Understanding power in order to share hope: A tribute to David Smail

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The psychological consequences of poverty, abuse and discrimination are palpable and debilitating, and clinical and community psychologists are in a position to represent this in our research and practice. We can account for how economic, social and organisational inequalities and deprivation influence communities and individuals, and understand how social processes can be undermining and also how they can generate resilience. We can also use our resources to work with others actively and publicly.

While recognising that psychological interventions are inherently limited and problematic, I would like to suggest that they may share hopeful ways forward with individuals, organisations and communities. Acknowledging and understanding the overwhelming physical and emotional consequences of the misuse of power can be a validating process that generates collaborative alliances. We can draw on David Smail's framework for analysing people's proximal powers in the context of distal forces to consider the scope people have to act individually or collectively, and to be open about the limitations and potential of psychological interventions.

I HAVE VALUED David Smail's interest and influence in my working life since meeting him as an undergraduate over 30 years ago, and I have also appreciated his significant impact on clinical and community psychology. He always insisted that those who worked with him in the Nottingham Department of Clinical Psychology accounted for our views and practice through presenting and discussing our work. It is important to continue this discipline. So, in this paper, I aim to illustrate how I have used David's analyses of the role of proximal and distal powers to inform my work in mental health and community settings. While psychological practice can be problematic, and may undermine and further pathologise individuals and communities, I aim to show that it can share hopeful ways forward. The potential for benign impact depends on taking account of how power is brokered within and beyond people's individual lives.

David's work suggests particular tasks that we should seek to address:

- To understand how experiences of wellbeing and distress are linked with the operation of power.
- To share understanding and 'outsight' as a means of furthering personal and social change.
- To act with common humanity and compassion to 'mitigate suffering in others as in ourselves' (Smail, 2004).

Understanding how experiences of wellbeing and distress are linked with the operation of power

Understanding our experiences of wellbeing and suffering requires the analysis of our current and historical access to power and resources. We are affected by where we are located in hierarchies of status, and our social positions are defined by such conditions as our class, gender, age and sexuality, as well as the status of our employment or whether we use mental health services, or live in a particular area. Power may be used benignly or maliciously and, confusingly, it may not be immediately apparent to us how power is being deployed now or in the past.

Powerful influences operate at different distances from us and are well represented in David Smail's *Impress of Power* (1996). For example, we are all affected by cuts to funding in public services that are decided in Whitehall. The impact is felt through redundancies, job changes or important services becoming unavailable. The consequences of a policy change are dealt with and experienced locally to us via managers or local service providers, and it is often these more proximal players who affect our wellbeing.

Richard Wilkinson's work (2003; 2004) links the universally consistent findings of inequalities in health outcomes with the following: low social status (which is experienced more negatively in proportion to the extent of income inequality); weak social affiliations and poor social support; and childhood adversity. We can combine David's social-materialist and Wilkinson's psychosocial analyses to develop accounts with people about prevailing influences on community and individual wellbeing.

To do this, we need to consider: (1) **public and personal status** often signified in individuals' age, class, gender, race, mental health status, and their social position in their families; (2) **access to a range of resources** that Hagan and Smail (1997) have mapped out and which include past and current access to support, control, education, physical health assets, psychological resources (such as problem-solving skills); and finances; and (3) **exposure in the past and currently** to life events, long-term difficulties, and critical incidents that put pressure on individuals.

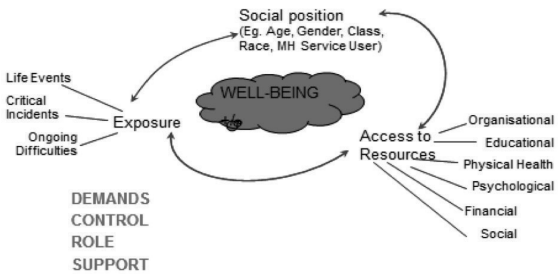
Occupational psychology research has revealed key characteristics of our environments that, if present, reflect high levels of wellbeing and functioning in organisations, e.g. employment demands, how much control we can exert, the clarity and value

of roles we hold and access to support (Health and Safety Executive, 2005).

The three elements of social position, access to resources and exposure to adversity (Figure 1), are linked. Poverty affects our status, our access to sources of support, and the likelihood of ourselves or those around us experiencing pressures such as health crises. The more stratified and unequal we are, the more potent the effects of disadvantage. Aspects of our status affect our access to a range of educational, cultural, occupational, social and economic resources, and the quality of our contact with others. Social solidarity is threatened in a society where people are set against each other, particularly those who are less advantaged. For example, political and media messages amplify divisions between poor, employed people and those who are poor and unemployed.

In seeking to highlight the impact of inequality and poverty, we need also to understand that people sense and react to injustice, both material unfairness and discriminatory attitudes. We compare ourselves with others, particularly those who are visible to us. Loss or threat to status affects us, as does the sheer drudgery of trying to live on insufficient money with the endless challenges this brings, such as not being able to buy clothes for the children, not being able to entertain the children's friends, not having a smart set of clothes to go to a job interview, or not being able to fix an electrical appliance when it breaks down. Not being able to do the things that other around us are doing is powerfully undermining.

Figure 1: What influences our wellbeing?



In 2015, 39 per cent of families in the UK were living below the poverty line, and the percentage of adults whose income is below 60 per cent of median income has increased despite net disposable income reducing (Marmot, 2015). We need psychological approaches that appreciate the scale of the challenge of coping with ongoing hardship and restricted opportunities, and address the associated difficulties.

Five key questions that are pertinent to initiating and evaluating social and psychological interventions emerge from David's work (1993, 2004, 2005):

1. What resources are available to this person/family/community?
2. What material, social and economic power is accessible to them?
3. What are their experiences of organisations, services and systems?
4. What possibilities for change are afforded by their situations and environments?
5. In whose interests is this intervention? Will potential change for this person be affected by the interests of others?

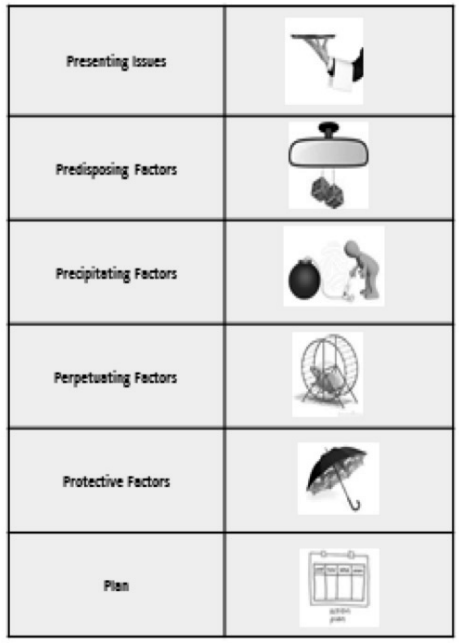
These questions can orientate our work with individuals and communities. They urge us to look from the outside in to gauge the scope for people to act on their situations.

Sharing understanding and 'outsight' as a means of furthering personal and social change

In mental health services, psychologists often seek to influence practice that tends to individualise and medicalise distress. Promoting formulation as a process of sharing understanding can help people consider the possible origins of their distress and options that may be open to them (Johnstone & Dallos, 2014).

In adult community services in Northumberland Tyne and Wear NHS Foundation Trust (NTW), we have suggested that formulations should be directly undertaken with service users and those multidisciplinary staff involved with them, and we have called our approach to formulation the 5Ps+Plan. This incorporates an understanding of: Presenting issues; Pre-disposing factors; Precipitating factors; Perpetuating factors and Protective factors, followed by a Plan of who is going to do what and when.

Figure 2: 5 Ps + Plan.



Using formulations with service users is a way to improve the quality of community mental health services. One advantage of a formulation-based approach is that it can accommodate different theoretical approaches and multidisciplinary perspectives.

In order to facilitate the incorporation of formulation in routine practice, a programme consisting of two half-days of training is being rolled out across all six localities in NTW which include services for adults, older adults and people with learning disabilities. So far, we have completed the full training with 265 staff. The two half-day training sessions have been well received and 60 per cent of the participants have said that they have since tried using 5Ps+Plan formulations with a service user.

In the training, we discuss how exploring formulation can improve our alliances with service users and their families in order to promote effective interventions and helpful outcomes. The 5Ps+Plan offers a consistent format which draws on individuals' strengths and needs, to aid communication and planning across pathways. We also outline what formulation is not, for example a list of symptoms or goals, a summary of the past, or static and unchangeable.

The 5Ps+Plan aims to enable a formulation to evolve in partnership with the service user to inform a shared understanding of current issues, and agree goals which inform intervention plans. A number of staff have identified themselves as 'formulation champions' and are keen to develop and progress the work meaningfully.

Service users have strongly supported and influenced this work, and the 5Ps+Plan training has been produced with service users who also co-facilitate the training. Inevitably, in delivering the training and supporting materials, there are biases to address, such as being very problem-focused, or assuming that 'pre-disposing' issues suggest an inevitable individual determinism in the onset of difficulties. However, in some practice we find that the repercussions of historical trauma are underestimated, and we are assuming that a sensitive formulation process that includes reference to past experiences enables a more empathic and compassionate understanding from staff and service users themselves.

We plan to continue to roll out the formulation-based approach and training, and to encourage live supervision of formulation discussion in Pathway meetings with reference to a checklist which emphasises the engagement and involvement of service users; describing their strengths, validating their concerns, considering the possible impact of trauma and abuse, suggesting how interventions may help or hinder, and being sensitive to ongoing pressures in their lives. We are planning to further evaluate the impact of this work from service users' perspectives.

This quote from Albert Einstein about formulation captures what I think we can achieve through adopting a meaningful and enquiring formulation-based approach:

> *The mere formulation of a problem is often far more essential than its solution, which may be merely a matter of mathematical or experimental skill. To raise new questions, new possibilities, to regard old problems from a new angle requires creative imagination and marks real advances in science.* Albert Einstein, 1938.

To act with common humanity and compassion to 'mitigate suffering in others as in ourselves' (Smail, 2004).

People's histories cannot be unlived, but the effects can be ameliorated according to the resources that are available to them. A psychologist's job is to identify the potential for individuals and communities to act on situations and for power dynamics to shift. David instigated the innovative blend of clinical and community psychology roles which developed in Nottingham in the 1990s which enabled clinical psychologists to work with others and have an active presence in local communities (Fatimilehin & Coleman, 1999; Fenner, 1999; Melluish & Bulmer, 1999). Local participative action research about the community and GP practices generated ongoing support groups and a network of campaigning groups, such as for the development of a play area (Bostock & Beck, 1993). This work was collaborative but such work always risks the charge of colonisation by clinical psychologists. Although our practice improves with more outward-facing roles, we need to be mindful of imposing psychological frameworks on communities (Orford, 2008).

A participatory approach to research set the scene for later work in Northumberland which involved young people working to improve their services (Bostock & Freeman, 2003); work with voluntary agencies and women who had experienced domestic abuse (Bostock et al., 2009); and a qualitative study of influences on wellbeing in a particular locality (Bostock & Ridley-Dash, 2008). We also developed a wellbeing programme which had a positive impact on the attitudes of fire-service managers to mental health, and generated suggestions for improvements to the working environment (Moffatt et al., 2014).

Qualitative research with women living in rural Northumberland who had experienced domestic abuse, identified how various systems reinforced abuse through ineffective protection, failing to address the women's fear associated with abuse, or take account of the emotional and financial costs of leaving abusive relationships. Crucially, service providers also did not recognise the unacceptability of abuse. Services which took the victim's side, offered a common bond (by offering solidarity and a chance to learn from others in similar situations), and made effective, practical help available, enabled the abuse to be challenged. But the effects of the abuse were often long-lived and pervasive, and influenced later experiences of relationships with children, partners and friends.

This research was used to inform workplace wellbeing policies about domestic abuse and as part of a regular training programme run by the local authority. It was also used as the basis of a self-help booklet, and is a specific topic in a suite of booklets concerned with general mental health problems.

The Psychologists Against Austerity initiative is an inspiring example of community activism by psychologists. In their briefing paper, they identify the indicators of a healthy society as providing opportunities for agency, security, connection to others, meaning and trust (McGrath et al., 2015). These indicators give a good basis for promoting societal change, as well as highlighting the damaging effects of current economic policies. This is a refreshing alternative to the usual focus of psychology which tends to be on individual psychological therapy.

Encouragement to act for individuals means understanding the balance between agency and lack of control for people in constrained situations. This is central in David's writing and is a core dilemma for psychologists.

We continually underestimate what we need to overcome abusive or traumatic situations – the physical stamina and good health, the recognition of demands and threats, social skills, being able to voice one's thoughts and express one-self clearly, self-belief, a composed appearance, practical and emotional support, money and doggedness. Even all these resources are of limited effectiveness in the face of persistent material disadvantage and ongoing abuse, injustice or discrimination. Generally, the resources we have can be deployed and sustained only if there are sufficient supportive people around us in our private and public lives who also have some resources and authority to share. We need 'fertile soil in order to thrive' (Perkins, 2015), and where people have robust connections to others who rate and support them, they are much more likely to find ways forward through adverse or traumatic situations.

The public generally, and clinical psychologists in particular, overestimate the power of individual therapy to help people overcome the psychological legacies of historical disempowerment and marginalisation that are often exacerbated by current pressures. We cite evidence-based practice, yet seem to ignore that even in trial-based therapy, average recovery rates are 58 per cent and therapists tend to be over optimistic about their impact (Lambert, 2011). But I take a more compromising view than David's about the potential for psychological therapy and psychologically informed interventions to be hopeful and helpful with individuals. Service users respond to the chance to establish trusting relationships, a shared understanding of the tasks of the intervention, and agreed therapy goals. Approaches that are structured, collaborative, consistent, validating, motivating and encourage self-observation are linked with more favourable outcomes (Castonguay & Beutler, 2006).

Enabling socially and psychologically informed practice needs to take a broader view than formal branded therapies. In my experience, service users, mental health practitioners, and community and clinical psychologists can draw on some established therapies (Gilbert, 2009; Ryle, 1990) These can inform specific interventions in mental health settings and can take account of the power imbalances that I have outlined.

Cognitive analytic therapy offers the concept of reciprocal roles and patterns of relating that can help people define in their own terms the positions that they and others take (Ryle, 1990). These may put them in constrained or more empowered relationships, and naming them can illuminate some of the perpetuating forces that make some situations so immobilising. Common patterns linked with abusive histories often involve roles and behaviours which are crushing/abusing, controlling, belittling and intimidating. These engender related survival strategies to ward off further danger, to manage overwhelming emotions, and thus gain as much control as possible. This was apparent in the Northumberland domestic abuse research (Bostock et al., 2009) in the active and passive 'status quo strategies' the women used in living with abuse.

Gilbert (2009) elaborates on the importance of status and the destructive consequences of sustained interpersonal competitiveness and acquisitiveness. Compassion-focused therapy provides carefully argued physiological evidence for the importance of comfort and breaks from threat and incentive-focused behaviour. Understanding the impact of past and current events on our emotions and how this may link with affiliative, incentive-focused or protection-seeking behaviours is both clarifying and validating, and leads to the sharing of ways to de-escalate distressing feelings.

Comfort comes from being heard and respected, and from experiencing the compassionate solidarity that David describes. Therapy is limited and potentially harmful if the challenging nature of people's circumstances is insufficiently understood. Validation is a crucial aspect of contact between service users and providers, as is accepting that confusing and distressing thoughts and feelings can be considered for their meaning and relevance.

We need to get a balance between idealism and pragmatism. We need to be critically aware of the limitations of available psychological insights which tend towards the individualistic and politically blind, while also continuing to find ways to improve current practices in psychology and mental health and more widely. David encouraged us to work alongside people in individual, group and community settings, while always questioning our motives and impact. This is never a comfortable balance.

Alisdair Cameron from Launchpad, an organisation for mental health service users in Newcastle, urges us to hold the world to account and argues:

We need, more than ever, public professionals who can help us to understand and public professionals who can help support the legitimacy of the problems raised with society from those with least power and with least other forms of influence.

We need clinical psychology to get out of the office and beyond the therapy room because we need someone to help make the case for those who are losing out. To do that we need a clinical psychology that has political understandings but which also is close enough to people to be able to offer pragmatic support, too.
Alisdair Cameron, Launchpad, Newcastle, September 2015.

Our legacy from David is to foster effective collaborative relationships with stakeholders at all levels; to hold compassion as decent human beings; and to go beyond individualistic and voluntaristic concepts for understanding and working with people and communities who are distressed or marginalised. I treasure memories of David's kindness and warmth and also his tough insistence that we engage with burning issues of injustice, build connections between people, inspire debate, question, demystify, and address the causes of psychological struggles.

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