one of the projects of the mental health arts charity called the Mental Fight Club, of which I am on the board of Trustees. The aim of ReCreate psychiatry is to create a space where doctors and people with experience of mental health problems can engage in a genuine constructive and open hearted dialogue.

As you might imagine, there is considerable conflict between a patient admitted to a psychiatric ward and the professionals looking after them, not least because most do not choose to be there and are detained against their will. One of the more contentious issues arise with those diagnosed with 'borderline personality disorder' or 'emotionally unstable personality disorder' (EUPD) who present with suicidal thoughts and are hospitalised often repeatedly after taking overdoses or self cutting. I would typically have between one and three patients on the ward at a time. The difficulty is over what label is used, I met very few who were comfortable with the diagnosis of borderline or EUPD. Many said that the label is pejorative or stigmatising. This is one situation where the clinical language clearly does not match with the subjective patient experience. The language of diagnosis rather than providing relief and clarity, instead gives rise to feelings of being misunderstood.

The concept of personality disorder is controversial in psychiatry, and how this terminology is understood by patients is important. If someone is told they have an illness, the idea also includes the potential for recovery, but if someone is told that they have a personality disorder there is a permanence inherent in the word that can be interpreted as condemnatory. Unsurprisingly people who have been given this diagnosis often seek the more acceptable terms like bipolar disorder or depression. For psychiatrists however bipolar means a condition that is different and treatable with antimanic drugs like lithium and antispychotics. Whereas as medications have little therapeutic effect on the pattern of emotional instability seen in people with EUPD. This is an example of where there is a disjuncture between psychiatry and the people it sees. In the case of EUPD alternatives have gained ground. For example relabelling the condition as 'emotional instability disorder', or 'complex post traumatic stress disorder'. In response to dissatisfaction with mainstream provision, new initiatives informed by service users have arisen like the SUN project - which avoids labels altogether.

In contrast, I found that British Bangladeshis with psychosis were, in many aspects, allied to the diagnosis they had been given by psychiatrists, and accepted treatment. I conducted ethnographic interviews with 18 people for my MSc in medical anthropology to look at the meaning of illness in this group. The lens I used was that of explanatory models proposed by the psychiatrist and anthropologist Arthur Kleinman. I was looking for individual meanings within the various narratives that people had. Causation was important, patients had an explanation of why they became unwell ranging from bereavement to family conflict, jinn possession, struggles with education and employment and challenges of cultural difference and migration. I found they held multiple models simultaneously. They accepted diagnoses of paranoid schizophrenia or bipolar affective disorder, but at the same time held beliefs that they might be helped by prayer, or family support.

Since doing this research I have thought a lot about why the medical narrative doctors gave for psychosis was so readily adopted. Psychiatry gives an explanation of what happened to these individuals, and provides a structure of care: hospital admissions, regular appointments with doctors and care workers, and sometimes accommodation. Coercion is one element, as many of

those I interviewed were detained in hospital under the Mental Health Act, and outside hospital many were subject to Community Treatment Orders compelling them to take medication. I would venture to propose that biomedical models have an authority that can have an effect because this group is relatively marginalised. The mental health care system has resources and power, and the word of the doctor has some prestige. This is not to say that biomedical models are completely adopted. I think it is this differential in power between the system and the group it is treating that results in it's partial acceptance.

Re-Create Psychiatry is a service user initiated endeavour to address the power imbalance between mental health professionals, particularly doctors, and their patients. It started 4 years ago as a series of public dialogues at the Dragon Cafe, a weekly arts space run by Mental Fight Club in Borough just south of the Thames and the City of London. We have developed this into a platform to discuss psychiatric labels, the effect of institutions on both services users and psychiatrists, and how we can change the system. We have a few slogans that encapsulate the ethos lfor example "Doing with rather than doing to", and "No them and us, only us". Doctors who have participated find genuine learning from the experience of mental illness from patients. The value of the project is that it humanises both parties. Allowing health professionals to also express their vulnerability enables service users to see their care givers in a different light. The effect is an equalisation in the relationship, or at least a move towards it. These conversations have happened in settings ranging from NHS hospitals and clinics, to psychiatric conferences and public arenas like the Wellcome Collection. The future aim of the project is to embed spaces for this dialogue in psychiatric training and the NHS. The idea is to put the wellbeing of both the doctor and the patient at centre stage, and develop this as a method for reciprocal peer support, leading to enrichment on both sides.

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