People-Centered Innovation: Becoming a Practitio

by Pedro Oliveira

A sample of the opening pages

People-Centered Innovation: Becoming a Practitioner in Innovation Research

Chapter One

A Fly over the Psychosis Nest

For confidentiality reasons, I will call him John. John and I are in a session. Rooms of psychiatric units never feel too comfortable. They must feel clinical in order for the session to prove effective. There are two chairs in the room, a table, and a panic button. We are in West London. But perhaps I should start by telling you who John is.

John is someone who was labeled 'schizophrenic' a few years ago. He is a young man in his late twenties, from a middle class family, who grew up in London's West end. He is of British-Pakistani origin. John's GP referred him to mental health services when he first started hearing voices, a few years ago. John's life has been far from easy. Working as an IT person, a point came when he started hearing voices telling him to kill everyone at the office. Over time, the voices got worse and more demanding to the point that John confided in someone at the office what was going on. After a long experimentation with different mental health services, John came to this particular service, on the advice of his GP. John likes our sessions. He likes talking to me. He tells me that he feels safe in our sessions. I, on the other hand, don't always feel safe. For some time now, I have not been feeling safe with John or others. Listening to one psychotic patient after the other, I am starting to feel scared. Psychosis is scary. The system where patients like John move around feels just as scary, if not more.

As I listen to John I know that we are not alone in the session. John's voices are there with us all along. They come with John to the sessions and when his eyes glaze for a long time, I ask him if the voices are commenting on us. John says that the voices are asking him to wake up by night and smoke cigarettes. Occasionally, they also tell him to kill random people in the street. I sometimes wonder if the voices are after me as well, even if I try to treat them with the same respect I grant to John. But perhaps I should start by telling you who I am.

My name is Pedro Oliveira. I am a Portuguese clinical psychologist practicing in the UK. After my original training in clinical psychology, in Portugal, I went on to study anthropology in the

UK. I completed a Masters and a PhD in anthropology thanks to two generous grants provided by the Portuguese Foundation for Science and Technology. In a year talking to John, I will become a consumer researcher and a corporate anthropologist. Like others before me (Genevieve Bell at Intel, Melissa Cefkin at IBM, Jan Chipchase at Nokia, Patricia Sunderland and Rita Denny at Practica LLC, to name a few), I am not originally trained in business research, yet I will find a way of using my original training in anthropology to do ethnographic work for corporations. For the time being, the idea of becoming a corporate anthropologist is still in its early stages. Every night, after leaving the unit, I come home and look at the shelves in my room. My shelves are filled with books and articles on consumer research and business research written by anthropologists. Patricia Sunderland and Rita Denny's Doing Anthropology in Consumer Research stands at the top of the list (Sunderland & Denny, 2007). The more I read and reread passages of these books, the more the idea of working in innovation research comes to mind.

At this point of the story, I don't know that I am concerned with people-centered innovation. Indeed, I see design as something that designers do in which I have no role and I see innovation as something done by people called innovators. I am yet to find out that there are anthropologists like Genevieve Bell working on design research and making a significant difference in the corporate world. Previous doctoral training in anthropology has not alerted me to the plethora of 'applications' of anthropology beyond academia. In fact, my doctoral training in anthropology was far from easy to accomplish. While doing my PhD I suffered from what could be called an identity crisis.

Two years into the PhD I started losing hope about anthropology as a discipline. Originally trained in clinical psychology I have been taught to apply concepts, to turn ideas into things that contribute to fixing things or sorting them out. As a clinician, I carry with me particular kinds of tools that can either provoke change in individuals or groups. Moreover, during the PhD years in anthropology, I did not find a community of people committed to creating material change outside academic settings. I became an anthropologist in a community of people for whom discussions among anthropologists seem to be the 'practical component' of the discipline. Indebted as I am for all their teaching, affection and sentimental education, it is clear that in many ways we do not see eye to eye. Hitherto I cannot see in anthropology the kind of applied practice I was once taught in clinical psychology. Hence, at this point of my life, I have finished a PhD in anthropology, remained in the UK and gone back to psychology where I am now practicing in the UK as a foreign-trained psychologist.

Like others who have trained in clinical psychology abroad, I am simultaneously working, doing placements and writing papers in order to render my original training 'equivalent' to British-trained clinical psychologists. On paper, according to the British Psychological Society, I am called a 'migrant psychologist'.

When talking to mental health colleagues, with some honorable exceptions, I try not to mention

that I have a PhD in anthropology. Why should I? Anthropology has become a secret carried with a sense of shame. Like Gillian Tett, anthropologist and director of the Financial Times/New York, for a long time I will hide my background in anthropology from peers trained in different disciplines, as some kind of dark secret that should be contained.

Interdisciplinary thought is more often celebrated in theory than practice. The division of labor our societies are built upon dictates that in order to succeed one should insist on the same discipline or line of work over and over again, with little deviation. At this point, while back in clinical psychology, I am failing to see that anthropology is there all along. John's voices, however, seem to know that there is something different in me, something more accepting of their existence and perhaps less threatening than the stereotypical mental health worker. I often ask John if the voices are there with us in the session and whether there is something they would like to ask me. John seems to have no problem translating to me what the voices are saying. Part of the reason why I am able to navigate so fluidly in the conversation going on between John, myself and his voices is that there are ways of imagining the world in anthropology that contemplate a vision of the world where John's voices are not stemming directly from his 'mind'. I can, for instance, think of the voices as manifestations of structural categories of which John and I are part, in a universe that is not necessarily made of our conscious thoughts. Here, Lévi-Strauss comes to mind (1974). As a clinician, however, I am not supposed to indulge excessively in this way of imagining the world due to the risk of collusion with the patients' symptoms. Broadly speaking, collusion is a derogative term referring to an excessive and uncritical alliance with the patient's symptoms. As a clinician, I am expected to make John recognize that the voices are stemming directly from his mind and as a product of his history. Collusion, in this context, is the point where you engage with the patient in some form of betrayal of the system we are both part of, by granting the voices more of a real existence than they are supposed to have. Thou shalt not collude with patients is the first commandment of working in psychosis.

From an anthropological viewpoint, there are so many ways I can imagine my relation with John, I cannot start to tell you. If I start looking at the consulting room from an external perspective (like John's voices are doing when looking at both of us and commenting on our conversation) I can think of John and myself as two people engaged in a form of ritual to make sure the system we are part of remains the same. Like any other form of ritual, the acts of repetition in the way we meet, the objects present in the room where we meet, the initial questions asked in my time with John, the setting of the place, all conspire to make sure that what we are doing there will keep John and his voices in place. But should John and his voices be kept in place? And what place are we talking about?

Is this the kind of place that divides a world into feelings of purity and impurity, safety and danger, in which voices are seen as unclean products that require sterilization via clinical words? If purity and danger is what this is about, then Mary Douglas comes to mind (Douglas,

1966). Or is my relation with John merely a process of surveillance, a part of a 'panoptic' that must tame John's madness for the sake of a system that finds diversity too hard to handle? If this is the case, Foulcault comes to mind (Foulcault, 1977). Perhaps John's voices can see right through me. Perhaps they too can tell that I am haunted by a particular kind of voice commenting on what is happening between John, his voices and me from a much broader context. Perhaps John's voices know that I too struggle to keep my own voices away, even if mine tend to come out as an appreciation of the much larger social, political and cultural context in which John and I stand, rather than words telling me to do things. Whatever is happening between us I know that there is no such thing as John and his voices on the one side and I on the other. Whatever reality is coming out of John, I am contributing to shaping this reality as I go along, with my questions, silences, my choices of where to lead the conversation, my punctuation, his punctuation, a ritualized clinical room and a panic button standing between us, should things get out of order. Anthropologists know that they make the realities they describe as they go along (Marcus, 1986). Once you know this in your skin, there is no escaping from it.

All in all, I do not seem to mind John's voices terribly, that is, unless they're telling him to go to the streets and get rid of a few people. Then, anthropology or psychology aside, I get worried. I worry for John and I worry for the people the voices are telling him to go for. I worry if the system I am part of is responding to John's needs in the way we should be responding. After my encounter with John, I have a series of tasks to accomplish that are system-centered, rather than John-centered. I have to turn on the computer and make notes on our interaction.

As an anthropologist, I can produce notes on an hour's interaction with another human being that go from the twitching of an eye to extensive verbatim reports in chronological order, even in the absence of a recording device. My memory has been trained that way. The task of note taking after a clinical session, however, is one that rests on registering detail as much as its obliteration. To use an expression from anthropologist Gregory Bateson, in this system, note taking after a clinical session, is no more than a 'double-bind' (Bateson, 1972): a task marked by paradoxical injunctions of which success is hardly achieved.

On the one hand, my notes must signal to other mental health workers involved with John if there are aspects of John's mental state that need further looking into as a team. On the other hand, these notes should not go into excessive detail to the point of breaking the confidentiality involved in my encounter with John and ultimately, losing his trust. I end up being as descriptive as I am elusive, hoping that enough information is given to prevent risk successfully and that enough information is hidden to preserve a sense of privacy in our encounters. The closer we get to each other, the harder the choice of coping with the information systems after our meeting is over. In the unlikely chance that John ever gets into trouble and the team psychiatrist authorizes a court to go through these notes, I will be assessed for my various assessments of John. The system seems to be designed in such a way that neither John nor I get to close and too comfortable with one another. The risk that John and his voices represent must

be carefully distributed among the various professionals involved with the case. The information systems are designed in such a way to make sure this happens. Indeed, these days, plenty of us spend more time filling in forms that having face-to-face encounters with the patients. As a more experienced clinical psychologist once told me as a friendly warning 'this is not about what you do with the patients, but about what you put in the system'. Over Christmas, I get a nice card from our director. I am told that my efforts of dealing with patients in a compassionate and emphatic way are truly appreciated but that I should also be taking a look into what the real priorities of the service are. At this point, I am baffled by this note and with little idea of what this means. Like some of my patients, I am in denial. Of what, I am soon to find out.

My encounters with John and his voices will soon became far and few between. A budget cut in mental health services as a consequence of economic recession dictates that we must increase our patient numbers if we want to stay in the game. We are heading for a major change. Like our psychotic patients, we must prove the worth in our survival. I spend the following weeks doing assessments. Time spent with current users of the service is largely cut to the detriment of evaluating new people who may become suitable to our team, over other mental health teams. The suitability criterion is changing right before my eyes. We seem to be getting more and more people of different profiles and patterns. There are numbers that need to be achieved if we are to stay in the game. Patients are becoming service-users, in a one-dimensional kind of way. Service-users are becoming numbers. Numbers are becoming something in themselves.

New changes in the information systems are introduced almost by the week, to ensure that risk is carefully managed and controlled, that is, that things are kept in order. I am starting to feel that I am no longer part of a public body but of a privately managed business. Adding onto this, like other foreign-trained psychologists, I face the extra pressure of proving myself as efficient as British-trained clinical psychologists through more and more requirements that should be met in order to gain the 'equivalence' of my foreign training.

New patients come to the service with what feels to me as contradictory information that they have received from different parts of the system: from GPs, to family members, to professionals of previous services, to online information on psychosis, to my own colleagues in multi-disciplinary assessments. No one seems to be attending to the fact that for every new mental health professional met along the way patients are being left to make meaning of contradictory information. This happens while different professionals keep producing notes on the information system to ensure that issues of risk are carefully distributed amongst us and other teams.

A change of life is at hand. As I come home and stare at my shelves, the colors of books on anthropology and consumer research are becoming more vivid and bright. In fact, the whole practice of the mental health system I am part of, in my mind, is on the verge of becoming a problem of consumption. Daniel Miller's 'Stuff' is springing to mind as much as books on mental health (Miller, 2009).

End of sample

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