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Correspondence regarding: Is 'another' psychiatry possible?

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Rose and Rose's paper, 'Is 'another' psychiatry possible?' (Rose & Rose, 2023) is an ambitious attempt to move our thinking beyond the status quo. They firmly ground mental distress within the lifeworld of those who experience it.

Engaging in helping people entails a risk of setting up a power dynamic which undermines their sense of identity, autonomy, agency and authority over their own lives. Knowledge and meaning-making systems held by those in dominance in a power relation often trump other knowledge. Meaning-making systems used in traditional psychiatry including diagnoses, biological treatments and randomised controlled trials are prime examples of knowledge which is widely privileged but described as unhelpful, dis-empowering and de-humanising, even by other doctors (Stanton & Randal, 2016). Using a post-modern approach, as advocated by post-psychiatry, we can hold a number of knowledges which can be evaluated according to impact or usefulness rather than as 'true' in some absolute sense. Traditional psychiatry knowledge can be offered as one way of making sense of a situation and providing options for interventions.

The issue is much wider than the privileging of traditional psychiatry knowledge. As Rose and Rose point out, other alternatives such as the Power Threat Meaning approach and clinical formulation, also privilege the clinician's meaning-making system, albeit based on careful questioning and listening. Even when the formulation is shared with the person or family and feedback sought the question remains, 'Whose formulation is it?'

Both the medical model and psychological approaches prioritise asking questions and listening carefully to the answers in an attempt to hear the voice of the person. However, as Rose and Rose assert, 'Simply listening' is not enough. In the clinical encounter, one person is struggling with living their life and the other is in the role of the so-called expert with skills and knowledge to help. The power dynamic inherent in this inevitably privileges the clinician's knowledge. This creates a risk of epistemic injustice in any clinical interaction.

As clinicians we have a responsibility to develop expertise in bringing out the voice of the other person; to bring forward their skills, knowledge and resources. To do this, we need to structure the clinical encounter as a collaborative discovery process. The person brings their knowledge of the niche they live in, the experiences they have of agency and competence, their values, intentions, etc. This is likely to be augmented by involving family and community members. The psychiatric professional also brings their personal lived experience, what they have learnt from other service users, their professional and academic knowledge, and last but not least, expertise in engaging the other person in a conversation structured to bring their resources forward. This provides an opportunity to build a unique narrative which makes sense of what they are experiencing. Most importantly, this is a narrative the person can feel ownership of, which also appears to be an outcome of the Open Dialogue process. To be able to facilitate collaborative development of this sort of narrative, the professional needs understanding of the toxic exposures Rose and Rose describe. We have worked together with colleagues to make freely available two sets of tools which we have found to facilitate this joint discovery process (Randal, 2022; Stanton & Windelborn, 2022a, 2022b).

Rose and Rose propose research methods that 'capture how adversity gets under the skin' to make the voice of the patient available in the public domain. We also need to address the challenge of how to make the richness and depth of the data available in the public domain in a way in which people engage with it. We have explored a range of avenues.

I, (PR) have used my recovery story in the context of The Re-covery Model (Randal et al., 2009) in conference presentations, workshops and teaching clinicians over decades. Participants in workshops practised bringing forward their own stories, including personal risk behaviours, and sharing them with each other. They used my model and the prompt cards that I co-created with others with lived experience (Randal, 2022). They embraced this framework enthusiastically, but a number of them, often psychiatry registrars, found that despite their intentions they were unable to apply it when they returned to the frontline demands of institutional psychiatry.

We also used transcripts from our qualitative research involving doctors with experience as patients of psychiatrists (Stanton & Randal, 2010, 2016) in workshops for psychiatry registrars. Each participant read excerpts in turn, leading to rich discussion stimulated by participants engaging with the voice of lived experience. This is a format which could be used more widely.

We have also written a book together focused on my (PR's) story of recovery from psychosis (Randal & Stanton, 2022). Both of us also explored our experience of training in medicine and psychiatry and trying to provide more meaningful psychiatric care. We used the process of duo-ethnography. Like auto-ethnography, this involved using our stories to investigate wider social and political meanings. However, in duo-ethnography, two researchers come together with their own understandings and share their lived experience in a repeated, reflexive and reiterative process. We moved to and from each of our stories, culture and different perspectives with a commitment to disrupt our own and each other's thinking. This transformed our understanding, uncovering and exploring new dimensions of the issues. This was a hard, but exhilarating and enlightening process. We wrote using an evocative approach (Ellis, 1997), rather than telling readers what they should take from the book. We hoped that this would enable them to connect with our voices in a way they found meaningful. We advocated for a 'both/and, and beyond' approach. This would involve making the learnings from institutional psychiatry available as one of the knowledges which can be used, 'on tap, not on top'. We need both/and. Rose and Rose go beyond this from a broader sociological perspective. For a psychiatry which makes a meaningful difference to people's lives, we need to go beyond.

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