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# **Across the Great Divide: reflecting on dual positions in Clinical Psychology to enhance equality and inclusion between those working in and those referred to services**

## **Abstract**

In the United Kingdom there are guidelines and policies to facilitate boundaries within professional interactions which recognise power differences between those employed in services and those referred to them. However, perhaps we must acknowledge that these boundaries may have indirectly resulted in an unbridgeable division between professionals and those that use services in current professional policies.

This paper considers what it means to be a Clinical Psychologist and user of services or carer with the complexity that surrounds this dual position. Through incorporating personal reflections, it seeks to highlight how hard it can be to break down 'them and us' barriers despite the best intentions of the profession and policy makers. The suggestion is that to be truly equal and inclusive we must shift from relating differently to service users, professionals and professionals who may use services by acknowledging our personal positions; otherwise breaking down barriers will remain an ideal rather than a reality. When it comes to our overall well-being breaking down these barriers could shift us from direct or oblique misunderstandings, judgements and stigma towards understanding, tolerance and acceptance within and between all of us.

## **Keywords**

Clinical Psychology, dual positions, personal and professional, service user, carer and co-production, communication, them and us, equality and inclusion

## **Introduction**

In the United Kingdom (UK), Clinical Psychology (CP) is a profession that works with distress and well-being, placing inclusion and equality at the forefront of policy, interventions and training (BPS, 2016). It is a profession with far reaching boundaries, yet current policies imply 'service user' perspectives only come from outside of the profession. The inspiration for this paper stems from a bridging of worlds; within professional and personal spheres. To navigate this dual position, one must be mindful of the way each aspect influences the other. Indeed, it is important we embrace ways that facilitate this dialogue (Chamberlin, 2005). One way of achieving this is by professionals acknowledging their personal positions. Forefronting this position results in taking a confessional stance:

*<sup>1</sup> I am a Chartered Clinical Psychologist and carer of a child with a disability – attending multiple appointments in health care and educational settings.*

<sup>1</sup>Personal reflections will be indented and in italic throughout the paper.

This reflective paper focuses on the experience of being a ‘carer’ or ‘service user’ and what it means to be in a dual position, the terminology used to describe those referred, and what, if anything, we might do to improve those positions and subsequent conversations. The aim at best is to encourage transparency in conversations, or at least to encourage mindful conversations about how we talk about people while they are not present, and how this might influence our subsequent interactions with them. Furthermore, it seeks to value an open curiosity about underlying issues and an acknowledgment that professional training does not equate to knowledge or experience within all areas we might work with.

**Definitions: Me, them, us, we**

In the UK, a recent British Psychology Society document on equality and inclusion includes the following quote:

‘Civilisation is the process in which one gradually increases the number of people included in the term “we” or “us” and at the same time decreases those labelled “you” or “them” until that category has no one left in it.’ (BPS, 2016, front cover)

Quite explicitly it aims to cross the divide between ‘them and us’. As a profession we are entering a transformative phase increasingly valuing knowledge derived from lived experiences and emphasising the importance of language in making sense of people’s dilemmas and how to negotiate these (BPS, 2015).

The terminology to differentiate between the professional and those who use services has seen rapid change in the UK’s healthcare context (the National Health Service (NHS)) and is reflected in a recently published principle within guidelines on diagnostic-based language use (BPS, 2015):

Table 1: Principle 2: Replace terms that assume a diagnostic or narrow biomedical perspective with psychological or ordinary language equivalents.

<b>Examples of language assuming diagnostic/biomedical perspective</b>	<b>Examples of psychological/ordinary language alternatives</b>
Patient	Client, service user, survivor, person with lived experience, expert by experience

Looking further afield, the Social Work profession offers additional considerations raising similar quandaries (McLaughlin, 2009).

*After reasoning with terminology, I encountered a dilemma. I initially wrote this paper using current accepted terminology, and it was on reflection that I*

*considered how these core words were defined: service and service user. It brought up interesting definitions and made me rethink my language use, even questioning the preference of user to patient (particularly as I have had helpful experiences with GPs). I wondered about the way psychological professions dissociated themselves from the terminology still commonly used in healthcare, thus, inadvertently creating a separation which may even perpetuate stigma in mental health.*

The main definitions are set out in Table 2:

Table 2: Dictionary definitions (Oxford University Press, 2017: <https://en.oxforddictionaries.com>)

Word	Definitions		
Patient	Able to accept or tolerate delays, problems, or suffering without becoming annoyed or anxious	A person receiving or registered to receive medical treatment	
Service	The action of helping or doing work for someone	An act of assistance e.g. Assistance or advice given to customers during and after the sale of goods. For example, the action of serving food and drinks to customers	Employment as a servant
User	A person who uses or operates something	A person who takes illegal drugs, an addict	A person who exploits others
Professional	Relating to or belonging to a profession	Worthy of or appropriate to a professional person; competent, skilful, or assured	Engaged in a specified activity as one's main paid occupation rather than as an amateur
Expert	A person who is very knowledgeable about or skilful in a particular area	Having or involving a great deal of knowledge or skill in a particular area	
Experience	Practical contact with and observation of facts or events	An event or occurrence which leaves an impression on someone	Encounter or undergo (an event or occurrence)

*On re-evaluating my terminology, I came to acknowledge that I struggle with definitions concerning people as they are invariably self-limiting*

Indeed, it has been suggested that inventing a new word could be a viable alternative (McLaughlin, 2009); thus, I have opted for descriptive language and shorthand. For example, for myself in a personal context at times I will be M – this stands for ‘me’ a person who is a ‘service user’, ‘carer’ and professional. For myself in a professional context I will use CPs, as this is the label of my profession; and for the paid professionals involved in others’ care, I will use ‘professionals’. I remain unsure about the words ‘service’ and ‘user’; even though I may use these I do this for pragmatic reasons. Throughout, I will forefront the importance of owning personal positions.

This paper will now consider a personal reflective narrative on a range of issues and tensions on dual positions before offering some concluding comments. The aim is to generate dialogue rather than to be *correct*. To aid the narrative flow, sub-headings will be used throughout.

#### **A Reflective Narrative:**

##### **Owning personal positions**

In the UK most people are registered with medical General Practitioners (GPs) and described as *patients*. Rarely do people question this terminology of our shared status; yet in the UK this belonging does not readily cross into psychologically-based services where different terminology is used – this is a place GPs can refer to when greater knowledge or time is required. Yet, whilst we may not all access psychological services, we all carry burden in our personal and/or professional lives; we all have childhoods, have experienced struggle, and with this have experienced psychological processes and responses to those experiences we face (Hayes et al, 2003). Nevertheless, from my own personal position I believe the ‘them and us’ experience is ever present in professional contexts through the way communication occurs between professionals and those who are referred to them. Indeed, other professions such as Occupational Therapy note an unwillingness to embrace greater involvement of those that use services suggesting this might be due to challenges that this involvement poses to professional identities (Wright & Rowe, (2005).

*Despite our best intentions, we should acknowledge that differing standards may contribute to disempowerment; with this occurring through our conversations about involvement of those that use services and our (un)willingness at times to recognise our or others’ personal worlds within professional contexts.*

It is fitting that these conversations are now occurring, for example, a recent acknowledgement that those using and providing services are not mutually exclusive groups (Butchard & Greenhill, 2017).

## Privilege

*When I reflected on terminology earlier I then wondered if it was all too easy to use the current politically correct term to enable us to show our compassion and understanding for others, emphasising our ability to place people on an equal footing; however, is using that terminology indicative of our ability to include and be equal?*

Considering (dis)empowerment further, within my profession privilege is often used to highlight power-based inequalities in society (Smail, 2004) and the differing positions between people. As one definition states, privilege is 'having a special right, advantage, or immunity granted or available only to a particular person or group'; another meaning is about acknowledging a special honour attributed to what one might do, or how one might work (Oxford University Press, 2017, <https://en.oxforddictionaries.com>).

Shared with many CP colleagues is the belief that, despite power differentials, creating environments that enable people to express unspoken experiences is an honour. Indeed, painful moments may be hard to say or hear and take courage to voice them; with the derived knowledge enabling informed decisions. Professionals in health services undertake training to listen to and facilitate ethically sound conversations ensuring boundaries, particularly relational ones, are paramount (BPS, 2018). By highlighting our commonality with pain and suffering, this indirectly states that we all occupy dual positions. This acknowledgement, over and above our ethical boundaries, enhances our therapeutic efficacy through our humanity (Lazarus, 1994). This is about acknowledging personal pain, whilst containing it; acknowledging therapeutic relationships, whilst maintaining friendship/romantic boundaries; and admitting the robustness/weakness of our knowledge base. Above all, it is about enabling open and compassionate dialogues between professionals, colleagues and those they work with.

*Personally, I have found myself in the position of having multiple meetings with professionals and educationalists. As I sit in those meetings, it is from my M position that I sit not knowing the content of the conversations those professionals have had about us, without us. Even when I directly ask they are invariably unwilling to say.*

So, whilst hearing the private inner-most thoughts of others in moments of their greatest need is a privilege, professionals are privileged in the special access they have to their own knowledge and private conversations.

### The privilege of privilege

To *feel* privileged to be a CPs is an honour yet to *be* privileged can immediately set people apart; environments, circumstances, health, education and knowledge may encourage division and position CPs in the 'us' category.

*Existing within a dual position means I am privileged to be able to access knowledge directly and promptly via my professional colleagues – a far cry from NHS contexts where people may never access a psychological assessment or may wait many months for one and sometimes 1-2 years for the intervention; then, most interventions are time limited or non-existent. They are left with accessing information via websites or social media amongst other sources.*

So, within dual positions our conversations and access to knowledge can differ and, on a personal level, poignant yet repeated experiences relate to communication processes of speaking up, silencing or feeling (un)heard (Keville et al, 2010). This process can be empowering or disempowering whatever side of the divide one is on.

*Whilst this is conjecture, when I have conversations about my child with professionals, there are sometimes shifts or escalations in their stance indicative of private conversations that occur between my own meetings with them without me; this makes it appear that they do not openly share why they have shifted that thinking. For example, on one occasion one meeting and subsequent phone call acknowledged an understanding of my child's complex health needs and, thus, absence from school. In the next meeting I walked into a room facing a wall of professionals, some unbeknownst to me, the space remaining for me was facing them – this positioning made me feel as if I was facing an inquisition. Earlier understanding was replaced with an escalation to reintegrate my child back into school despite the impact this had on their physical health. As a professional I am privy to those behind-the-scenes professional discussions; as a parent, when they remain unheard to me, it is a strange and uncertain place to be. It is from this position that I teach trainee CPs to be mindful of what it might feel like being on the other side of the divide and I use my personal experience to add meaning to that message.*

Indeed, it can be disempowering as a parent disentangling advice for the benefit of one's child, from advice that benefits an organisation.

*As I experience exclusion from wider discussions both as a parent and a professional, being a professional who has personal experience is humbling.*

Thus, to enhance the decision-making process it makes sense that the views of those using services are increasingly forefronted in policy making; and to train professionals to consider this from the outset.

### **Influencing the decision-making process**

Globally, mainstream educational settings are large organisations that require common pathways to function effectively; however, not all children fit into these pathways or

frameworks. Complex needs coupled with communication difficulties may mean gaps in knowledge both for the child and those tasked with caring for them; consequently, appropriate understanding and care can be hard to attain.

*We all know the metaphor of fitting a square peg into a round circle – there is no great fit there. Nevertheless, this can be achieved if there is awareness of needs and flexibility within the circle or square. However, fit can be difficult or impossible if, underpinning adherence to policy, there is misunderstanding, lack of knowledge, or an inability for professionals to hear or communicate with carers.*

Whilst it is commendable that many services currently give carers and children opportunities to state their views and influence the decision-making process in the UK, stretched services, professional beliefs about what is best and a lack of understanding of the needs or abilities of the child can sometimes mean this is an unachievable ideal. The CP profession has good intentions and compassion that is stretched to capacity by the scale of need and lack of resources (Nutt & Keville, 2016). This tension can impact on what ‘them and us’ means and how we, as a profession, talk about that divide.

### **The Professional and Me**

The UK CP professional body wants to ensure diversity and equality in the profession (BPS, 2016); indeed, this is a ground-breaking strategy to encourage equality and inclusion across populations. In its policy statement, the focus of diversity areas is as follows:

*‘Clinical psychologists.....will not discriminate against anyone in terms of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, social status, or any other grounds.’ (BPS, 2016, p.10).*

Clearly the CP profession in the UK is inclusive on these broad grounds with an open caveat of ‘any other grounds’. However, separately to these groupings is the experience of health and care.

*Having read these documents and sat in meetings with CPs colleagues I do not believe we have crossed that divide and properly owned that Ms come from within and that we can be them.*

Whilst there is acknowledgement of the importance of enabling ‘service user’ involvement through organisational and policy levels (Bee et al, 2015) there is minimal consideration of the dual relationship between the professional and ‘service user’. Indeed, within CP, the tone of the BPS (2016) document fosters a ‘them and us’ separation such that there are those that work *in* services (‘members’, BPS, 2016, p11) and those referred *to* them (‘service users and carers and other experts by experience’ (BPS, 2016, p11)). Thus, in terms of service



development, recruitment and research, whilst the term co-production (Voorberg et al., 2014) is now commonly used to explain partnerships influencing policy making between those that use services/carers and professional staff, those in explicit dual positions are minimally acknowledged. To truly cross the divide for inclusivity and equality and influence policies, we must openly acknowledge and listen to Ms *within*. To enable this, perhaps we must first acknowledge differences in accessibility to knowledge between these two positions and this will now be considered.

### **Empowering the disempowered**

*Since qualifying I cannot help but wonder just how privileged I was to be within my profession and utilise the knowledge and skills I had gained to manage my own life. It was not a conscious driver to becoming a CP but it was a welcomed outcome.*

Disempowerment tends to occur in marginalised groups or for those in less powerful hierarchical positions (employer-employee; service user-professional; parent-child; have-haves). Yet, what about those in explicit dual positions, and thus, on both sides of a professional-personal context?

*Experiences of disempowerment form a repeated occurrence within my daily personal life - the impact of this inevitably ripples into my professional life. For example, I have been open at work about my personal circumstances, yet on one occasion I was struck by the lack of connection between service user/carer involvement (not to have it on that occasion) and my own openly acknowledged personal position. It seemed obvious to me, just cross the divide and ask and you will have some input from a carer! Previous experiences meant I did not share this at that point, and it also led me to conclude that my own personal circumstance was easily forgotten; when I advocate for an M perspective the two positions are not readily connected in my colleagues' minds, thus, from my personal experience remaining unheard forms a common experience. This inspired me to write this paper, probably as an antidote to the overwhelming (doubtless unintended) disempowerment that washed over me in that moment.*

This experience is a common one for those who use services likely fuelling co-production (Voorberg et al., 2014). The value of hearing personal perspectives is, understandably, a big driver for ensuring the voices of those using services and carers are represented in policy making and staff/training appointments.

*Whilst I understand contexts of work pressures dampen the ability to hear, I still do not expect to experience this in my professional world, an experience I repeatedly have despite best intentions. Yet, it helps me to see just how easy*

*it is to say we value M voices when we may not always have the capacity to hear that voice, for whatever reason.*

Indeed, there is complexity in having dialogues about personal issues for the CP professional as it is not appropriate for professionals to highlight their own vulnerability when there is a greater need within those referred. Yet, inconsistent provision of genuinely safe, professional spaces for these dialogues may be one factor perpetuating the 'them and us' divide.

### **Conversations about us, without us**

As a means of opening a dialogue about the tension between personal and professional positions I have attempted to reflect on my own experiences. One aspect that particularly reverberates is the way we communicate on these issues.

Already raised, there are many occasions when conversations occur just between professionals.

*It is from my professional position that I know there are conversations that happen about us, without us. I hear professional conversations from multiple sides; on one side are my colleagues, trainees and students aspiring to be CPs. On another, I attend referral meetings, supervision, or have phone conversations with other professionals that occur beyond the hearing of those we talk about; and on another side, GP appointments aside, I feel unheard professional conversations (medical, psychological and educational) sensed through the way interactions transpire between me, as a parent, and the professionals. For example, on 2 occasions I have had a surprise home visit or an email from one professional following an earlier phone conversation from another. The sense I have is professionals may have other intentions to those shared, indicated by almost dramatic shifts with no preparation or signposting. It is not about having those conversations, it is the lack of transparency, understanding and openness that occur with them.*

These conversations may happen for practical reasons or for a wish to understand and enable; or because of an unwillingness to speak openly; or perceived boundary issues applied overzealously (Lazarus, 1994); perhaps they might also reflect hidden opinions deemed inappropriate or technical conversations that may appear impersonal or dense.

*Whilst these hidden conversations might be about the service and time demands placed on professionals, from an M position it makes the journey lonelier and harder, especially when developmental demands for children and unknown issues prevent the access of appropriate care to enable people to reach their potential.*

There may also be an underlying driver to this sense of not knowing that might be based on a tension between what is 'known' through experience (personally or professionally) and what is 'known' through one's knowledge base or professional colleagues. Underlying this tension, and a domain professionals may find harder to acknowledge, is the realm of what is unknown, and this will now be explored.

### **A gap cannot bridge a gap**

*It is within this context of experienced and un-experienced knowledge that I find myself.*

Despite our professional training and personal life experiences perhaps we are unable to truly understand the contexts of others whom we do not know, or deeply understand experiences we have not actually experienced. This leads us into the realm of the *un*-experienced and this can make us *in*experienced. To prevent beliefs attained through psychological knowledge blinding us, it is crucial we acknowledge this. Thus, bridging the divide is essential, and those in dual positions might be useful in naming this.

Whilst knowledge accrued via professional training and work may enable us to fill gaps and fulfil the competencies of our profession we are unlikely to have in-depth knowledge in all areas and may have superficial or no knowledge across some areas. Whilst gaps in knowledge may be filled through training, research, attending conferences or reading, there are so many advances in psychological, neurological and medical knowledge that we may not keep abreast of everything, particularly in a field as diverse as CP.

*I have developed the understanding that sometimes we have little or no control over the direction we end up taking despite our best efforts – once our children are in the care of others in non-home environments, the impact of these stimuli can sometimes be more influential on well-being and development than parental or carer influence. On my personal journey, my deepest knowledge was not accessible through mine or others' professional world(s). Instead it has come from personal experiences alongside my family's, my child's and other parents' (of children with disabilities) experiences.*

Yet it is more than accessing knowledge; whilst we can acknowledge that we suffer too (Allan and Hill, 2017), perhaps it is more than this.

*It is about courageously showing our vulnerabilities about not having the answers at the time of our greatest need and I believe that is hard for the professional to do. Indeed, how willing or able would we be to seek support via a public referral process if we could choose not to? As professionals it is crucial that we openly acknowledge our personal experiences and positions alongside understanding our own gaps in knowledge and expertise – a gap (in this context inexperience) cannot bridge a gap. For this we need learned*

*knowledge and/or awareness derived from personal honesty. This does not always need to be openly disclosed, just personally acknowledged. I believe it is this honesty that enables us to honour our and others' humanity.*

Indeed, therapists' awareness of how their background and character impacts on interactions can improve effectiveness (Wampold, 2011). However, despite burgeoning literature acknowledging the 'self' in the professional context, for trainee CPs there are fears and dilemmas about the acceptability of bringing a personal self into the professional domain (Woodward, Keville & Conlan, 2015). In Woodward et al.'s study it was apparent between trainee CPs and supervisors. Yet for all of us, we come from a personal world that existed before we entered the professional world; when we enter that world it exists alongside us, and when we exit training it coexists beyond. This personal world may include experiences of using clinical services. In society stigma in the context of mental health (Corrigan, 2004) may have been personally experienced - by ourselves, our families, or our friends. Experiences of others' misunderstandings and judgements may impact on our willingness to have open dialogues regarding our own personal use of services. As professionals it is for us to embrace the parallels that personal contexts hold with our professional worlds; for example, Hawker (2017) openly acknowledges obtaining an autism spectrum diagnosis, after gaining his CP qualification.

### **How can we integrate us with them?**

To bridge this gap, we can provide the building blocks from the bottom up of our profession, as with the approaches used in Learning Disability services (Roberts et al., 2013) and co-production. For example, by clarifying areas that incorporate 'any other grounds' in the equality and inclusion categories (BPS, 2016, p10) by openly naming psychological well-being. The aim is to connect *them* with *us* by explicit acknowledgement of the commonality in our diverse experiences and the range of psychological responses we use to manage them. Furthermore, understanding that neurodevelopment, physical health, physiological and psychological responses to suffering indiscriminately cross economic, ethnic, cultural, social and political domains can enable us to gather on the side of shared suffering.

Whilst I argue for acknowledgment of a commonality between professionals and those who use services it remains important to maintain personal boundaries alongside recognising how pervasive and damaging poverty and consequent economic, social and emotional deprivation can be for well-being and achievement (Smail, 2004).

*Thus, despite being an M, I must still acknowledge my own privilege which enabled me to access the appropriate support and education to gain knowledge and employment. Above all I had the privilege of health which enabled me to stand:*

*Where the rivers change direction  
Across the Great Divide*

(Kate Wolf, *Across the Great Divide*)

*It was there I could thrive rather than flounder with a life course that protected and enhanced my resilience rather than debilitated me. Yet, life and health are not always so kind, even with privilege, and as an M co-existing in a professional world, I still experience exclusion. I may also contribute to this; even if it is unintended, the experience of it remains the same.*

As a means of opening a dialogue I will now consider exclusion as a potential outcome from the separateness that exists between these positions.

### **Acknowledging the ease of exclusion**

To facilitate conversations, it is crucial we compassionately admit our own (in)ability at times to enable people to connect. Being included is a privilege and the process of exclusion can often be socially driven – via the groups we belong to, the connections we make outside of those groups, the conversations we have with people, the eye contact we make or the willingness we have in approaching and including people in our interactions.

*In my own experience of using services, I would say many people can sense if those hidden professional conversations occur through a desire to understand or from judgement or simply from not knowing what to say. With any of these responses, if on the other side, one can feel included or excluded.*

Whilst it may be hypothesised that people who feel excluded may be oversensitive, misinterpreting dynamics negatively, as professionals we do have a significant role in addressing this. It is our responsibility to follow up meetings or answer direct questions - particularly difficult ones – with honesty. This would include acknowledging gaps in our own knowledge and a willingness for the professional to reach out and connect through compassionately understanding people's struggles over and above their own. In hierarchical dyads, this would involve transparency. This is pertinent in carer/cared for dyads, where the needs of the carer must be considered alongside the needs of those they care for – after all, it is the carer that often cares for and fights for the physical, psychological and emotional wellbeing of those they care for, sometimes 24/7.

*If consideration of the burden of caring for those with additional health needs cannot even happen between colleagues when personal worlds enter the professional world then, in my experience, we are speaking the speak rather than walking the walk and, thus, organisational intentions and inclusion of perspectives from those who use services is likely to be tokenistic.*

Thus, it is crucial that we acknowledge our limitations, and this will now be considered.

### **Acknowledging and understanding limitations**

Given that we all want to believe we are doing a good job, just looking at our own experiences highlights differences in understanding, listening, hearing, helpfulness, knowledge, explanations or punctuality.

*As a professional I must accept that I have been experienced in ways I had not intended. For example, when I have not had knowledge (and did not realise that gap) to properly understand a presenting issue*

Given diversity we must expect misunderstandings derived from our own or others' inexperience and language barriers – how language and meaning is constructed may differ and we might not always know if we are using language in the same way and with the same intent and purpose (Hems, 1977). Thus, as professionals it is crucial that we listen beyond our own personal barriers and allow those in vulnerable positions to articulate and say what they need to say even if we may perceive this to be 'wrong', 'unfair' or 'judgemental'. It is also essential we do not delve into potentially abusive scenarios and, so, enable private and confidential communications between professionals to prioritise the needs of those in more vulnerable positions. This is where our colleagues become vital through the process of supervision, reflection and peer support. It is in these conversations that we can embody compassionate, thoughtful reflections to help us maintain compassionate, professional interactions with others. If the system is too stretched, this can result in burnout for professionals, and may be a factor for those facing difficult work place situations who may, in turn, feel unheard (Lewis, 2005). Thus, it is crucial we understand the needs of our work colleagues; acknowledging we may all exist on the same continuum could be one way of ensuring we work collectively. However, as the very nature of the profession exists within the realms of theory and practice this may inadvertently create and/or maintain a divide as we psychologise others and shirk from others psychologising us.

### **Psychologising normal experiences and processes**

Psychologists constantly devise models to explain psychological processes; in the clinical setting this can enhance understanding and improve effectiveness in interventions. However, some aspects can feed into a 'them and us' perspective inadvertently implying that only the *afflicted*, aka 'them', experience life in this way. At its worst it can infer personal or familial responsibility (nature or nurture) in the aetiology and/or maintenance of distress. This can be particularly true in the communication of ideas from novices as they begin to learn and articulate psychological theories and philosophies.

*When I was reflecting on this separation I recalled a chapter called 'Them and Us' in *Madness Explained* (Bentall, 2003). On re-viewing it I realised this ground-breaking book did not fully break down barriers between professionals and those referred to services in the way I had recalled; the concluding*

*sentence stated '.....it would almost certainly make the world a better place for mad and ordinary people alike.' (Bentall, 2003, p512). Despite our best intentions, by using dichotomous terms, we separate people into groups: we are 'mad' or 'ordinary'; a 'member' or 'service user'.*

Given this dialogue it is crucial that we break down barriers and *walk* more fully than we have walked before.

### **We respect by listening and accepting**

If we are to walk with others in this way, the way we listen to and hear people is crucial. Yet styles of communication may differ between professionals and those who use services. We must remember silences or non-acknowledgement of what has been said or disclosed can be interpreted as ambivalence, judgment or withholding (Back, Bauer-Wu, Rushton, & Halifax, 2009); a consequence in many human interactions. Even more subtle behavioural responses to what we might say can have far reaching consequences. For example, a lack of eye contact or long pauses can be interpreted as disinterest (Leach, 2005). Core skills in therapeutic conversations may not be so readily transferred or utilised in colleague interactions; being interpreted as psychologising or personalising our colleagues by highlighting vulnerability and potentially questioning resilience in the face of life events; a belief perpetuated in the way mental health is viewed in professionals' work. For example, one paper discussing therapeutic boundaries, indiscriminately stated that having a 'mental illness' impaired the therapist (Simon, 1992, p275).

Thus, communication between those who use services and those working within them may differ in the way they are interpreted and understood. By acknowledging our commonality and differences we may more readily understand and accept our positions. Communication is not always about agreeing, it is about encouraging open and honest dialogues and with this enabling and allowing true difference to co-exist, providing real and diverse opportunities for learning and understanding.

### **So, whose needs do we listen to and meet?**

This is an even trickier dilemma as it is about crossing that barrier; it involves listening to ourselves and those around us on multiple levels to create a space where an honest dialogue exists. Thus, it involves deciding whether we share our own personal histories with colleagues. If we do, it puts us in the firing line of peer judgements; trainers considering our resilience and boundaries to undertake training; our employers wondering about our professional suitability; and our own personal comfort zone in sharing experiences (Keville et al, 2010) where our personal history may be forever remembered by others in their way rather than ours.

In our profession one of the key features that all training programmes must promote is:

‘Deepening collaborative practices with service users and carers (including in ways informed by DCP good practice guidance on the involvement of service users and carers in clinical psychology training)’ (BPS, 2016, p.19)

As a profession we must demonstrate the ability to collaborate through co-production with people who use services and carers in advancing psychological initiatives such as interventions and research; dialogues such as this may be crucial in that process. It is important we shift from a ‘them and us’ culture and acknowledge that we may become *them* and they may become *us*. Viewing *us* in these circular terms where we can acknowledge similar destination points despite differences in the journey may enable honest dialogues, break down barriers, and build bridges across a divide that may have seemed unbridgeable despite rhetoric and desire.

### **Concluding comments: Respectful dialogues and respecting experience**

To navigate this boundary a solution may lie in striving towards humanity. As professionals this means embracing the complexities that lie within and between us. It means reaching beyond our own personal needs to enable others to exceed their potential. It also means being aware of a propensity for professions to transform ‘well-intentioned ethical guidelines’ into ‘destructive prohibitions... undermining clinical effectiveness’ (Lazarus, 1994, p255).

In CP this means listening and enabling all to feel heard, particularly those in marginalised groups whose very existence may lie in the realms of the unheard and unseen. Indeed, this could be attained through co-production (Voorberg et al., 2014), and enabling CPs who explicitly inhabit both spheres to speak out.

The embedding of perspectives in all aspects of policy making is seeing a tidal wave, shifting the focus from ‘them and us’ towards a sense of togetherness. As humans one of our greatest tools for achieving this is through language and communication. However, it is a process of negotiation that requires mutual understanding, flexibility and respect. This takes love, compassion and tolerance for the plight of others and the differences that emerge.

To conclude, one way this might be achieved is through music and songs:

*Music has played a significant role in the way it names and processes my experiences and emotions.*

Through experiential learning methods in training CPs, music can be connected to typical CP referral letters to convey a person’s lived experience and emotional story (Keville et al, 2018). One vignette devised in 2009 told the story of loss in early life and disconnection in later life via Lucy Kaplansky’s ‘For once in your life’. With permission from Lucy Kaplansky this song was played to 18 UK based trainees and CPs. The tears that emerged within and between people that day emerged because of the music; those tears formed the river that connected



both sides. Sometimes crossing the great divide requires a connection that exists beyond language and beyond our singular personal and professional positions.

The finest hour that I have seen  
Is the one that comes between  
The edge of night and the break of day  
It's when the darkness rolls away

Kate Wolf, Across the Great Divide

## References

- Allan, S. and Hill, E. (2017). Bringing together psychologists and the public: the challenges and opportunities of a Division of Clinical Psychology branch involvement initiative, *Clinical Psychology Forum*, 294, 4-8
- Back, A. L., Bauer-Wu, S. M., Rushton, C. H., & Halifax, J. (2009). Compassionate Silence in the Patient–Clinician Encounter: A Contemplative Approach. *Journal of Palliative Medicine*, 12(12), 1113-1117
- Bee, P., Brooks, H., Fraser, C. & Lovell, K. (2015). Professional Perspectives on service user and carer involvement in mental health care planning: A Qualitative study. *International Journal of Nursing Studies*, 52, 1834-1845
- Bentall, R.P. (2003). *Madness Explained. Psychosis and Human Nature*. Penguin Books: London
- British Psychological Society (2015). *Guidelines on Language in Relation to Functional Psychiatric Diagnosis*. BPS: Leicester
- British Psychological Society (2016) *Inclusivity Strategy 2016–2018*. Division of Clinical Psychology, BPS: Leicester
- British Psychological Society (2018). *Code of Ethics and Conduct*. BPS: Leicester
- Butchard, S. & Greenhill, B. (2017). Human rights: Giving clinical psychology a backbone. *Clinical Psychology Forum*, 289, 8-14
- Chamberlin, J. (2005). User/Consumer involvement in mental health service delivery. *Epidemiologia e Psichiatria Sociale* 14(1), 10-4
- Corrigan, P.W. (2004). How Stigma interferes with mental health care. *American Psychologist*, 59(7), 614-625

- Hawker, D. (2017). Practising Clinical Psychology on the Autistic Spectrum. *Clinical Psychology Forum*, 294, 9-13
- Hems, R. (1977). New Possibilities. Conference presentation. ITT Fluid Handling Sales Conference, Majorca, September, 1977
- Keville, S., Nel, P.W, Jeffrey, S., Ford, D., Leggett, S., McCarney, R., & Uprichard, S. (2010). In the eye of the storm: Should I stay or should I go? Reflections on the middle phase of a problem-based learning group. *Reflective Practice*, 11(5), 669-680.
- Keville, S., Nutt, K., Brunton, I., Keyes, C., and Tacconelli, E. (2018). So many lifetimes locked inside: reflecting on the use of music and songs to enhance learning through emotional and social connection in Trainee Clinical Psychologists. *Reflective Practice*, 19(3), p1-13. DOI: 0000-0003-2401-5226
- Lazarus, A.A. (1994). How Certain Boundaries and Ethics Diminish Therapeutic Effectiveness. *Ethics & Behavior*, 4(3), 255-261
- Leach, M. J. (2005). Rapport: A key to treatment success. *Complementary Therapies in Clinical Practice*, 11(4), 262-265
- Lewis, S.E. (2005). Women's experiences of workplace bullying: changes in social relationships. *Journal of Community and Applied Social Psychology*, 15(1), 29-47
- McLaughlin, H. (2009). What's in a Name: 'Client', 'Patient', 'Customer', 'Consumer', 'Expert by Experience', 'Service User' —What's Next? *British Journal of Social Work*, 39, 1101-1117.
- Woodward, N; Keville, S. & Conlan, L. (2015). The buds and shoots of who I've grown to become: the development of reflective practice in Trainee Clinical Psychologists. *Reflective Practice*. Volume 16, Issue 6
- Oxford University Press (2017). <https://en.oxforddictionaries.com>
- Roberts, A., Townsend, S., Morris, J., Rushbrooke, E., Greenhill, B., Whitehead, R., Matthews, T. & Golding, L. (2013). Treat me right, treat me equal: using national policy and legislation to create positive changes in local health services for people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 26(1), 14-25
- Simon, R.I. (1992). Treatment Boundary Violations: Clinical, Ethical, and Legal Considerations. *Journal of the American Academy of Psychiatry and the Law*, 20(3), 269-288
- Smail, D. (2004). Therapeutic psychology and the ideology of privilege. *Clinical Psychology*, 38, 9-14

Voorberg, W.H. Bekkers V.J.J.M. & Tummers L.G. (2014): A Systematic Review of Co-Creation and Co-Production: Embarking on the social innovation journey, *Public Management Review*, 17(9), 1333-1357

Wampold, B. E. (2011). *Qualities and actions of effective therapists*. Retrieved from American Psychological Association Education Directorate:  
<https://www.apa.org/education/ce/effective-therapists.pdf>

Nutt, K & Keville, S. (2016) '...you kind of frantically go from one thing to the next and there isn't any time for thinking any more': A reflection on the impact of organisational change on relatedness in multidisciplinary teams. *Reflective Practice*, DOI:10.1080/14623943.2016.1159552

Wright, C. & Rowe, N. (2005). Protecting Professional Identities: Service User Involvement and Occupational Therapy. *British Journal of Occupational Therapy*, 68(1), 45-47