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**SELF-HARM:
MINIMISING HARM, MAXIMISING HOPE**

Asylum

the magazine for democratic psychiatry
Volume 20, Number 2, Summer 2013

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and community development

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Sketch of the hand (p. 13) "from the sketchbook of Sarafin, during her last hospital admission"

Comic strip (p. 22) from Asylum Squad Side Story: The psychosis diaries, a graphic novel by Sarafin

Asylum magazine is a forum for free debate, open to anyone with an interest in psychiatry or mental health. we especially welcome contributions from service users or ex-users (or survivors), carers, and frontline psychiatric or mental health workers (anonymously, if you wish). The magazine is not-for-profit and run by a collective of unpaid volunteers. Asylum Collective is open to anyone who wants to help produce and develop the magazine, working in a spirit of equality. Please contact us if you want to help.

The views expressed in the magazine are those of the individual contributors and not necessarily those of the Collective. Articles are accepted in good faith and every effort is made to ensure fairness and veracity.

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Self-Harm: Minimising Harm, Maximising Hope

This special issue on self-harm came out of a conference in September 2012 that Asylum co-hosted with the University of Central Lancashire in Preston, alongside harm-ed and Manchester Metropolitan University. The conference highlighted some of the tensions between the perspectives of people who self-harm and those who care for them. For example, some participants felt the conference was “biased towards service users’ own opinions” and some workers felt “unheard” and “criticised”. Others felt that workers could be “overly defensive”; “applauded the speakers for talking so openly and honestly about their experiences”; and went away feeling “inspired” and “enlightened”. In this special issue we have tried to honour our diverse perspectives and illuminate issues facing workers and carers, as well as users and survivors. We have included presentations from this event, with some other related submissions, alongside our regular features.

We bring together survivors/service users, workers/professionals, carers, performers and poets. It is no coincidence that most of the contributors are women. The majority of the pioneering work in this area has been developed by women, often in women’s organisations, and out of feminist activism, for example, against sexual violence. The way we see self-harm has changed considerably over the years and this shift would not have been possible without feminist, as well as user/survivor, activism.

Some contributors heavily criticise therapies (especially dialectical behaviour therapy, DBT) and diagnostic labels (such as borderline personality disorder, BPD). We appreciate that others find them helpful. Marsha Linehan, the originator of DBT, has recently ‘come out’ as a person with a BPD diagnosis. Does this make DBT a ‘user-led’ therapy? Does this make it any more acceptable?

In addition, most contributors endorse the idea of harm minimisation. Although proponents of harm minimisation have been clear that it should be an overall *approach* to practice, not a simple technique, it is often misunderstood and even misused. This is especially the case in the current context, where services are under increasing pressure. Harm minimisation has never been about simply giving people things to hurt themselves with. However, the tabloid press love to sensationalise and blame (and are especially keen to scapegoat public sector workers). For example, the *Daily Mail* recently covered a story of a special school in Surrey “handing out razor blades” so that a pupil could self-harm. Another story we heard concerned a nurse who fatally left a young woman patient with a ligature because she thought it was giving her comfort. The reporting of these instances illustrates the real anxiety the general public feels about the dangers of self-harm. On the surface, these stories appear to be about neglectful, or even harmful, professionals. However, they can also be read as being about caring professionals who are genuinely trying to support individual choice and autonomy, albeit having misjudged issues around enabling safety. Balancing the tension between preserving individual freedom and managing risk is never easy. These are complex situations that require greater understanding and reasoned debate because they acutely illustrate the life-and-death issues at stake. We hope this special issue will contribute to a wider discussion about these issues.

Asylum magazine has never been an easy read and this issue may be especially difficult. The subject matter is, by definition, distressing. *Asylum* rarely provides ‘good news stories’ nor easy answers. However, we have tried to include some positive experiences and examples of good practice. We simply ask that you read with an open heart and mind.

Self-harm and Recovery: Minimising harm and maximising hope, Uclan, Preston. September 2012

Conference Feedback

Self-harm doesn’t have to be shameful, it can be something *celebratory and affirmative* – underlying this is the positive need for assuming control of one’s experiences.

However, there are ambivalences in this area: for instance, the desire or impulse to self-harm might arise out of trauma, despair, or anger, but it can also be a way of confirming and ‘placing’ one’s experiences, or be a period of intensity/creative channelling. For carers and friends, though, feelings may involve powerlessness, inadequacy, shock, incomprehension, fear, and distress.

In regard to ‘therapy’, *getting to know the person* who is self-harming is *essential*.

William Park, Conference attendee and member of ASYLUM collective

Living with Scars

Clare Shaw



It's impossible for Clare to talk about her scars without acknowledging the story they tell. It is a story which involves not just physical, but also emotional, injury; not only injury, but also healing. It's a story of living with visible difference, and of the benefits this brings, hand-in-hand with the costs. And she tells a wider story: about how we choose to live with scars – our own and other people's.



I'm someone who lives with the scars of self-injury. I'm not going to waste the next 2000 words on techniques for covering up. That's not to say they aren't part of the story – but only the smallest part. My scars aren't just marks on my skin. They are kind of writing; a way of telling a story. A story of wounding and damage, and of healing; of being marked; and of living with visible difference. It is my story – but not my story alone. 'Living with scars' – our own and other people's – opens up important choices and opportunities for every single one of us.

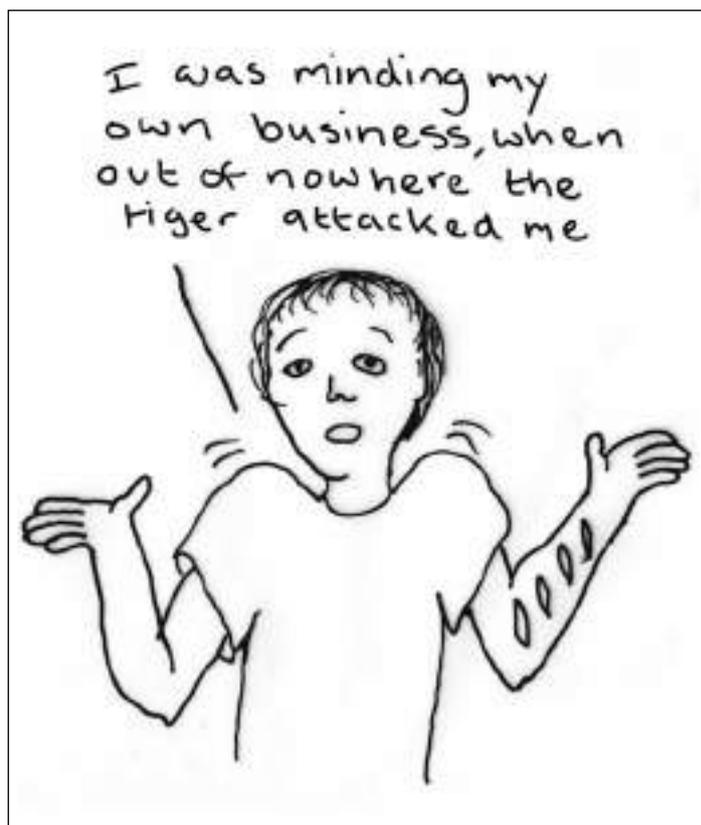
According to the Penguin English dictionary, a scar is:

a mark left on the skin or other body tissue by an injury, especially one that has healed or is healing; a mark of damage or wear; a lasting ill effect.

I have 7 scars on my right leg, 11 on the left. 23 on my stomach and 43 on my upper left arm. 61 on my right wrist and 12 on my chest. 3 on my throat, 1 on my left palm, and 189 on my left wrist. I started self-harming at the age of ten. I carried on because it worked.

Survivor accounts tell us that self-harm is a way of surviving, preserving and affirming life in the presence of intolerable distress, which often includes abuse, violence, neglect, loss, conflict and isolation. Other people have told us how their self-harm works for them. For example, by feeling real or alive; punishing self; exercising control; communicating; providing comfort and relief of feelings.

Despite these common themes, everyone's story is different.



My own self-harm was less about the sexual violence that I experienced as a young person, and more about the culture of silence that surrounded it. A combination of fear, confusion and suffering – alongside a clear message that these feelings should never be named, even to myself. I learnt from the outset that suffering is something you do on your own. This was the personal equation which led directly to self-injury.

I have a particular connection with the function of communication, which probably explains why I'm now a writer. Communication – in all its forms – is our only way of being with each other. Without the ability to communicate what we're going through, we are completely on our own with it. This is why it is vital that self-injury – whatever other functions it might serve – is recognised as an expression of pain. In Lou Pembroke's *Self-Harm: Perspectives from Personal Experience* (1994), Maggie Ross said:

It's a silent scream ... It's a visual manifestation of extreme distress. Those of us who self-injure carry our emotional scars on our bodies.

But no matter how loud the scream – if no one is prepared to listen, make sense of, or respond to that expression of pain, an important opportunity is missed. At 20, with ten years of self-harm and five years of bulimia behind me, I went to see the university psychiatrist who informed me that I had 'Third-Year Nerves'. So having unravelled, I encountered the emotional wounds of trauma and difficulty. Behind the physical scars of self-injury, now we encounter another layer of harm – 'iatrogenic' harm (an inadvertent adverse effect or condition resulting from medical treatment).

Here, I'm talking about lasting damage caused by service responses to self-injury. At the age of 21 I was admitted into

psychiatric hospital for the first time: a chaotic, dirty inner-city ward where deeply distressed men and women were detained together in cramped conditions, and harassment and violence were an everyday reality. I became a psychiatric patient. I was crazy; my craziness was the explanation of my suffering; it was also the reason why I could be treated as less than human. At 23 I was diagnosed with borderline personality disorder, and effectively told that everything bad I'd ever suspected or been told about myself was true. I was faulty, I was crazy, I was manipulative, attention-seeking and hopeless. I was not going to get better.

But a scar is not just evidence of injury; it's also evidence of healing or recovery. By this I do not mean the return to some former state. Just as we acknowledge injuries leave scars; we acknowledge that experiences change us.

I am not talking either about the recovery agenda – as manipulated by the current government into an excuse for closing services, taking away desperately needed resources, and pushing people into dead-end employment. I am not referring to the patronising practices currently endemic in NHS Trusts. As a patient in suicidal despair, I cannot conceive of the frustration of being asked to work through my “Living Skills ladder” or to identify my “wellbeing jewels” to place in my “recovery treasury chest”.

And we're not talking about stopping self-harm. Recovery shouldn't be about symptom elimination, but about what an individual wants, how they can get there, and how others can help and support them to get there. Others can help, but how?

My scars don't just tell a story of damage – they also tell the stories of the people who have supported me – friends, family members, and staff like the nursing assistant on a medical ward who treated me with warmth, making me feel cared about. And as well as telling the story of the support I've experienced along the way, my scars tell the story of my own immense determination not just to survive, but to have a life worth living. A determination which also motivated me to define myself in a way which works for, not against, me; and to act on that by building a life that is full of hope and meaning.

As well as telling a story of damage, they tell a story of self-care.

People are often directed to think of scarring as a way of discouraging them from self-harming. It's true that people should be enabled to make an informed decision about the consequences of their actions. However, presenting this as ‘don't self-harm because you'll get unsightly scars’ is patronising and destructive. It fails to address the real issues; and it reinforces the message that scars are bad.

If we are serious about reducing the potential negative impact of scarring, we need to learn from the harm-minimisation approach – working not to prevent self-harm, but to lessen risks – by, for example, providing reliable anatomical and first aid information; having thoughtful discussions about the risks of different implements; or providing access to resources like appropriate sterile dressings. It is about having services that

respond appropriately to emotional and physical injuries; and challenging negative attitudes around scarring.

There is nothing inherently bad about scars. The A&E doctor who told me that she wasn't able to stitch my arms but “it doesn't matter because they're a bloody mess anyway” was, to say the least, missing the point. Scars can be a source of comfort. At times of great distress, I needed my scars. They reassured me about the reality and validity of my suffering. They gave shape to and made sense of how I felt. They were proof that I was strong, I was wounded, I was worthy of help, I was able to heal. It should not be assumed that they are unwanted.

Scars on a landscape are beautiful. There are times I can appreciate the complicated patterns of my interesting skin. Living on the margins – by virtue of scarring, ethnicity, disability, sexuality or any other visible signifier of difference – can be a powerful place; a place of celebration, resistance, solidarity, and strength.

But it can also be difficult. Part of this paper was written on holiday in Spain; some of it on a hot afternoon when I had three sets of people confront me about my scars; eventually I gave up sunbathing because I felt so self-conscious. Scars, for all their strength, leave us vulnerable to the judgements of others. Wearing long sleeves is just one way of negotiating this. Having a variety of cover stories to draw on is another. There are now several children in Spain who have met an Englishwoman who was attacked by a tiger! Being clear about which questions I'm prepared to answer, and in what circumstances. From the woman in the shop who screamed when she saw my wrists, to the drunk man who wanted me to promise not to do it again, having to negotiate difficult reactions takes a heavy toll. Every person who self-harms has the right to make their own decisions about what makes this process bearable, and to have access to the resources they need to enable this. This may involve:

- Hiding:
 - Long sleeves
 - Jewellery, watches, scarves etc.
 - Tubagrip
 - Camouflage makeup, e.g., skin camouflage services
- Healing:
 - Good wound care
 - Silicon sheets/pads
 - Vitamin E cream
- Removal:
 - Plastic surgery
 - Skin grafts, dermabrasion, steroid injections

But the most effective way of minimising the potential negative impact of scars is to change attitudes; our own and other people's.

So I'd like to end by focusing on our collective responsibility to live positively with scars. Writers like Lou Pembroke and Mark Cresswell have for years been drawing attention to the political nature of self-harm; and there is a moral necessity of addressing the root causes of the suffering evidenced in self-harm. When it is recognised as an expression of distress, self-harm alerts us to the need for change – to aim for a world in which children are

not abused, in which people do not live in degradation, and are not treated as lesser on the basis of their colour, sexuality, ability or class.

But 'living with scars' implies something more pragmatic than idealistic. It states that shit happens, has happened to most of us, and will continue to happen for the foreseeable future. We are all, in our different ways, hurt and scarred, whether physically or emotionally, and we need to live respectfully and thoughtfully with each other's differences and needs. At times this will necessitate a reformed mental health system; at times a well-resourced social care system. Sometimes it will require a humane criminal justice system.

These are the challenges many of us face in our work and activism. But the biggest and most constant challenge – and opportunity – is to live with each other – and ourselves – with acceptance and love; to show by our lives that living with hurt, and that being scarred, is nothing to be ashamed of.

Those of us whose scars are the result of self-injury face some other choices. Whether to accept the third-rate treatment so many of us have been offered, or to stand up for the care we deserve. Whether to live with embarrassment – or to draw on whatever resources we need to live at ease in our own marked

skin. Whether to believe the shaming, blaming labels we've been offered, or to create our own stories of strength, survival and personal meaning.

Whether the physical scarring of self-harm, or the emotional scarring of loss or sexual violence, scars should not be read as evidence of faulty pathology or a defective personality, but instead, as evidence of distress, meaningful in the context of a life; evidence of the human capacity to endure suffering; to fight to survive; to create meaning in the midst of chaos; to keep loving and living and hoping against all the odds; to struggle and heal, over and over; to reach out to each other; to stand with each other, to move forwards together.

Reference

Pembroke, L. (1994) *Self-Harm: Perspectives from personal experience*. Chesham: Survivors Speak Out.

Biography

Clare Shaw has been a key figure in the self-harm survivor movement. She is a freelance trainer, delivering workshops and consultancy on self-harm and related issues to services across the UK. She is also a creative writer and poet, with two poetry collections published by Bloodaxe, *Straight Ahead* (2006) and *Head On* (2012). <http://www.clareshaw.co.uk/>

Performing our Experience

Clare Summerskill

This piece is based on the writing and research of *Hearing Voices*, a play that Clare Summerskill wrote, performed in, toured to theatres around the country, made into a film and published by Tollington Press, (2010). It is based entirely on interviews with a group of mental health service users who all became friends on a secure psychiatric ward where they met Clare.



CLARE: For two years I had been feeling suicidal and I was exhausted. I had been living in a world with no joy, no hope and my only thoughts were about how to stop all this pain and end my life. I went to Paris on my own for a holiday, hoping that the beauty of that city and the contents of its galleries and museums might somehow calm my troubled mind. But you know that van Gogh painting? The

one of his room with a bed and a wicker chair and the perspective's at a slant? That one? Well there I was, looking at it in the Musée d'Orsay, and the objects in the picture started sort of coming out at me, like it was 3D. And at that moment I understood that the painter had clearly been mad and I could now see that madness in his work and amongst the bright and vivid colours I could also see his pain. And then I looked at some of the other van Goghs and they all seemed to be coming away from the wall, calling for my attention, and I began to freak because it was like hallucinating and it was then that I knew what this all meant ... that I was maybe going where he had been.

Over the next few weeks things went from bad to worse until one morning I went to visit my GP and asked him for some sleeping pills. Then I went back home and I took the whole packet. I could feel myself slipping into a seductive state of unconsciousness when, completely on the spur of the moment, I decided to call my therapist



... I just wanted to explain to her what I had done and why and to say sorry that I didn't have the strength to keep battling on.

But the reason I'm still here to tell my tale is because she phoned me back a few hours later, got no reply because I was unconscious, and she then called the police who sent the fire brigade round to my flat to break in and rescue me. But I knew nothing about all that. A day and a half later I vaguely remember being at a general hospital and I was then transferred to a secure psychiatric ward. (Excerpt from the play, Hearing Voices)

And so began a stay that lasted two months. During my time there I met some other patients with whom I became friends; when I was discharged I asked them if I could interview them. As I began to work with the interviews it struck me that these were stories that not many other people had ever heard. In hospital you got to see a consultant twice a week for ten minutes who would ask you what your mood was – high or low – and decide whether your medication should be changed. When I asked my fellow patients if anyone had ever asked them in hospital how they were feeling, the answer was always the same: No. So I decided that I would write a play that was to be entitled *Hearing Voices*, because no one in hospital had ever wanted to hear ours.

This play, like much of my playwriting, is in the style of verbatim theatre, in which a number of people are interviewed about a specific issue and a script is produced in which nothing is allowed that has not actually been said by one of the contributors. One of the main differences between myself and some other playwrights in this field is that I was one of the patients; I was writing about what I had witnessed at first hand. During the writing of the play I decided to include a few of my own experiences of the ward as well but, after merging them all together, I realised that the piece was looking a little bleak. I couldn't change my memories of what had happened to me in there, nor could I change the opinions of the contributors, but I decided I could lift the piece by offering some examples of best practice.

So in the play there are extracts from four interviews from people I call 'alternative professionals'. One of these is Paddy Bazeley who was a founding director of Maytree, a short-stay respite home in north London for suicidal people. There are also extracts from interviews with Dr Rufus May, Dr Rachel Perkins, and Pam Blackwood. Pam was Head of Operations with Samaritans between 2003 and 2009. She told me that she thought self-harm was "... a way of coping with emotional distress and emotional pain ... it's a survival mechanism".

With regard to the treatment by psychiatric nurses of self-harmers on hospital wards, Pam Blackwood said, "I think one of the difficulties is that nursing is about medicine and you might choose to specialise in psychiatry but, in a way, it's still about treating people with medicine and making them better and that's the reward of the job. But if there is somebody who is a revolving-door patient, and people who self-harm often are, there's a sense of impotence for some people who think, 'My skills aren't helping you and therefore I feel bad'. But for other people I actually think there may be something punitive." I also saw a variation of attitude from the staff towards those of us who

they believed to have 'medically treatable' psychiatric conditions and those of us who were suicidal, self-harmers or both. But however horribly the nurses reacted, I still needed to do it.

I remember early on in my stay saying to a nurse late one evening, "I'm really worried that I'm going to cut myself tonight, would you mind very much just popping by my room every now and then to check on me?" To which she briskly replied, "We don't have time to do that sort of thing." So that told me.

We presented a rehearsed play-reading of the piece at The Cochrane Theatre in London. Certain audience members during the Q & A session which followed the reading seemed cross at what I had written about; one even suggested that I had either misremembered or made it up, because of course I'd been ill at the time. Another of the audience members said, "Well there must have been *some* nice nurses on the ward." To which I replied, "Well no, sadly, there actually weren't on that particular ward, during my particular stay." And then it was suggested by another audience member that perhaps I should have put a nice nurse in the play, to balance things out. To which I replied, "But this is a verbatim theatre piece based on interviews, with my own personal story woven around them." But on she went, "But if you did have a nice nurse we could more readily listen to the bad examples of treatment in the play."

Nowadays I am quite prepared to own the artistic decisions that I made. I am content that for the service users who see the piece it can offer validation of their experiences and a knowledge that someone else has seen what they have seen, and documented it to the extent that they can say "That was my story".

Deb is one of the contributors to the play. She is an amazing woman and she has been diagnosed with bipolar disorder. She followed the development of the play very closely, posting her own review of the play on YouTube. She said, "Clare Summerskill's play has opened my eyes because the treatment Clare perceived as wrong, inhumane, unjust, uncalled for, I had been accepting that as the norm."

Through her involvement with the play I would like to think that Deb had moved a little from feeling like a victim of her illness and her often brutal handling, towards a place of ownership. She was now telling her story on her own terms and in her own words.

bell hooks (1991: 153), a feminist writer, talking mainly about African American women, states:

We are transformed, individually, collectively, as we make radical creative space which affirms and sustains our subjectivity, which gives us a new location from which to articulate our sense of the world.

I believe that the play, presenting "a radical creative space", was for Deb a site of resistance.

Deb's feedback about the play was invaluable – as was anything said by a fellow service user. I wanted to see if my experiences reflected theirs and, I'm sorry to say, that all around the country,

the story was the same. The world of the mental health service user, especially the time spent behind locked doors, is a hidden and neglected area of social concern. There is still a high degree of stigma, shame and social exclusion around anyone who admits to struggling with mental illness.

A few of my closest friends were unable to come to terms with my illness and have been unwilling to talk to me or listen; members of my family also reacted in strange and uncaring ways. I am now convinced that the odd and often cruel reactions that I experienced stem from the enormous threat that mental instability poses to those who are themselves trying hard to hold onto a semblance of sanity. There may be a link between this and what I have observed in my work with oral history. Some people are willing to engage with people's experiences and learn from them; others just do not want to know. They do not want to understand, to be reminded, to hear about the abuse that some of them may still be inflicting upon other human beings.

Over the last few months I have been following with interest a court case about a young Asian girl who was driven to suicide after cruelty from her family. The verdict was that her parents were responsible, by their behaviour, for her suicide. You might see why this case interests me with regard to issues of self-harm and suicide. It sends out a message that legally it is the fault of those who inflict the cruelty on people who then go on to harm themselves. I wonder if the courts and people working in mental health have thought through the future possible implications of this particular decision.

A Beacon of Hope: Working with self-harm in a survivor-led crisis service

Fiona Venner

Fiona reflects on her 20 years of working with people who self-harm, particularly focusing on the work of Leeds Survivor Led Crisis Service, the charity she currently manages.



Working from a person-centred, survivor-led approach is integral to the philosophy, identity and practice of Leeds Survivor Led Crisis Service (LSLCS). We are proud to be part of the survivor movement, having been founded in 1999 by a group of campaigning mental health service users who wanted there to be an alternative to psychiatric hospital for people in acute mental health crisis. Our organisation is still governed, managed and staffed by people with our own, direct experience of mental

Those who inflict cruelty on other people – often as way of avoiding their own shadows – have come up with the clever strategy of blaming the victim. The psychiatric profession, I believe, plays into this system by suggesting that incarceration and medication are the appropriate treatment for people who collapse mentally. In fact, what they see as a *treatment* is only a way of avoiding the real matter: dealing with the perpetrators of the abuse that cause so many people to break down. And the people who do not admit to their own mental confusion are afforded even greater power. I cannot do much about this on my own. But I can tell people about what I have seen.

Reference

hooks, bell (1991) *Yearning. Race, gender and cultural politics*. London: Turnaround.

Hearing Voices is available as a DVD

www.claresummerskill.co.uk
www.hearingvoicesplay.co.uk

Biography

Clare has written several plays, many of which have been written from interviews using the verbatim theatre technique. These include *Gateway to Heaven*, (based on the memories of older lesbians and gay men), *Once Upon a Lifetime* (a reminiscence play written for Age Exchange Theatre Company) and *Hearing Voices*. She also has her own theatre company, ARTEMIS, and is a stand-up comedian (see 'In the Writer's Chair' interview on page 26).



health problems. We have developed our services based on this expertise, whilst also listening to the needs articulated by our visitors and callers.

We provide out of hours services, as an alternative to psychiatric admission or statutory services. Dial House, a place of sanctuary and support, is open 6 pm–2 am Friday, Saturday, Sunday and Monday. Our helpline, Connect, is open every single night of the year, 6 pm–10.30 pm. We also provide group work; a Hearing Voices group; a peer-led men's group; a peer-led social group; and during 2012, a group for women who self-harm.

Most of our work is with people at very high risk of suicide and/or who self-harm. During 2012, 192 people made 1,381 visits

to Dial House and there were 4,781 calls to Connect. Suicide was a presenting issue in 60 per cent of visits to Dial House and self-injury was a presenting issue in 45 per cent of visits to Dial House.

Our person-centred approach

Our therapeutic approach is the person-centred approach. A core principle of this is the organism's tendency to 'actualise'. We understand this to mean that people do the best they can, in the circumstances they are in, with the resources they have and are innately motivated towards growth. Carl Rogers, the gentle soul who founded the approach, used the following metaphor:

The actualizing tendency can, of course, be thwarted or warped, but it cannot be destroyed without destroying the organism. I remember that in my boyhood, the bin in which we stored our winter's supply of potatoes was in the basement, several feet below a small window. The conditions were unfavourable, but the potatoes would begin to sprout – pale white sprouts, so unlike the healthy green shoots they sent up when planted in the soil in the spring. But these sad, spindly sprouts would grow 2 or 3 feet in length as they reached toward the distant light of the window. The sprouts were, in their bizarre, futile growth, a sort of desperate expression of the directional tendency I have been describing. They would never become plants, never mature, never fulfil their real potential. But under the most adverse circumstances, they were striving to become. Life would not give up, even if it could not flourish. (Rogers, 1980, p. 118)

We understand self-injury to be a manifestation of doing the best you can, with the resources you have, in the circumstances you are in. We have the highest respect for the tendency for growth and the creative attempt to survive even if we don't like the outcome. When we supported someone who had limbs missing due to self-injury, although this is horrifying, we honoured and understood this as the person's attempt to survive unbearable, intolerable distress.

We certainly do not see self-injury as a symptom of a person's disordered personality, though this is the label many of our visitors and callers have attracted. We are fiercely non-diagnostic, as an organisation set up to be an alternative to psychiatric services. We pride ourselves on providing a non-medical approach to working with extreme mental distress. Our philosophy is about being alongside people in crisis, not treating them, and we believe passionately in the transformative and healing power of human connection. As it says in our philosophy:

We believe that to deal with a crisis, a person must feel safe, listened to, and connected to other people. (LSLCS, n.d.)

Self-injury and trauma

Most of the people we support at Dial House are survivors of trauma. Rapes, sexual violence, abuse (in the past or present) were presenting issues in 56 per cent of visits to Dial House in 2011. In this context, we understand self-injury to be a logical response to unbearable distress. When we hear a woman describing inserting razor blades into her vagina, we don't think 'that's a symptom of your personality disorder' but 'that is an

understandable response in someone who has endured a lifetime of sexual abuse and sexual violence and is creatively trying to find a way to stop it happening again'.

Our self-injury policy enables people to self-injure on our premises, within guidelines that this is done safely and discreetly and that people get medical attention if required. This has always been respected. Our experience is that because we are so accepting of self-injury as a coping mechanism, it can be openly discussed and our environment is experienced as warm, welcoming and empowering. As a result, people rarely feel the need to self-injure at Dial House.

Our own reactions to self-injury

Personally, I would rather people did not self-injure and see accepting and respecting self-injury as a pragmatic response. That doesn't mean it doesn't upset and disturb me, or sometimes even cause me to feel disgust or repulsion. These feelings are totally natural and understandable. Self-injury is very counter-intuitive. On a gut, human level it is hard to accept that people hurt themselves and that it is helpful to them.

When one of our visitors told me that she cut herself deeply and poured acid into the cuts, I was sickened by the idea of this level of injury. But these feelings were my problem. I had to work quickly to process how I felt and I had to own the feelings. If we, as workers, don't take responsibility for our feelings of shock, repulsion and disgust, the danger is we will project our feelings on to the people we support – and then in our eyes they becoming, shocking, repellent and disgusting. We must own and process our visceral responses to self-injury, so we can still be warm, loving and kind to the person in front of us.

A converse reaction to being horrified by self-injury is to feel nothing. A danger for workers immersed in this work is the normalisation of extreme distress. At LSLCS we only work with people in crisis. This means that suicide attempts and self-injury become our normality. We are more in danger of being desensitised and blasé than of being horrified. As a worker you tread a fine line between being accepting of self-injury and non-judgemental, and normalising what is not normal. We cannot avoid a level of desensitisation when working with crisis over many years and to a certain extent this is probably necessary to survive. In a strange way I am reassured when I feel horror, which is a natural response to someone describing slashing their breasts or attempting to castrate themselves. I would feel I had lost my humanity if this didn't distress me.

And in a circular way we are back at respecting the person's attempt to survive and thrive, even if the manifestation of this is truly terrible.

Trust and risk

In referring to some of the more extreme forms of self-harm we encounter, it feels necessary to state that most self-injury is not severe or life threatening. Superficial cutting is much less dangerous than smoking and, yet, still much more stigmatised. We trust the people we support who self-injure, because they

have usually been doing it for years and know what to do and how to do it safely. Trust is one of the most defining elements of how we work with risk. Our emphasis is very much on our visitors and callers being trusted to manage the risks they present, whether to themselves or other people.

Hope and recovery

At LSLCS we believe that people can recover from extreme distress and self-injury. We attempt to hold hope for people even when they cannot hold it for themselves. There are many inspiring examples within our team of people who have personal experience of self-injury. We have received feedback from our visitors that this in itself is a hopeful aspect of a survivor-led service. The existence of survivor staff gives our visitors some hope for the future.

I think Dial House staff are so dedicated to their work ... At the minute I am not able to work due to my mental illness being at its worse ... However, in the future ... I hope to become a volunteer at Dial House. Survivor led help is amazing because I know that people who talk to me here

understand what I am going through. Thanks for being my glimmer of hope – every cloud has a silver lining and Dial House is mine. Smile. (Dial House Visitor Feedback Book)

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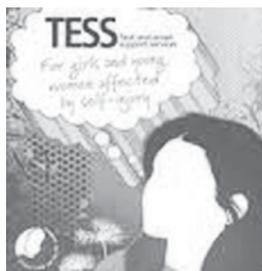
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Biography

Fiona Venner has been the manager of Leeds Survivor Led Crisis Service since 2005. The organisation is a multi-award-winning and unique survivor-led crisis service in the voluntary sector. She previously worked at 42nd Street, in Manchester, and Leeds Mind. In her spare time, Fiona runs marathons and collects Persian cats.

Bristol Crisis Service for women: TESS



TESS principles are:

- To respect the rights of an individual's relationship with self-injury and to avoid being prescriptive or predetermined in our responses.
- To provide completely confidential and non judgemental emotional support
- To recognise and build on the resilience and existing skills of the young women who use the service
- To provide a positive experience of reaching out for help
- To deliver a service run by appropriately trained female volunteers
- To provide access to objective information about self-injury

Bristol Crisis Service for women is a long-standing organisation which has campaigned and supported women who self-harm for many years. melanie lavin gives an overview of TESS – their new text and email support service.



Bristol Crisis Service for women was set up in 1986 to support women who are in emotional distress and who injure themselves to cope with strong feelings. The organisation provides training to professionals (national programme and bespoke), a range of publications and resources, web-based information and self-help resources and direct support services for women.

The national helpline unfortunately had to close last year as a result of funding cuts. with the loss of the national Self Harm network helpline as well, the UK now has no national telephone support service – a situation which we will hopefully be able to remedy.

BCSw currently runs a text and email support service (TESS) for girls and young women affected by self-injury. The TESS service provides non-directive, non-judgemental emotional support. The service is completely confidential as all service user details are made anonymous by the iT system.

To uphold these principles the TESS service offers a particular style of support. The work borrows aspects of rogers' person-centred approach that involves acceptance (valuing and caring about people for who they are whatever their situation/actions); empathy (trying to understand the person's perspective) and congruence (being genuinely ourselves without adopting a role/facade). The style is reflective – reflecting content, emotion and process, in order to give regard to what people are saying, to show we listen, understand and value them, to pay attention to their feelings, to be gentle and non-directive, to be willing to be with them in the moment and to enable them to further explore their own situation. The service provides lots of reassurance, warmth and recognition of people's strength and courage to cope with emotional stress and also aims to provide some normalisation around self-injury. we generally try not to give direct advice but if people want specific information, for example, around distraction techniques, we will link people to our web information resources.

The TESS service is open 7–9pm Mondays to Fridays

Text: 0780 047 2908

Email: www.selfinjurysupport.org.uk

The Naughty Child

Fiona Jones



Fi recounts her experience of a pivotal therapeutic relationship that was the catalyst in her recovery.



I've hurt myself since I was a small child but didn't realise that this was known as 'self-harm' until I was older. I used to pull my hair out, but it wasn't until I was slightly older that I started to really harm myself.

My first recollection of self-harm was when I was 9 years old. I went into the kitchen, pulled my Mum's vegetable knife out of the drawer and slashed my wrists. I had to go to hospital for stitches but no one asked me what was wrong. Around the same time I started running away, staying out and I was constantly cutting myself and failing at school. I was reasonably clever at school but there was something not quite right and I didn't know what it was. I carried on cutting my arms, taking overdoses of paracetamol and that carried on until I was 14. It was at this point that my Mum and Dad put me into care.

I was bullied quite badly in the care system because I didn't come from a council estate or a broken home; it was my behaviour that had led me there. Because I was hurting myself, they saw it as 'attention-seeking behaviour' and it got to the point where I couldn't take anymore. It was at this stage where they found me, unconscious on the bathroom floor of the children's home with my throat slashed. Luckily, I was found by staff.

After staying in general hospital where I was treated for my wound, they transferred me to an adult psychiatric ward. It was a mixed ward and sometimes it was really weird. I'd never knowingly met someone who suffered from a mental illness, but there were people having electro-convulsive therapy and it was frightening to see. I felt really unsafe because we had to sleep in dormitories with people I didn't know or trust and I was stuck with older people.

The nurses there, because I had no diagnosis at that time, thought I was just a naughty child. So they told me to go away and watch TV while they dealt with the real patients. Whilst at that hospital I repeatedly cut my neck and it got so bad, they sectioned me and took me to the Gardener Unit in Manchester for a 28-day assessment.

I went to the unit and the doctor asked me lots of questions

and decided I had borderline personality disorder (BPD). This was 1988. The diagnosis was explained to me in brief terms: that there was nothing they could do for me; I wasn't a proper patient who needed to take medication, what I needed to do was modify my own behaviour and stop being a naughty child.

In the unit, I didn't do very well. I wasn't there because I suffered mental illness like the other kids. Nor was I there because I'd committed a crime and was too young to go to prison like some of the kids. Some patients had done terrible things but I had only hurt myself and I felt really isolated. A lot of the time I had staff with me constantly to try and stop me hurting myself but that meant that the other patients wanted nothing to do with me because every time I walked into a room, the staff would be with me. After 28 days, I left there and went to foster parents but that placement broke down and I was sent to Aycliffe Centre for Children. I stayed there until I was 16 years old.

There was no thinking around BPD at that time and if you had that label you were just seen as a naughty kid and that was it. Nobody ever asked 'what is wrong?' Nobody talked to me, they just gave me a label and told me to go away. The way it was conveyed to me was that it was something that I had to change about myself. But I didn't know what it was about myself that I needed to change because I was just myself. People said, "*You are bad*", "*You do bad things*" and "*We are going to lock you up for it*".

Somehow, I got to the age of 28 and by then I had ended up in High Secure Services after being transferred there from prison. It was a chance meeting with a nurse who came onto the ward that helped me transform my life. She was, I think, trying to see who was suitable for transfer to medium security. Just on an off chance, she heard me talking and we realised we were from the same county. She was just really nice, friendly and chatty. She had asked me about what sort of music I liked. The next thing I knew, they closed the Women's Service at Ashworth and I was transferred to Guild Lodge in Preston.

The nurse who I had met a few months earlier in Ashworth was there and she became my named nurse. She was just lovely.

When I first got there, I didn't have any family support so she brought me clothes and things from home. She didn't do any clinical work initially, that didn't start until later. She was more interested in the aspect of me being '*worth more than this*'. I

couldn't see it because I'd lived that life for so long. I couldn't see any other way of being and I think I would have carried on hurting myself until I was dead, if she hadn't stepped in.

We used to go for walks in the grounds of the hospital and she would actually ask me what was wrong and what had started all this negative behaviour. She used to take me out to the local village in her car and we'd go shopping, chatting and she just generally helped me. She talked to me about cognitive behavioural therapy but I never realised she was doing it and she never said, 'this is a CBT session'. She just used to talk to me and say, "When you think like that, is there not another way you could think?" It was almost like she helped me re-programme my brain. She told me, "You've got to believe in yourself, that's what you've got to do" and so I started to believe it myself. Over those years in hospital she was my named nurse and then she left the service.

As luck would have it, when I left the service about a year or so later, she became my community psychiatric nurse. It was very difficult for me to go back to the community because so much had changed. I had to deal with family issues but she helped me through it and helped me regain custody of my son. She helped me get a house, pushed me and encouraged me to sort out problems. I got a voluntary job working for a charity that helped people like me through the running of user groups. Every week she was there.

But once I was back on my feet, we had to say goodbye. It was really hard and she gave me an 'angel in my pocket' (which I still have) and a card saying 'Believe in yourself' which is what she said all along. It was very hard letting her go but I realised I didn't need her and that's what she wanted all along, for me not to need her anymore. She helped me and gave me the tools to deal with things in the future.

I'm doing great now and I haven't self-harmed for 10 years, the longest time in my life. I'm sure she would be absolutely amazed at what I'm doing now. I don't think she realises the impact she had on my life. Not only that, but her work informs future practice because I talk about this now as being the single thing in a 27-year history that I've had, that kick-started my recovery.

CORRECTION

peter lehmann's article in the last *Asylum* issue on Thomas Szasz (20:1, page 24) meant to say that "Szasz was also very close to the so-called Church of Scientology". peter would like to point out that in Germany, the organisation does not have the status of a religious organisation. This is important because he does not want to inadvertently support their demand for non-profit status.

She helped me believe in myself because I was always told it's something about you. "*You're a naughty child, go away while I deal with the properly poorly patients who need help.*" She didn't take that view. She took the view 'Fiona needs help'. She might not need medication, but she definitely needs help and it was nice for someone to take an interest because nobody else had. She saw beyond the behaviour. She wouldn't let me live down to the label. The label of BPD conjures up all sorts of negative images and if you're not careful, you can live down to the list of 'symptoms'.

This is just the way I am. I don't need medication to stop it, I just need to believe in myself and believe I'm much more than a naughty child.

Biography

Fiona has been an active in a number of local and national mental health organisations such Preston Mental Health Service Users Forum, with EmPowerMe and MIND. She is currently working as a service user researcher at the University of Central Lancashire. Fiona would like to acknowledge Karen Wright for her help writing this piece.

BREAKING NEWS

MAY 2013

*JUDICIAL REVIEW JUDGEMENT *

Judges in the Upper Tribunal ruled in favour of two claimants who challenged the manner in which people with mental health difficulties are assessed for their fitness for work through the Work Capability Assessment (WCA). The court held that the WCA process discriminates against people with mental health problems.

The Mental Health Resistance Network (MHRN) welcomed the judgement and said: "We remember those of our friends who have been driven to despair and suicide by the actions of this government, the DWP and Atos. We will continue to struggle in their memory in order to try and prevent needless deaths and trauma in the future".

From State Control to State Support

Sam Warner



Sam draws on her experience of working in statutory mental health and social care systems to demonstrate how they can work for people who self-harm. The approach she describes underpins her relationships with Vicky Hudson and Tracey Greaves who write about their experiences, as client and support worker, later in this issue.



Many people who self-harm must navigate the choppy waters of statutory mental health provision. Some people hit rocks and are capsized through misunderstanding, misrepresentation and mistreatment. Others sail through with the support of individuals who rally to their side and provide help that is desired rather than imposed. In this article, I identify some of the key issues that distinguish neglectful and controlling services from services that understand and enable.

From histories to herstories

The National Institute for Health and Clinical Excellence (NICE) considers that the gold standard for research is large-scale randomised trials that are evaluated 'blind'. But self-harm doesn't fit neatly into this model of evaluation. Not everyone views stopping self-harm as their number one priority. People who self-harm have different aims and favour different types of intervention. As such, if we want to develop more personalised services we need to have detailed personal conversations with people who have direct experience. Survivors and activists have long advocated for the need to value personal experience as an important source of knowledge that can be drawn on to develop theories and practices: to transform the personal into a shared political enterprise. It is important then to recognise that much of our knowledge base about working progressively with people who self-harm comes from women who have direct experience of using self-harm, caring for others who self-harm and/or have a commitment to transformative liberation politics.

Some key texts by women on self-harm include first-person narratives, researched personal accounts and practice-based evidence such as Pembroke (1994), LeFevre (1996), Spandler (1996), Babiker and Arnold (1997) and Spandler and Warner (2007). A common thread running through all these narratives is the understanding that traditional biological psychiatry has little to offer people in distress. Diagnosing people with mental illness and personality disorder does not help them recover. Instead we need to listen to their life stories.

Recognising the social roots of self-harm

Self-harm is associated with real-life – challenging – social experiences, and hence is always meaningful. People self-

harm when they are bored, isolated, angry, sad, anxious and in despair. It is crucial, therefore, to understand clients' personal intentions and motivations – because the meanings of any single act shift from person to person, or from situation to situation. For example, people may drink alcohol and take drugs 'just for fun' or to mask feelings of emotional pain. People often self-injure when they feel out of control and when they do not like themselves and/or feel excluded – hence experiences like child sexual abuse, bullying, domestic violence, racism, homophobia and incarceration are associated with self-injury. Key issues, then, are around power and identity.

Self-harm helps people cope (e.g., by providing distraction or dissociation) and communicate to oneself and/or others (e.g., 'this is how bad I feel/this is how bad I am'). People rely on physical methods of coping and communication when words do not work. This may be because others do not listen; people cannot make themselves understood; or people never learnt how to use words to manage their feelings in the first place. This is sometimes true of people who have been born with communication difficulties. It is also true of people who had inconsistent and/or abusive carers when they were young. If their carers didn't care, and didn't show them how to use words to 'soothe' themselves (such as, 'I'm loved, I'm ok, it will be alright'), children – and the adults they become – learn to rely on physical methods of emotional regulation, such as letting blood or tying ligatures. People will use whichever method works best for them (the most salient, meaningful and effective) from the choices that are available to them. These methods then become part of that individual's strategies for managing feelings of distress and trauma.

Maintaining hopefulness and aiming for harm minimisation¹

The recognition that self-harm is mostly associated with traumatic experiences is a good starting point for developing progressive

1. This type of principled approach underpins my relationships with Vicky Hudson and Tracey Greaves who write about their experiences, as client and support worker, later in this issue.

practices. This is because it invites consideration of what has happened to that person, rather than provokes the search for a pathological identity: people self-harm for reasons, not because they are mad. A harm-minimisation approach to understanding trauma should address a range of social factors including factors associated with the client, as well as factors associated with the service and service provider. Harm can be broken down into three main aspects: physical, intellectual and emotional, all of which can be considered as targets for harm-minimisation strategies.

Physically, people might aim to use the least damaging method of self-harm that is effective for them and to make use of appropriate techniques for managing their injuries. Intellectually, people might aim to have better understanding of and control over their self-harm, through increasing their knowledge about their bodies – how self-harm works for them, when they need to use self-harm and why. In respect of emotions, this involves addressing feelings associated with problems around power and identity that underlie self-harm. This may involve reflecting on how the person's past and current relationships may disempower and invalidate them. It may also involve exploring how some statutory services can also disempower and invalidate clients.

For example, practitioners sometimes inadvertently re-traumatise clients when they physically restrain them and thereby engender feelings of powerlessness, fear and/or anger: feelings often associated with earlier experiences of abuse. This does not mean, however, that patients should never be restrained. Even from a harm-minimisation perspective, there are occasions when it can be argued that physical restraint may benefit the client. Unfortunately, open discussions about the potential benefits of physical restraint are often avoided because this issue is so contentious, and arguments for and against physical restraint too quickly become polarised. Yet this issue is too important not to be addressed.

A small case for some external care and control

Sometimes clients need physical help not to hurt themselves or others. There are very few occasions when more, rather than less, external control is warranted and when harm cessation, rather than minimisation, is desired – albeit for a limited time only. One such time is when people are *temporarily* suicidal. Although clients may resist physical restraint, physical restraint is not always a totally negative experience for patients – there may be positive aspects too. For example, sometimes patients may feel valued by staff when staff physically restrain them. This is because physical restraint can mean: 'I don't want you to hurt yourself, because I care about you and you matter' as much as it can also mean: 'I can overpower and control you'. When patients feel safe with their professional carers they sometimes, as noted, try and resist being physically held. For some people who have previously been abused this may be the only time they have ever felt safe enough to resist physical control.

This does not mean that violence by patients – or staff – is ever justified. In fact it is the opposite: it can be incredibly important for clients to experience being held, without being hurt and abused. If physical restraint is to be beneficial for clients then it has to be provided in the right way, for the right reasons. As such, identifying and promoting strategies for safe physical

care of clients has to be part of any comprehensive service-level agreement on harm minimisation.

Ultimately, safe physical care will be best promoted by being understood in the context of the overall relationship between client, practitioner and service. Clients need to feel safe, validated and empowered. This happens when clients feel they can make real choices about their lives. Even at times of temporary despair, when clients may be unable to think clearly because they are so overwhelmed by their feelings, control can still be shared. 'Advance directives' can be written, in advance, when clients feel more able to think and articulate their needs. In this way, people can take some control into their most out-of-control moments.

Underlying an empowering approach is a strong sense of hopefulness, even about self-harm, because from this perspective self-harm is largely life-affirming: it is something that helps people cope. People who self-harm are viewed as being capable of positive change and more than able to set their own goals for recovery. These might include: going out; making friends; understanding and managing self-harm, voices, visions and/or dissociated parts; understanding and coping with past abuse and current hurts etc. The result of addressing these goals may be that self-harm stops – but that is more likely to be an end point, not a starting point, for intervention and it may never be a primary aim for some individuals. And for any of this to work there has to be safe, supportive supervision in the context of positive multi-agency collaboration.

Using research, guidance and laws

If we are to work collaboratively we have to have shared policies that all key stakeholders understand and agree on. This is difficult when we are a diverse group of service users, policy makers, commissioners, practitioners and researchers. In order to facilitate shared understandings I think we need detail: more practice-based evidence. Practice-based evidence is what we all produce – every day we work and use services. We bring the nuanced understandings that are needed to make sense of large-scale studies. If we are to demonstrate the utility of a harm-minimisation approach then we need to record this in-practice information. As suggested, in-practice data can be organised around the three aforementioned behavioural, cognitive and emotional aspects of self-harm. If behavioural data is to be recorded this needs to be more than simply whether self-harm has occurred. FIND is a useful mnemonic to structure more nuanced data collection (Warner & Spandler, 2012):

Frequency of self-harm (e.g., once or twice per week)
 Intensity or severity of self-harm (e.g., needs hospital visit or can be managed at home)
 Number of self-harm actions (e.g., 1 or 100 cuts)
 Duration (e.g., cutting over 10 minutes or all afternoon)

This data can demonstrate positive change – that recording number of 'incidents' alone cannot. For example someone may still cut frequently but do far fewer cuts, with less severity, over a shorter period of time. Cognitive and emotional information explains *why* self-harm may have decreased over time and will point to those strategies and aspects of care that are most effective in minimising harm.

Whatever our routes to knowing, there is a growing consensus that services should be personalised and harm reductive. However, service users may need the law to ensure a personalised harm-reduction approach. The Human Rights Act is important because it shifts the focus from the service user to the service, ensuring that if a service wants to change aspects of care, the service must demonstrate how any alternative matches or improves on what the service user is already getting. The service must prove its worth. This means that, under the law, a harm-minimisation service cannot be changed purely on the grounds of expense. This is often important at times of transitions, e.g., from child to adult services. Another aspect of law that could be used to support harm minimisation is the *Bolam Test*. This is the standard test for health care negligence. In simple terms, to be lawful, an intervention (such as not intervening when someone self-harms) must be consistent with a practice accepted by a responsible body of relevant opinion – i.e., one's peers. There is now qualified support for self-harm minimisation from a range of relevant bodies, including NICE (2011) and the Royal College of Nurses (2006).

Last words

Only when we recognise the social roots of distress and commit to trying to minimise harm will we move state services from neglect and hopelessness to hope and recovery. If we accept that abuse and neglect underpin much self-harm then we have to agitate for social change as well as supporting individuals. We need to be more than sticking plasters for a shitty world. We could also be warriors fighting for safer, more equal, less stratified societies.

Making friends with self-harm: A story about distress and survival

Vicky Hudson

Throughout my teenage years I suffered from panic attacks and severe anxiety. I also had flashbacks to earlier traumatic events and over time I started to dissociate, and to hear voices and see visions, which caused me more trauma and distress. At the age of 12 I was given antidepressants to help with some of the symptoms of my distress. The pills did help a little, but they did not take away the pain, anger and hurt that I was experiencing. My self-harm dramatically increased and I became suicidal, angry and withdrawn. I no longer wanted to be alive and overdosed on any tablets I could get my hands on. I ended up in hospital. My family were concerned about my behaviour as it had become uncontrollable and I was so unpredictable. Unfortunately, with no other options, I was taken into care for my own safety.

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Biography

Sam has worked in the area of sexual violence and child abuse since the late 1980s. She started by volunteering in women-only community groups and then trained as a clinical psychologist and qualified over 20 years ago. She is now a consultant and chartered clinical psychologist and works independently within community and secure care contexts.



I was placed in foster care. After a few days I was back in hospital following another overdose and yet again I was back on the children's ward. From there I was sent to a young people's unit for teenagers with mental health problems where I stayed for two months. During that time I was very depressed and continued to self-harm and overdose. I'd cut myself with anything sharp to get release. It wasn't for attention, which many people automatically presume. It was so I could feel: I was that numb I didn't feel any emotions. Watching the blood flow helped me to feel alive again.

getting re-traumatised

Whilst at the children's unit, I started doing dialectical behaviour

therapy (DBT) which I thought was a load of bollocks (excuse my language)! I didn't feel any better whilst doing this as I felt I was being forced into stopping self-harm, which was the only thing in my life I had control of. Because my self-harm had not decreased I was told I wasn't making enough progress and would have to leave the unit. I left remembering very little of the DBT I had actually done and gave up trying their so-called 'coping mechanisms'.

I was sent home. Within hours of being at home I was back in hospital where I remained sedated until a new placement was found. This placement was an open unit for 'challenging' children, where I remained for five weeks. My self-harm became so unmanageable at this time that I was placed in a secure unit where I was locked in with other teenagers, some of whom had been sent there by court for offences they'd committed. I was being punished for trying to make myself feel better.

I spent hours in restraints – placed there so I couldn't self-harm. This just made me more angry and aggressive. I saw a psychiatrist there and a counsellor but I was unwilling to speak to them as I just wanted to be left alone, and I felt it was none of their business how I felt and what the voices I heard were saying. My self-harm continued, as did the flashbacks, the voices and the emotional hurt and pain. I stayed on the secure unit for nine months.

Being free, heard and accepted

I was finally freed from 'the prison' and back out in the community. Although free, I did not feel any better. My self-harm got worse and I would cut myself numerous times daily, drink cleaning products, swallow glass, make myself sick, head bang and use up to 10 ligatures a day. I was on antidepressants, as well as antipsychotics. I met many therapists, counsellors, psychiatrists and even gave DBT another try, which was still as unhelpful as it had been in the past. One problem of DBT was that if I had self-harmed I couldn't contact my therapist for 24 hours. As I was self-harming so much on a daily basis I never got to speak to her after our first session! I gave up talking to all the professionals. Why would I want to see someone who was trying to make me stop the only thing that was helping me survive?

I met Sam,¹ my current therapist, years ago when I was 15 years old and at first was reluctant to speak to her as I thought she would expect me to stop self-harming like all the others had. But she didn't. She accepted that this is how I cope. This felt very different. Because I felt accepted, I felt able to talk about difficult issues – including my self-harm. During many of our sessions I have self-harmed by using ligatures. When we talked about the past, my voices would get very loud and insistent. I would then become dissociated and frightened by my visions. Tying a ligature around my neck stopped the dissociation, the visions and voices. A member of staff would then cut the ligature off my neck and when I came round I could then go back to talking with Sam. If I hadn't been able to tie ligatures our sessions would have been much shorter, it would have taken much longer to make sense of my trauma and I would have probably given up on therapy all together.

Being looked after

My staff team also take a different approach and don't stop me from self-harming (see the following article by Tracey Greaves). They offer support and talk to me about how I'm feeling. This is instead of coming in, taking my blades away and restraining me. This way I am more open about when I self-harm and I will let people know if I need medical attention instead of hiding it away. I can do this because I know they understand that self-harm is my coping mechanism. When I have therapy, Sam and I feed back to the staff member who is on that day what we have talked about during therapy. This also helps staff understand what issues are around for me and helps them in supporting me. I am really grateful that my local NHS Trust and Social Services have supported this way of working with me. Without this type of service I would have ended up stuck for years locked up on a secure mental health unit, or even worse – because my self-harm would have escalated – I could have ended up dead.

I use self-harm as a way of coping, a way of living. Now when I cut I mainly do it because I'm angry and when I see the blood I feel calm. I tie ligatures around my neck till I go unconscious. This is not a suicide attempt it just gives me a break from all the horrid stuff in my head. When I self-harm I'm not judged for doing it as the people who look after me understand that that is how I cope. In the past when I have been stopped from doing it, I've felt panicked and angry. This has, many times, led to me causing significant harm to myself from feeling so out of control. I now only use one ligature a day and cut rarely. Self-harm has become part of my life and maybe one day in the future I will stop: but only when I'm ready. Self-harm has become my friend, at times my enemy, but without it I wouldn't be here today.

I get so angry

By Vicky Hudson

I get so angry deep inside
No matter how hard I've tried and tried.
I just can't put the blade away,
Self harm has won yet again today.
I cut myself till I see blood
And instead of feeling angry I now feel good.
Watching the blood flow
Makes me feel better when I'm depressed and low.
It's something I can turn to
On the days I feel lonely and blue.
When I feel I've got no one around
I breakdown and cry: I sink to the ground.
I'm lucky I've got people near by
To hold me, support me, wipe away my tears as I cry.
They help me see life's not as bad as it seems
And one day I'll be able to follow my dreams.
I'm glad I've got people there;
To protect me and care.
And although my blade's just an arm's reach away
Self harm hasn't won for the first time today.

1. This is Sam Warner who wrote the previous article

Some thoughts from a support worker



Tracey Greaves

Introduction

I have worked with young people, as a support worker, for seven years and have met many young people who have self-harmed in various ways and to different degrees. There are two young women who particularly stick in my mind. This is partly because their self-harm was so much greater than I was used to and partly because they were significant in helping me to realise the value of a harm-minimisation approach.

Some thoughts on the limits of dialectical behaviour therapy

I first met Shelley when she was 14 years old and Vicky was 16 years old, when I came to work for the organisation that provided individual homes for them. They were both offered dialectical behaviour therapy (DBT) to help them stop self-harming. As Vicky writes elsewhere in this issue, apart from the first time Vicky saw her DBT therapist she never spoke to or saw this therapist again because she never had a 24-hour period free of self-harm. According to DBT, unwanted behaviour, such as self-harm, should not be rewarded. Hence, it is common practice for the client not to be allowed to see her therapist for 24 hours after self-harming. Shelley did try to stop self-harming. This caused her more anxiety and she had to find other ways to release her feelings. This often resulted in damage to property and belongings, and aggression towards the staff and/or her family. It also made Shelley feel like she was a failure precisely because she had self-harmed. This was made worse because she couldn't speak to her therapist afterwards. This delay only made Shelley feel worse, which made her want to self-harm more as she became evermore angry with herself. Both Vicky and Shelley, and the other young people I have worked with, needed a different approach.

Practical harm-minimisation

Self-harm helps people cope with overwhelming feelings and emotions. Taking this coping mechanism away only seems to aggravate the person more, resulting in them channelling their feelings elsewhere and in other ways that can be less safe and more damaging. As such, harm-cessation approaches often seem to result in greater self-harm, not less. In my experience, if a young person has items taken off them that they use to self-harm they will then try and use other items that will cause them more harm than the items taken away. For example, using serrated tin lids or broken CDs gives more chance of infection and complications than allowing the young person to keep razor blades that they can clean or change each time they self-harm.

Hence, minimising harm is easier with some *methods* of self-harm than others. Harm can also be minimised by managing *access* to methods of self-harm. For example, when Vicky was younger she tied multiple ligatures around her neck with socks every day. The staff would keep Vicky's socks and would give them out only when she was leaving the house and only when she needed a new pair. This allowed staff to monitor Vicky's use of ligatures. This meant that Vicky was kept safer than if she had an endless and immediately available supply.

Some benefits of planned self-harm

Young people also benefit from sharing their intentions with staff, who can then plan how to care for them in advance. Strategies can also be put in place so that it is safer for everyone if the person decides to use a method that could also harm others, such as burning. Young people can also be helped to understand the physical health consequences of their actions so that they can make an informed choice about self-harm. They can be taught how to treat their injuries, when to seek medical advice and where to go for treatment if required. They need telephone numbers for relevant services, opening times, and a stocked first-aid kit so they can self-treat if necessary.

Some benefits of understanding how self-harm works

Young people, like Shelley and Vicky, benefit from being listened to by someone who will not judge them for self-harming. They need people who do not tell them off; who will help care for wounds; and will give them space when needed. All of this can be emotionally challenging for staff. In my experience getting to know the young person, their issues and how they use self-harm, is paramount. This is because it is crucial to understand that their use of self-harm is not a suicide attempt but a coping strategy, however severe the self-harm may appear. Having this understanding helps reduce anxiety and this helps staff focus on the young person's immediate needs (e.g., to talk, to be cared for) rather than get lost in their own panic and worry. And self-harm can be really worrying. I can remember the first time I had to help Shelley after she had cut herself, whilst sitting in the bath (with her swimming costume on). I had to enter the bathroom as she was not responding to my calls. The sight of the red water caused me to panic as there appeared to be lots of blood. In fact the wounds Shelley had inflicted were very small. On future occasions I was aware of this and my state of panic was diminished.

Some benefits of good supervision and shared responsibility for care

Removing ligatures can also cause staff to panic. The young person will have turned a shade of blue/purple and may have passed out. Staff may then worry that the person may have stopped breathing. The only things that can relieve this fear are having a shared plan, discussing it with other staff, experience and training. When I first started to work with Vicky I was nervous about using ligature scissors to remove the ligature. I feared that I would cause some injury to her and worried that I would be reprimanded for this. As I worked with Vicky and other staff more I found that this wasn't the case. Sometimes injuries would occur to Vicky's neck. However these injuries were superficial and less damaging than if the ligature wasn't removed at all.

I know lots of care staff who choose not to work with people who self-harm. They either cannot cope with blood, they find it difficult to understand why people self-harm and/or they have a deep fear that the young person will die, accidentally or by design. Staff then fear that they will be blamed for the young person's death, or they fear that they could not deal with the guilt afterwards. In some way I believe all staff fear this, it's how they manage this fear that makes the difference. Staff need support, otherwise they lose patience and are unable to care. When staff are feeling mentally and emotionally exhausted, staff need to be able to take a break and go to another room, or make a drink and call someone for support. In the early days of working with Shelley, I frequently had to deal with Shelley's self-harm and challenging behaviours for 24 hours straight. She refused to let me go to another room for a break and wouldn't let me go to bed at night. At these times I would call my manager for support, and she would often come out to the house to sit with Shelley, whilst I had a break. Afterwards, my manager would sit and talk to me about how I was feeling in these situations, giving me time to 'vent' any anger or upset that I was experiencing.

For staff having a strong and consistent support system in place can help immensely. When a new member of staff starts I have found it helpful for them to do 'shadow shifts' with an experienced staff member to gain advice and understanding on dealing with different aspects of self-harm. Having regular individual and clinical team supervision is also beneficial as it helps staff to discuss what they find difficult about managing self-harm, to gain insight into how others manage it and to ensure that everyone is supporting the young person in the same way. To this end, we have found that when a young person has regular therapy, it can be beneficial for the staff team to have clinical supervision with the young person's therapist. Clinical supervision allows staff to gain further insight into the young person and what triggers them to self-harm. Young people are generally positive that staff share information about them, that staff receive relevant feedback from therapy and that staff have access to supervision (as noted, preferably by the young person's therapist). This is because young people have a greater sense of safety and security knowing everyone in the team understands them and shares a common approach. This is how Vicky's package of care works with Sam Warner (who has written elsewhere in this issue). As Vicky has got older, she also sometimes attends team supervision sessions alongside staff.

Promoting choice and control

Using a harm-minimisation approach means that choice and control is not taken away from the person. Some people see harm minimisation as condoning the person's self-harming. I see it as accepting that the person uses self-harm to deal with difficult feelings and situations. We can still encourage young people to understand and manage their feelings in other ways. But surely it is better that when young people self-harm they do so in as safe and controlled a way as possible, rather than engaging in evermore damaging self-harm techniques?

Tracey Greaves is a senior support worker.



Being Human? My struggle with self-harm

Nicki Evans



Talking about self-harm is never easy; it has taken years for me to be open and honest about the subject. It's uncomfortable to read about and difficult for people to understand why someone would be compelled to purposely hurt themselves. There's never a simple answer; the reasons for self-harm are complicated.

My own experiences

It was gradual at first, my breakdown, if you want to call it that. Then it became something that was my entire existence, I descended into a place and world I felt I had no right to be in, feeling like I had no right to exist.

I saw no way out, nothing mattered, least of all my own body.

I self-harmed daily. I hated life and was full of self-loathing. I felt angry and frustrated in a world that I felt I did not belong nor function in. Self-harm seemed a clear and logical response to my distress. It seemed the only clear thought within my chaotic mind. I had no regard for the severe damage I was doing and started a cycle of attending A&E regularly to get my wounds seen to. Yet all too often the attitudes I encountered, and the shame I felt, resulted in attempting to deal with wounds myself when they really needed stitching. As a result I am left with some very bad scars.

I was very driven to self-harm in any environment I was in. I can only begin to imagine how difficult and frustrating this is for the NHS staff and mental health professionals seeing someone intentionally hurt themselves who is unwilling to see past what they are doing on a day-by-day basis or consider any help. I felt I was beyond help. Any challenging of what I was doing was met with me answering that I had no future therefore it did not matter what I did to myself.

Anything harmful I repeated in ever-more damaging ways; anything positive I rejected. Often I hear self-harm referred to as a coping strategy for distress but I feel this analogy alone does not fit me entirely. I do not doubt however that if I had not self-harmed, I would have taken my own life.

Self-harm represented something much deeper for me. For me, it was a fight against the human condition that I dwelled on and internally panicked about.

It was a response to the questions I continually asked myself, and the subsequent feelings I had. What is it to be human? Would we know if we were not human? Why are we here? Who am I? What is reality?

I felt that I was not human. Often I felt no pain when I hurt

myself, which left me with an appalling sense of curiosity in myself and the further need to do something far worse to almost try and affirm in some way that I *was* human. But it proved nothing to me. I thought too much; it's easy to drive yourself crazy at times, asking questions.

Don't get me wrong. These are important questions to ask in the right emotional state. But this constant questioning was the dominating presence throughout my distress and wasn't helpful to me at that point in my life.

The world felt unhinged and frightening, hurtling at a catastrophic pace while I felt helpless looking on. This feeling of being out of control is something I struggle to describe, but it invaded all my senses. It felt like all my being was hurtling both mentally and physically to a dark demise within something infinitely vast.

diagnoses and treatments

Much of the experiences I describe may appear to fit the 'criteria' for 'borderline personality disorder' (a.k.a. emotionally unstable personality disorder). I feel this is a devastatingly damaging diagnosis. The relief I felt in knowing I was not alone was short-lived. In many ways we are alone, I am under no illusions there. I feel I would have been far better off never learning of such a diagnosis, as I felt defined by how I was characterised by others rather than learning to know myself and think for myself.

I felt I was revolving and repeating myself, through both the hospital ward doors and psychiatrist's office. The doctors have seen it all before and I felt like a parrot giving a recital of negativity and anger. The recommended treatments were trial and error of going through every medication in every combination until I made the decision medication was not for me.

Talking therapies only started to make an impact when I became less medicated. For those of you who have experienced how emotionally numbing and crippling taking psychiatric medication can be, I feel the true problem cannot be seen clearly when taking huge quantities of medication. I often found it paradoxical to be treated on the one hand with medication that prevented me from expressing myself and then to be sitting in therapy, which is all about expressing and communicating feelings. It's difficult to speak from the heart when you're numb.

Different approaches were used in hospital. Sometimes I was told I would be discharged if I self-harmed. This made me dangerously self-harm and seek no medical help, withdrawing further into myself, staying out of the way of staff. There was no way I could be

stopped from hurting myself; I was impulsive and opportunistic in finding things to harm myself with.

A different approach was that I was allowed to take some responsibility for my actions. I agreed that if I cut myself I would get it looked at by a nurse and that I would talk about it more. This worked far better. Not only did I go to nurses more if I self-harmed but, more importantly, the severity of the cuts reduced and eventually became far less frequent.

In hindsight, my initial acceptance of this kind of approach was the start of wanting to change and to realise that repeated un-cooperation and defiance was ultimately hurting only myself. I was growing weary of my own repetition.

Things change

I felt I had systematically thought through so many unanswerable questions and resulting crises that I had to move away from this pattern of thinking. Gradually, and often unnoticed by me, the dark, infinite, out-of-control feelings were replaced with more 'normal' uncertainty and worry of what the future holds.

In the past I thought that people were part of the problem, not the solution. The very notion of wanting to be around people who enriched my knowledge and life would have filled me with nauseating fear a few years ago. I would have rejected such sentiments. But attitudes change. I believe no one could have stopped me self-harming. Only I could do that, and I had to do this in my own time, when I was ready. I started to want to look after myself and began to see a future that was not constant torment. It is one of the most liberating things to no longer consider suicide as a way out if things get unbearable.

The scars I live with represent to me how far I have come – that I have survived the destructiveness that could have cost me my life.

Biography

Nicki is currently a service-user consultant and volunteer in her hometown of Shrewsbury, with a fondness for animals, especially her dog, the outdoors, travelling, photography, website design and writing poetry.

The impact of caring

Terri Shaw and Karen Wright

Terri and Karen draw on their own experiences of nursing and caring to discuss the personal and professional response to self-harm.



People usually take on caring roles because they want to help, yet there seems to be something inherently difficult about self-harm that leaves staff/carers struggling to respond in helpful ways. In this article, we try to address this often overlooked issue. In particular, what is the impact of caring for someone who self-harms? And how are staff supported to deal with the emotional demands of caring?

People who self-harm are clear about what they want and need from services: positive staff attitudes, along with involvement and information. Yet research shows time and time again that responses experienced by service users are often profoundly negative. Service responses that have been reported as 'unhelpful' include: 'condemnatory, dismissive and punitive attitudes', 'ignorance and misunderstanding' and a 'failure to listen to or address underlying issues'. Put simply, the gap between what people who self-harm want and need and what they often receive couldn't be wider. By considering the impact of caring for someone who self-harms it is possible to identify explanations for this apparent lack of care.



Both of us draw from our own professional experiences as nurses and acknowledge that it can sometimes be really difficult to offer care and support to someone who self-harms. Although we have worked in different environments, we can both identify having felt frustrated, inadequate, hopeless and powerless at times and can admit that these emotions sometimes gave rise to responses that may have been perceived as negative. However, whilst it may have seemed that we were acting in a callous or uncaring

manner towards the people we were meant to be helping, it was certainly not our intention.

So what else could explain our perceived lack of care? With the benefit of hindsight, grounded in a much better understanding of self-harm, we both realise now that some of our 'unhelpful' responses were rooted in our own efforts to try to protect ourselves from the emotional impact of self-harm. In our efforts to protect ourselves, we never stopped to think about how our defence strategies might impact on the people we were meant to be supporting. The reality was that we were trying to do the best we could in extremely difficult and demanding circumstances, often with very little support or training from the organisation in which we were working. In fact, there was a degree of ignorance about self-harm that bred defensive attitudes rather than any admission of weakness.

The personal emotional investment of caring is often not appreciated or acknowledged. The very act of being compassionate and empathic extracts a cost. In an effort to view the world from the perspective of someone in distress, we expose ourselves to the hurt they feel and this can elicit parallel feelings of vulnerability and fear in us. Self-harm can be a particularly emotive issue, often leaving staff feeling in shock, horrified, distressed, frustrated, sad, powerless, fearful and inadequate. These are difficult emotions for anyone to deal with, even with support. Yet both staff and carers are often expected to cope with the emotional impact of self-harm with only limited support or supervision from the service.

So how do we cope? Certainly 'burnout' becomes a likely outcome if protective strategies are not put into place. Burnout is a state of physical, emotional and mental exhaustion that results from long-term involvement in situations that are emotionally demanding. When considering burnout in the context of a work environment, where staff shortages, increased workloads, lack of organisational guidelines and concerns around breaching duty of care are added into the mix then it stands to reason that eventually something will 'give'.

Burnout has been offered as an explanation for absenteeism and increased staff turnover and has also been identified as impacting on quality of patient care. However, if support is lacking, it is worth reflecting on how nurses/carers might implement their own negative defence strategies as a means of protecting themselves from the emotional demands of self-harm. Is it possible that these defence strategies go some way to explain the unhelpful responses identified by service users?

For instance, viewing self-harm as 'attention-seeking' or 'manipulative' means that we don't have to engage with the distress that lies behind the self-harm. Likewise, being drawn to explanations such as 'it's only superficial' or 'it's just copycat behaviour', means we can avoid listening to the often painful and complex stories behind self-harm and, as a result, defend ourselves from the difficult emotions that may result.

There is a plethora of literature that informs us about the impact of the professional response on the client

who self-harms and how dissatisfied people are with the care and treatment they receive. There is less written about the impact on the worker of caring for someone who self-harms.

For the nurse who enters the profession to 'make people better', it can be difficult to accept that some people need to harm themselves in order to feel better. It seems counter-intuitive. It can be upsetting and the nurses/workers' first response might often be to stop the self-harm from happening. Many people who self-harm are just not able to stop and so this response from workers seems to reinforce how little workers understand about how they feel. Nonetheless, this is sometimes difficult for healthcare professionals to make sense of.

The most effective practitioners are those who are able to stay on top of their emotions and make sense of them, reflecting on the impact on their presence and their practice. We often assume that people learn *experientially* and that some experiences are *educative* whilst other experiences are *miseducative*. All experiences are understood to be *continuous*, that is, each experience influences each future experience. Hence a stressful or difficult experience of caring for someone, irrespective of what/who created the disharmony can be miseducative. With this in mind, it is important to reflect upon practice (without attributing blame) to consider where progress can be made for both parties.

We have found the following helpful. Gibbs (1988) suggests that there are six steps to aid reflective practice:

1. Description – what happened?
2. Feelings – what were you thinking and feeling?
3. Evaluation – what was good and bad about the experience?
4. Analysis – what sense can you make of the situation?
5. Conclusion – what else could you have done?
6. Action plan – what will you do next time?

Unlike many other models, this takes into account the realm of feelings and emotions which played a part in a particular event. However, for this to be useful, honesty and self-awareness are crucial.

The myth that self-harm is a way of manipulating workers is one that is still believed by some. We should be worried if we believe that clients have to hurt themselves to get their needs met. It is our responsibility as workers to assist our clients to communicate their needs to us in ways that are not harmful to them or us. If we are struggling then we owe it to our clients



and to ourselves to seek help, whether that be via formal clinical supervision, reflection on practice, or education to better understand ourselves and the people we care for.

In summary, by reflecting on and identifying the emotional demands of supporting someone who self-harms we not only become aware of how it might be impacting on us but also how it might shape our responses to the person who self-harms. It is not a sign of weakness to admit that you are struggling and need help; self-harm can be a really difficult issue to deal with. By seeking out and accessing the support that your service is offering, you will be not only protecting your own mental well-being but also be much better placed to offer the help and support that people who self-harm want and need. From an organisational perspective, by not acknowledging the support needs of staff working within their service or ensuring that appropriate and accessible support is in place means the organisation runs the risk of failing – not only their clients, but also their staff.

Helpful further reading

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Biographies

Terri has a background in nursing but her real interest and involvement in the issues stem from the experiences of her sister who self-harmed over many years. She helped set up the self-harm training organisation, harm-ed.

Karen is a mental health nurse and academic at the University of Central Lancashire.

Both helped organise the 'Minimising Harm, Maximising Hope' conference.



What We All Know

Jackie Hagan

In here ...
 everything's broken: the activity cupboard's
 broken; the kettle's broken; this felt tip's fucked!
 Just keep hitting your head against the wall; we
 know that works.

Come and have a nervous breakdown; it's
 something to do.
 We wake up at 8, it's like an Enid Blyton boarding
 school
 but the girls have all grown up.
 Every day at 9 and 12 and 5 for meals we have
 food, that tastes like
 food
 and tomorrow for lunch it's
 ... food
 and we smoke our fingers to the bone
 and laughter breaks in
 two.

Come on in – you might as well, it's like a holiday
 from life,
 the view
 from the dayroom:
 men pacing and holding it in
 until they don't,
 crazy women in crazy women coats,
 force-fed hope and tired of trying, we smoke.

The library is a *Take A Break* with the teeth filled
 in;
 that fence keeps the world out
 and every day at 9 and 12 and 5 the kitchen
 battles with itself
 and smoking is compulsory.

Come on in, you're just in time –
 Beryl's kicking off and screaming all that stuff we
 all already know
 from the last time she kicked off,
 with more arms, legs, tears, the nurse's face and
 blood and later
 she'll come sedated into the dayroom,
 tail-tucked and shamed that we all know
 what we all know;
 what we all know anyway.

Amy's stealing everything
 with nothing to put it in
 and Paddy remembers back
 when he used to have opinions and a coat.

Come on in,
 it's like an Enid Blyton boarding school.
 Instead of Matron
 we've got Elaine the nurse who's overworked and
 going grey too early from empathy and no time
 to care,
 and Lucy, the young nurse, on who it's just
 dawning that this system,
 it doesn't work.
 But once a week we have ward rounds!
 It's all straighteners and bobbles and Beth
 thinks she's got a chance to go home
 and Erica's dying to see her kids
 and wait.

and wait.

and wait.

until the Lord Our Saviour!
 (the psychiatrist)
 is ready to look at us
 in his peripheral vision
 with his surprising lack
 of interpersonal skills
 (considering he's chosen to work with
 people
 and
 psyches)

See,
most
 psychiatrists need to learn one sentence:
 when someone tells you something horrific that's
 happened to them
 (which they will because you ask them *again and*
again)
 say this: "I'm really sorry that happened to you."

A quite depressing poem about poverty, austerity, the ConDems and shit with a bit of mental illness thrown in

Michelle Brown

The country's in pieces, and so is my mind
or maybe I'm just a particular kind
You'll have heard of my sort in the Sun and the Mail
An apparently simple morality tale
Of "parasite lifestyles faking depression"
So ok, here it is, signed and sealed, my confession.

Yet I ask, if you think you know all of our ways
Have you ever made ten pounds last for ten days?
Have you blinked back tears so the children don't see
And wondered just what you can buy with ten pee?
Have you ever dreaded the knock on the door
Demanding a payment due six months before?

Do you think I would choose to feel scared all my days?
Now it no longer matters what *my* doctor says
To have hostile strangers poke inside my head
And say yes she's mental, but quite far from dead
Perfectly able to work for no pay;
She better, or we'll take her money away.

I am a person, just like any other
We're all someone's daughter, a friend, someone's mother
We live and we love and we try to survive
And I'm sick of the system that eats us alive
But what makes me burn is the lies and the slander
Please look past the labels, the cruel propaganda

Don't give in to the impulse to turn on each other
We stand shoulder to shoulder and sister to brother
If the love in our hearts dies, that's when they have won.
But that day's not here for me, my fight's not done.
I won't call people scroungers, or workshy or skivers
I call them my people; I call us survivors.

Feeling Sad and Depressed?



Are you anxious?
Worried about the future?
Feeling isolated and alone?

**You might
be suffering
from
CAPITALISM**

Symptoms may include: homelessness, unemployment, poverty, hunger, feelings of powerlessness, fear, apathy, boredom, cultural decay, loss of identity, extreme self-consciousness, loss of free speech, incarceration, suicidal or revolutionary thoughts, death.

Ask your local doctor, union or occupation about MayDay_{Rx}

#MAY1

POST TRAUMATIC STRESS

DEAN SMITH

BOMB, BLAST, BOMB BLAST, HEAD BLOWN OFF,
BOMB, BLAST, BOMB BLAST.

SNAP OUT OF IT !!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!——

WORDS ARE EASY TO SAY BUT EMOTIONS ARE
HARD TO PLAY, I AM COMING TO TERMS FROM
MANY YEARS. YES, I AM TOLD, I AM A "MAN"
(AND!), BUT I HAVE TEARS!! FOR ALL THOSE
SUFFERING, PLEASE DON'T DISMAY, IT'S A
NATURAL
REACTION TO ACT THIS WAY ...

PEACE ... DEANO XXX

P.S. THANKS TO THE M.O.D. FOR NO HELP AT ALL
XXXX

NEWS & COMMENTS

DISABLED EMPLOYEES TWICE AS LIKELY TO BE ATTACKED AT WORK

Employees with disabilities are twice as likely to be attacked at work and they experience higher rates of insults, ridicule and intimidation, a new UK study has found.

Researchers from Cardiff and Plymouth Universities found that people with physical or psychological disabilities or long-term illness reported higher rates of 21 types of ill-treatment than other workers did, often from their managers and colleagues.

These included being given impossible deadlines and being ignored, gossiped about or teased.

The lead researcher, Professor Ralph Fevre, of Cardiff School of Social Sciences, said: "Up to now, researchers have generally assumed that ill-treatment in the workplace was causing disabilities and health problems. Our work suggests ill-treatment happens to employees who already have disabilities or health problems."

Among workers with a disability, those with a psychological or learning disability usually fared worse than those with physical disabilities or long-term physical health problems. Among those with a psychological or learning disability, 21.2 per cent said they were victims of physical violence, 44.2 per cent said they had been insulted and 56.9 per cent said they had been shouted at.

The research, which uses data from the British Workplace Behaviour Survey, was published in the journal *Work, Employment and Society*, March 2013.

Source <http://www.esrc.ac.uk/my-esrc/grants/RES-062-23-0312/read>

SELF-HARM INCREASING, ESPECIALLY AMONGST CHILDREN

In the UK, an estimated one in twelve young people are believed to have self-harmed at some time or other. Although self-harm is most common amongst older teenagers, children's charities are warning that more are self-harming and also that younger children are being affected. Children as young as 10 are calling helplines to say they have hurt themselves in this way.

Over the past two years, ChildLine has registered an increase of 167 per cent in people getting in touch about the problem. It was one of the top five concerns reported among 13-year-olds last year, whereas previously it was only seen as a big issue for older teenagers. Children as young as 10 are now contacting it over the problem. Out of more than 16,000 sessions on the subject among children and teenagers of all ages, in the last year there were more than 600 counselling sessions – calls and messages – between ChildLine and children aged 10–12, where the main concern was self-harm.

ChildLine, YouthNet, YoungMinds and the website Selfharm.co.uk have come together to try to reduce the stigma and expose myths about self-harm, so that more young people seek help.

In a separate news item, in one county self-harm amongst all age groups was said to be up by 80 per cent in one year. This is according to the NHS Together Trust in

Gloucestershire: 1,015 incidents were recorded during the last 12 months, compared to 612 incidents during 2010–11. The NHS says recorded cases have also risen nationally in five years – there were 94,000 cases of self-harm in 2007–08, and 110,960 during 2011–12.

A spokesman for Together Trust said: "There are a number of reasons why the figures show an increase. However a vast majority of self-harm incidents we report are attributed to low intensity, high frequency acts such as an in-patient slapping themselves."

Sources A. Harrison: 'More young people are self-harming, say children's charities.' BBC News, 1 March, 2013.

'Self-harm up by 80 per cent in Gloucestershire, says NHS Trust.' BBC News, 18 March, 2013.

CTOs DO NOT REDUCE HOSPITALISATION

Placing mental health patients on community treatment orders (CTOs) after a period of involuntary hospitalisation does not alter the likelihood of them being hospitalised again, and their use should be "urgently reviewed" a study claims. In what has been described as the largest randomised trial of CTOs, the study found that placing patients on CTOs, which curtail some of their freedoms in the community, does not reduce the chance of them being re-admitted to hospital, compared to the previous – and less restrictive – type of supervised discharge, called Section 17 leave.

The study looked at whether 166 patients on CTOs experienced fewer hospital admissions compared with 167 patients released under Section 17 leave. The researchers found that the number of patients re-admitted to hospital over 12 months did not differ between the groups. Nor were there any significant differences in the time to re-admission, or the number or duration of hospital admissions.

Given that CTOs were not introduced primarily to reduce hospital admissions but to lessen risk, we are left wondering whether they have actually increased patient and/or public safety – and, if so, at what cost?

Source Burns, T. et al. (2013) Community treatment orders for patients with psychosis (OCTET): A randomised controlled trial. *The Lancet*, Early Online Publication, 26 March 2013.



ASYLUM COLLECTIVE MEMBER AWARDED PRESTIGIOUS TRAVELLING FELLOWSHIP

Dr Tamasin Knight, a public health doctor based in Lancaster and member of the Asylum Collective, has been awarded a prestigious Winston Churchill Memorial Trust Fellowship to travel to the USA. She will explore alternatives to

conventional mental health services, in order to facilitate similar innovative mental health projects being set up in the UK.

The Winston Churchill Memorial Trust awarded 125 Travelling Fellowships for 2013 selected from 1,161 applicants. The grants are awarded to British citizens from all walks of life to acquire knowledge overseas to bring back the benefit for others in the UK.

“We are delighted to have awarded Dr Knight a Fellowship. Her trip will enable learnings from International best practice to be disseminated in the UK, in this hugely important and topical subject”, commented Jamie Balfour, Director General of the Winston Churchill Memorial Trust.

Asylum magazine will keep you updated on Tamasin's travels. Applications for the 2014 Winston Churchill Travelling Fellowship categories are open 8th May to 1st October 2013, visit www.wcmt.org.uk for more details.



In the Writer's Chair

We asked Clare Summerskill, our guest author, performer and comedienne, the following questions:

1. Room 101 of mental health – who or what?

Psychiatric nurses and consultants who can't manage to say "So, how are you doing today, I'd really like to know and while we're at it perhaps you could fill me in a little about your past."

2. Fantasy OT:

Judi Dench (no brainer!)

3. What diagnosis would you like to add to DSM-5?

Bullying. Whether within the family, business or politics. This condition shows a lack of self-worth and a need to hurt others without engaging in any feelings of empathy towards the victim. If medical treatment is not deemed appropriate a fixed penalty fine might work as a deterrent.

4. Suggest an alternative name for a well-known treatment or service acronym.

CBT should be called RCSTSPTB: Relatively Cheap and Short Term Sticking Plaster that Ticks a Box.



5. Who would you like to section?

The Pope who dresses in frocks and condemns homosexuals. Bashar al-Assad, President of Syria, a power-crazed tyrant showing psychopathic tendencies. All practising GPs – just for a day, so they can see what it's like before they do it again to someone.

6. A favourite psychiatric moment from literature or film.

From the book Even Cowgirls Get the Blues (by Tom Robbins). 'In my childhood, I was an imaginary friend.'

Clare is the author of *We're the Girls!* a collection of comedy monologues, short stories and song lyrics (Diana Publishing, 2008); *Hearing Voices*, a play based entirely on service users' experiences of the mental health system (Tollington Press, 2010) and *Gateway to Heaven*, a book of memories from older LGBTs (Tollington Press, 2012). Clare is currently touring her new one-woman show around the UK.

<http://www.claresummerskill.co.uk/>

Help! I've lost my diagnosis!

Barbara Riddell

I was a 'crazy, mixed up kid' who grew up to collect a clutch of psychiatric labels, including depression, eating disorders, phobias and substance misuse (a polite term for 'falling down drunk on a daily basis'). But I felt I'd hit the jackpot the day my GP said to me, "*Barbara, I think you have manic depression.*"

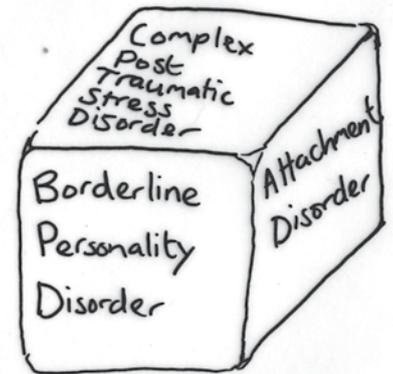
My GP had treated me for depression in the past, but said he'd "*never seen me like this*". 'Like this' meant my enthusiastic non-stop babbling about nothing and everything. It was, apparently, indicative of a florid state of bipolar disorder, which was then known more commonly as manic depression.

But the reason I'd gone to him in the first place wasn't because of my enthusiastic babbling about the millions of ideas and plans whirling round in my brain. Instead, it was because I'd decided to have a baby, despite the fact I have never been the maternal type, and wanted to check if I was too old at 41 to have a baby. I'd already identified a suitable sperm donor: a fellow student on my master's degree course. He was young, healthy, intelligent and had studied at Oxford. That seemed a good enough pedigree for fatherhood. (I never did tell my fellow student about the plans I had for him, nor did I get round to mentioning it to my GP as I'd been stunned into silence by his diagnosis of manic depression.)

And so began the long journey into the world of bipolar disorder and the land of medication, plus a new identity as someone with bipolar disorder, one of the two most severe and enduring mental illnesses (I read). The other is schizophrenia. The antipsychotics to calm my mania caused me to feel most odd – spaced out, not quite there. And then someone told me about the tablets which counteract the side effects of the antipsychotics. I felt I'd entered a Kafka-esque world: tablets to damp down the sparkling manic days, tablets to deal with the suicidal depressions, tablets to deal with the side effects of the original tablets, tablets to help me sleep so that I didn't become even more manic (lack of sleep is both a symptom and a trigger for mania).

This illness or disorder or lack of brain chemicals or whatever it was, was also the birth of a new me – the one who had bipolar disorder. I became a 'service user' and met other manic depressives through the Manic Depressive Fellowship (now Bipolar UK). We laughed about the madness of 'going high', cried when we heard of people who couldn't take the depressions anymore and took their own lives, and celebrated when people got jobs. We connected, we 'got it', we understood. This period of my life coincided with the worst (and last) two years of my alcoholism, so I was also trying to work as a freelance PR consultant from home, which only resulted in me starting to drink at ten in the morning and being comatose by three o'clock.

Diagnosis Dice



And then one day it was gone. My bipolar disorder was no more. I was no longer a manic depressive. During the bipolar years, something else had also been going on, but no one had seen it – or, more accurately, had dared to mention it.

I'd read an article about a woman who experienced a series of difficulties such as rapid changes in mood (often on a daily, even hourly basis), substance misuse, self-harm, low self-esteem, eating disorders, etc. These are common symptoms of borderline personality disorder, it said, and suddenly I knew what my underlying problem was – borderline personality disorder.

When I asked my community psychiatric nurse "*Do I have a personality disorder?*" she refused to give me a straight answer. Finally she admitted that borderline personality disorder (BPD) was something that had been 'skirted around' since 1997, when I'd first cut myself. I was astonished and furious. This had been mooted since 1997 and no one had thought to discuss it with me!

Borderline personality disorder seemed to me an ugly, negative description of my whole personality; not just a part of my mental health, but of my whole being. Reeling from this news, I read everything I could about BPD. And it wasn't attractive. People with BPD are (or were then) seen as needy, manipulative, attention-seeking, pain-in-the-backside patients, that no one wants on their caseload.

But being given this new diagnosis of borderline personality disorder was important for me as I now knew which books to read, which websites to access for help and information. For so long I had been searching for solutions to my eating disorders, my suicidal depressions, my alcoholism and self-harm. I felt relieved at being able to make sense of myself, my personality, my thoughts, feelings and behaviours.

My community mental health team (CMHT) has taken to putting your diagnosis at the top of the letters they send. The latest letter just had 'Borderline Personality Disorder' on it. "What's happened to the bipolar disorder?" I asked my psychiatrist. "*Oh, we no longer think you have that, that it was BPD all the time.*" But, but, but ... What about all those medications I took to treat my bipolar disorder? What about my description of myself as 'having' bipolar disorder? I've experienced moments of mania, as well as depressions so severe that I've got to the point of writing

out a suicide note. Not for the first time, dealing with mental health services left me speechless.

Today, I'm more stable and I take the view that I had both bipolar disorder and borderline personality disorder. One was more prominent than the other at certain stages in my life, that's all.

My alcoholism has been dealt with by joining Alcoholics Anonymous – a move which kick-started my whole recovery from mental illness. Aside from anything else, AA assists my borderline personality disorder. *“Twelve-step support groups provide a ritualized approach to recovery, while offering kinship with thousands of others who have walked the same path”*, says Richard Moskowitz in *Lost in the Mirror: An Inside Look at Borderline Personality Disorder* (1996, p. 130), one of my favourite books on BPD, because he respects people with BPD and the ways in which we have coped with our lives, even when they have been unhelpful or damaging.

I still have problems with intimate relationships, with food, with frequently feeling that suicide is my only option should life become difficult again. But the unpredictable emotions I experienced every day, the chaos and the unhelpful coping skills I used to obliterate the emotional pain, have eased.

Now when I'm asked *“How are you?”* my reply is not a tedious and elongated tale of the latest woes in my life, but usually *“Jogging along nicely, thank you”*. I have routine and order in my

daily life, which help me tame my chaotic tendencies, as well as 'me' time. 'Me' time might sound easy to achieve as I live alone, but the demands of daily life can easily crowd out this precious reflective space that I need to make sense of the emotions I experience each day.

I've been discharged from my CMHT; not a prospect that was as terrifying for me as it used to be (we borderlines can't deal with rejection and abandonment). The proviso is that I can come back should I ever feel I'm in crisis in the future, something which soothes my fear of abandonment.

I will always *“remain vulnerable in some areas that have healed, while you develop unusual wisdom and strength in others”* to quote Richard Moskowitz again (p. 160). Diagnosis has been vital to me in the past. It's helped me make sense of my often extreme symptoms, thoughts and feelings. Finding others who experience the same has kept me alive. I no longer label myself as 'having' bipolar disorder or borderline personality disorder. I'm someone who's experienced a lot of difficulties in the past. But now I'm healing.

(P.S. – if you find either of my diagnoses, you can keep them. I don't want them back.)

Reference

Moskovitz, R. (1996) *Lost in the Mirror: An inside look at borderline personality disorder*. Dallas, TX: Taylor Publishing.

Asylum QUIZ PAGE

one of our readers wrote to us recently objecting to our 'democratic psychiatry' tag. They said, "democratic psychiatry is an oxymoron." The ASYLUM collective only very mildly objected to being called 'morons' and so, in good humour (and all seriousness), we decided to take this opportunity to canvass opinion amongst ourselves.

To launch our brand new Asylum quiz we are asking: what is democratic psychiatry?

please note: this is no ordinary quiz. There are no right answers ... Here are some of ours:

I'd say that democratic psychiatry is aspirational. It's not necessarily an end in itself, nor does it seek a permanent substitute (for psychiatry). It's about widening, strengthening and deepening the spaces where we can have an open and honest dialogue with (and about) madness.

Helen Spandler

A political movement in Italy to close the asylums and set up community health centres that inspired people to find alternatives to medical psychiatry around the world.
ian parker

'psychiatry' = the management of mental disorder. 'democracy' = government by the people. 'democratic psychiatry' = managing mental disorder by way of the democratic decisions of everyone involved. obviously, this raises many questions. hence ASYLUM magazine = a forum for debate.
phil Virden

for me 'democratic psychiatry' is a particularly powerful articulation of an ideal of – or rather of a deep longing for – humane and emancipatory psychiatry that refrains from coercion and injustice and has the potential to heal.
dina poursanidou

Let us know your answers.

**Or send us suggestions for our next Quiz:
editors@asylumonline.ne**

What the Hell is Wrong with Everybody?

Alan Jennings

I'm not sleeping. It occurs to me that God never sleeps. He may rest; in fact I think He's always at rest, even when it's thunder and lightning. But we being human have our set limits. Quite right too. It's better to know what the boundaries are, isn't it? Well, usually. And what's got into everybody of late, hmmm?

I was out of circulation for quite a while. About a decade or more. And now I find that the whole place is upside down and altogether a bit of a shambles. Men pretending to be women; women acting like men; boys and girls competing against each other as though it were a completely level playing field.

I mean, can we just get back to normal, please. You know, where good is good and rotten behaviour is seen as such. All very well having a bit of fun with it, sure. Pirates of the Caribbean and all that. But it is only a story, right? Life ain't a Hollywood production folks! It's the real deal. It takes wits and guts and plenty of perspicacity. Try getting yourself admitted to the local acute psychiatric ward for a few months and see how you get on. Pretty sobering stuff in my experience. People die, you know. Really.

So, anyway, life gets tough. Yeah, seen it, been there, done it all and still waiting for the happy ending.

Aye, we have a lot on our plates these days. Plenty to be getting on with. No room for slackers at the front line. And yet the trick seems to be not to overdo it. Just take it at your own pace as the boss of the gardens project used to say when I was doing my therapeutic work shift. In fact it put me off looking for employment entirely. Too much like slavery. If we're going to do a job then we might as well do it well. And that means putting one's heart and soul into it. Therefore it requires a decent amount of good old-fashioned love, in my all-too-arrogant opinion. Without it we're really scuppered. Just run out of steam.

So folks, backs to the wheel and nose to the grindstone I'm afraid to say. One big heave and we'll have this lot shifted. It'll only take a moment. Then we can lop off down to the local hostelry and get merry.

Yes indeed, we seem to have been living in a daze or under a spell of enchantment that life is all roses.

Hehe, well, yes: it is that; and more besides. It is full of the joys and woes of existence. The happy/sad combination that defies outright description but innervates us forward and propels the race to its grand and ultimate end. What be that? Well, that would be telling. One foot at once; one step at a time, huh?

Peace and love. It's all we ever dream about. Justice and good health. Happiness and prosperity. Great!

Crooked Beauty and the Embodiment of 'Madness'

Ken Paul Rosenthal

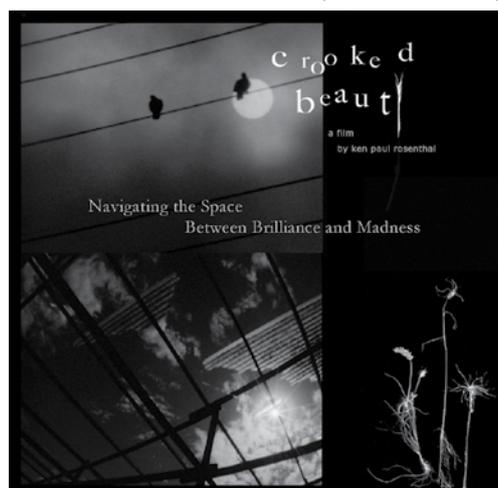
The cyclic and contrasting nature of manic-depressive illness is perhaps its most defining clinical feature. Indeed a strong argument can be made that the periodicities of the natural world – as well as its great beholdenness to light, its chaos, perturbances, agitations, and violence, its fluctuations, shadows, edges, and upheavals – all find their analogue in the periodicities and patterns intrinsic to both the artistic and manic-depressive temperaments. In fact there is an accumulation of evidence to suggest that those who have manic-depressive illness show an elevated responsiveness and sensitivity to changes in light.

In winter 2005, I read an article by the artist Jacks Ashley McNamara that touched the core of my identity as a

REVIEWS

filmmaker. 'Anatomy of Flight' chronicles her transformation from being a patient of the Western psychiatric establishment to a radical mental health activist. Jacks describes how "the world seemed to hit me so much harder and fill me so much fuller than anyone else I knew. Slanted sunlight could make me dizzy with its beauty and witnessing unkindness filled me with physical pain."

Similarly, my own experience of the world had always been one of visual osmosis; light clung to me like liquid to a dry sponge. As a child, I would frequently stare down the sun, holding my gaze until the sensation was unbearable. Whether holding my hand to hot irons, teetering on the precipice of great heights, or playing Russian roulette with my X-Acto blades, I felt invited to reach for places that were clearly unsafe. Was there something wrong with me,



or was I in need of models and mentorship that could help me make the transition from having my sensitivities overwhelm me, to having them give me information I could use?

While Jacks's journey and mine have been very different, my simultaneously inquisitive and self-destructive response to the phenomena of the world deeply resonated with Jacks's notion of the "dangerous gift", the idea that one's darker inclinations and experiences might also allow us access to more transcendent possibilities. With the Greek myth of Icarus as her guiding metaphor, Jacks's mission to "navigate the space between brilliance and madness" suggests that one's life could be more integrated and meaningful if managed with compassion and care rather than medicated into submission. This crucial idea helped me reconsider aspects of my own life, particularly my filmmaking practice as it related to the "mad" rituals of play in my youth. Like a moth drawn to flame, I was intoxicated by how far – and how furiously – I could fly. So I began to question what my mixed blessings could give me access to, if I learned to harness them. How could I see the light, rather than become consumed by it?

As I began to conceptualize my documentary film, *Crooked Beauty* (2010), the process blossomed into far more than a manifestation of my primal attraction to light. I recognized a complimentary relationship between film's literal grasp of light and dark, and the polarities of mania and depression. I also saw parallels between the disease model of treating 'mental disorders' and the industry model of mainstream filmmaking, both of which elevate power and profit over integration and insight. I imagined a film that approached mental health issues from unique thematic and visual perspectives – one that would restore authenticity to experiences that are marginalized and stigmatized in our society. Jacks's testimony would serve as a touchstone for viewers to reflect on their own stories. But portraying Jacks carried risk; she had survived childhood trauma, substance abuse, been diagnosed 'bipolar', and locked down in a psych ward by the age of 19. How could I recount her troubled history with compassion rather than exploitation typical of films about 'mental illness'?

The exploitation and annihilation of persons with disabilities in documentary film – from medical films of uncovered epileptic seizures to on-camera exterminations of persons with psychiatric disabilities by the Nazis – has evolved considerably since the first half of the 20th century. Contemporary independent filmmakers have advocated for themselves and



their characters with highly personal, complex and truthful representations of mental health struggles. However, many of these films either reference images of despair and self-harming, indulge in stylized excess to illustrate a highly subjective view of insanity, or perpetuate the myth of the mad genius/savant. For me, these films ultimately became portraits of 'otherness' rather than empathy. I became particularly obsessed with how we would see Jacks on screen.

The traditional model of the featured character speaking to an off-screen interviewer felt contrived and inauthentic because it deferred to an unseen authority. So I began to think outside of representation and more about embodiment. What if I dispensed with a talking head altogether, and found symbols for the face of 'madness'? Had I not discovered it by gazing into the sun as a child? Could the archetypal journey of Icarus offer possibilities that were more illuminating than misguided?

The "beholdenness to light", "shadows", and "cyclic and contrasting nature" that Kay Redfield Jamison describes in her book *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* (1993) also relates to cinema. From the division of every frame of light on a strip of film by a black line, to its intermittent motion through a camera, the mechanics of cinema operate through its interplay of fluctuations and contradictions, unseen by the audience like many conditions of the mind. But where so many films function like over-the-counter prescriptions for escaping the world, my film returns viewers to it.

Jacks's vision for making our own maps in response to society's prescribed models for normalcy inspired me to cultivate a new process for finding images that authentically embody 'madness'. In contrast to the conventions of carefully crafted screenplays and climate-controlled sound stages, I spent hundreds of hours wandering in deep observation, following the signs embedded in natural and man-made spaces alike. I look to birds perched on telephone wires as barometers for the incoming fog; I follow trails of discarded radios, shopping carts, and clothing like breadcrumbs to the margins of urban

space; and can almost smell subtle shifts in the direction, texture and weight of light. It's as if I can hear the shots call me. Am I 'crazy' or am I just highly intuitive? Sometimes I mistake doubt as curiosity, and defer to more obvious paths. I once spent three days shooting in abandoned mental asylums, ignoring the ghosts of the formerly interred, only to realize later that such structures – even in ruin – point too literally to the horrors they once contained.



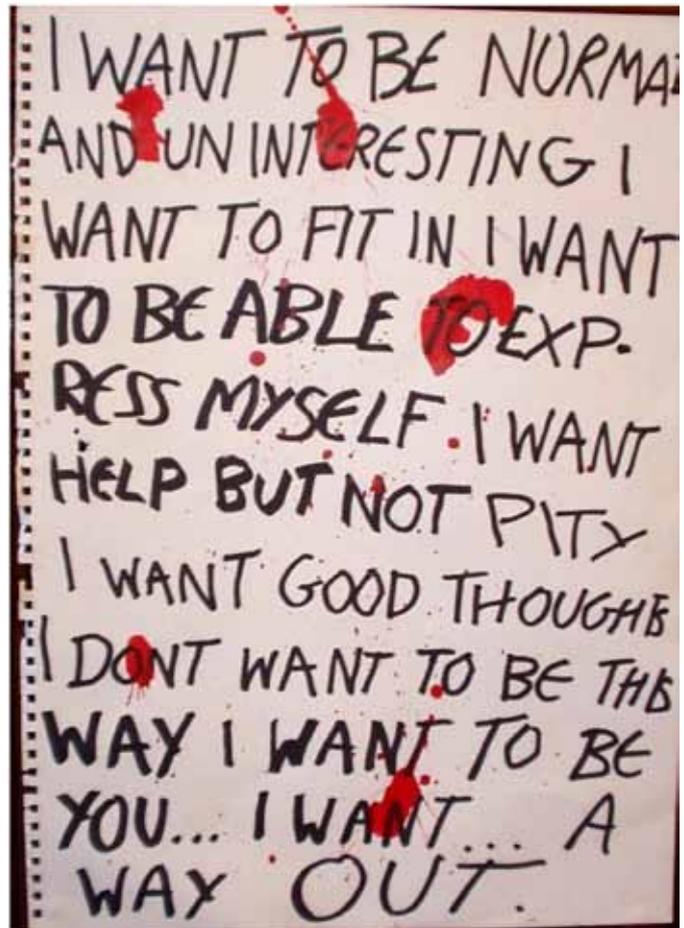
Jacks asserts that, “There would be a lot less mental illness, quote unquote, in our society if people were given spaces to work through emotions like anger and grief instead of denying and suppressing them.” In the mid-19th century, the cramped, poorly lit structures and layouts of mental hospitals were redesigned as sanctuaries of compassion intended to facilitate the patient’s recovery and self-healing. The power of architecture to shape human behavior affected how the patients saw themselves, as well as how they were seen. Similarly, the framework of *Crooked Beauty* supports a new moral architecture that liberates Jacks from the confines of photographic representation and encourages the viewer to freely integrate the testimony into their own experience. Cinematic space – both on screen and in the theater – is re-imagined as a collective site for navigating the space between brilliance and ‘madness’.

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- www.crookedbeautythefilm.com (Academic)
- www.crookedbeauty.com (Public)

Ken Paul Rosenthal is an independent filmmaker, teacher and activist. His films weave personal and political narratives into natural and urban landscapes. He received a SAMSHA Voice

Award for his film work in mental health advocacy. *Crooked Beauty* has won 14 awards, and been presented in person at dozens of peer support networks, hospitals, universities, and mental health symposia worldwide.



Wolf the Artist: From Apocalypse Back

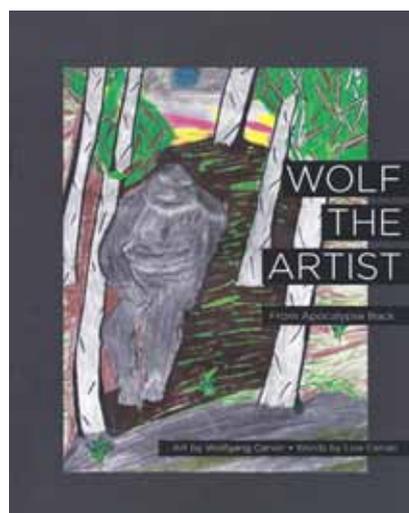
Wolfgang Carver, words by Lisa Carver

USA: Self Publishing, 2012

Reviewed by Kate Fear

Recently I read somewhere about the patience required of artists; a much-needed quality when setting out to repaint the world, one frame at a time. This slim volume of Wolfgang Carver’s paintings communicates simultaneously patience of a kind, a sort of stillness, whilst at the same time there is something undeniably wilder and energetic underneath the surface. It’s this dynamic that keeps the pages turning. What struck me most about Wolf was how much his work reminds me of Roky Erickson; the lurid world of the Night People, visions of meteors, aliens, apocalypse and (especially) beyond – it’s sometimes like seeing Roky’s songs translated into visual form.

One of my favourite paintings in the collection is called ‘turtles going to mate’, which look as if they’re striking some obscure synchronised swimming manoeuvre. A very personal mythology is being created here.



There’s this curious lack of a sense of ownership. His mother, Lisa Carver, the performance artist and author, tells me that once his creations are set down on paper, his focus has already moved on to the next topic, uninterested in the self-promotion or obsession with public image that so many other artists seem dominated by.

Running underneath the pictures, her writing, as with her son’s paintings, is unsentimental, a bare statement of some of the facts and experiences of Wolf’s life, who was diagnosed as having a micro-deletion in his 22nd chromosome. She ends the book by simply stating that Wolf “accepts nothing, creates all”. To me, this book has the same resonance as the social protests of Mad Pride, especially in response to the amendments made to the Mental Health Act beginning in the eighties. Considered alongside some of the obscene changes being wrought by governments in the name of ‘social inclusion’, books like this cannot be overestimated for highlighting the weaknesses of ideologies of equality, especially if they are forced upon talents as rare and unique as this.

More details available at: <http://www.suckdog.net/shop/wolf-the-artist-from-apocalypse-back/>

