SPECIAL ISSUE:

Self Harm

News from the Bridge Collective July – September 2007

Joan of Arc Project **Underground Sound** **Greenwood Project**

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Joan of Arc Project Special Issue: Self-Harm: Index

Editorial:

This special issue of the Joan of Arc newsletter is dedicated to the topic of self harm and self injury. Self harm is an area of study which has only relatively recently received the attention that it demands. Sometimes paradoxical, sometimes a cry for help and sometimes a consequence of deep developmental and abusive influences, it would be an impossible task to give here adequate consideration to the abundance of research and effort that has been focused on the area. As the issue of self harm is a very private, sensitive and emotive one, it is not an easy task to allow deep feelings to surface and be made visible. This issue does contain some contributions from people who self harm. Some have chosen to include their personal accounts and poems anonymously or under a pseudonym.

Following these expressions, a range of professionals working in different fields of self harm have agreed to write articles on their own area of expertise and experience. Read together, alongside the accounts of people who self harm, it is hoped that the reader may gain an insight into the suffering and pain associated with the experience of self harming behaviour as well as a hope that understanding and support can be afforded to those who suffer.

Acknowledgements:

I would like express my thanks to all of the professionals who contributed articles to this special issue on self harm. Although they worked in different areas of self harm, they were all committed and willingly participated. I am also very grateful to the individuals who wrote of their personal experiences of self harm and to those who shared their poetry. In particular, I would also like to say thank you to Elaine Hewis for her contributions to this issue, to Clare Coutts for her helpful suggestions and to Andrew Blewett for his enthusiasm in helping me to contact service users.

This newsletter is also available at the following sites:
www.recoverydevon.co.uk
www.beheard4mentalhealth.org.uk

I'm sending information of my self-cutting circumstances and my experiences of why I used to self-harm. I believe that it stemmed from the sexual, physical, verbal, mental and emotional abuse that I received from a number of men from my earliest childhood, through adulthood until recently.

Abandoned from my own family when I was raped I felt so dirty I started disliking myself trying to not self-cut but had losing control. At times I used to disassociate and go blank not realising on occasions what I had done until afterwards. I was trying to cut the self-cut the dirt out from the rape. It was not attention seeking as some health professionals see it: it was a release I suppose from my hurt and I wanted as I have said to cut the dirt out from the rape itself through being unable to cope with the many flash-backs and the numerous abuses that I have suffered. And abuse even to my own body only added more difficulties. For example, by making myself ugly so that men would not fancy me.

I had the belt and stick as a child, from my father which was a form of abuse and just continued as a way of life. I came to think that I deserved to be punished and hurt. I was bullied at school and later was married to an abusive husband. More mental and emotional cruelty from a violent husband who used to beat me. So, I would like to correct the health professionals. My self-harm had never been an attention seeking process but sometimes loss of control with my flashbacks and my not being able to cope with them; of rapes and other things I couldn't deal with but I then inwardly took out on myself and; lack of control, had gone beyond my control, I had seriously before gotten glass in my hand, which I would like to inform others of the complications it caused. It is not worth it to the extent that I had to have an operation on my hand to have a piece of glass taken out which was close to an artery and nerve endings and now I have permanent damage to my hand as well as other unsightly scars in places I would prefer to now have laser treatment to help them fade away. I have very nearly endangered my life on occasions. I would like people to be aware how dangerous it is to self-harm. To do so also upsets the people around you.

I think, A&E hospital departments should be more understanding that attention seeking self-harm isn't always the case and if it does waste A&E department time. Then it's worth it rather than hitting an artery or poison. I had an infection. It is possible to die of infection in cuts. I had belly button piercing once. I had been informed by my doctor that he wasn't happy because this was a form of abuse. My bloodstream became infected with septicemia setting in - antibiotics again. Also, I've learned not to have temptation in house. No more razors in the house.

Dialectical Behavioural Therapy (DBT) (see page 36) skills can help sometimes: it helps to learn some self control. I hope these notes are a help to all you self harmers, although I have also known people also doing self harm for attention seeking to be noticed, so to speak, but not in my case.

Anonymous, Devon

Self harm and Suicide are not the same

Self harm for me is part of me, but it does not mean that I want to die. It is more that I want to survive but I don't know how too, because the emotional pain becomes unbearable and somehow I have to get it out. I am so afraid of being judged, but I don't think I realised what I did was self harm, although I am not denying that I do harm myself. I cut and strip away at the layers of my skin until they bleed, seeing the blood offers a sense of relief, the pain is excruciating but it is what I have to have, I have to feel the pain. It helps a little to be able to feel the pain from the inside on the outside. It is difficult to explain in words, with out it sounding false and contrite. It is only recently that I have been able to acknowledge this is what I do to myself. For years perhaps I have been in denial, but I never gave words to it, it was my secret with myself.

Others think you are crazy if you admit to this act and ask … *Why?* That is difficult to answer. Why do I hurt myself? Because I want too, because it is the only way when the emotional pain gets too much, I have to some how release it. I can let go of some of it, the pain from the inside somehow makes me relax if I allow it to escape. Perhaps to the outsider this is all crazy, but I am not crazy, I am distressed sometimes, quite a lot of the time in emotional pain and I don't know where to go with that emotional pain.

Health professionals in my experience do not help. Please do not keep telling me to ping an elastic band on my wrist, or hold ice cubes, it doesn't work and it belittles the stress I feel. I feel already judged as soon as I open my mouth and admit I have destructive feelings about myself.

I don't feel, it is like my silent screams I don't feel …… I just don't feel. I feel after a few hours, a throbbing nagging pain, but it is just another expression of what I feel every day.

I don't do it for sympathy, I don't do it for labels, I hadn't consciously thought
I did it as a form of communication, I am not conscious that I want to communicate my pain ….

When I cut through the layers, that's all I think about the layers, the badness, the destruction of myself.

Suicide is quite different. The feelings for me are that I want to die; there is hopelessness in living. I am too tired to fight anymore; I just want the blackness the peace the nothingness. Rationality has gone, people around me family, children would be better of without me, I give nothing to their lives, I have nothing to give to anybody. I feel so sad, so alone, so nothing.

Ed

Self-harm isn't something that you do one day and think 'I'm a self-harmer'. The first time I self-harmed I scratched my skin until it was raw and found that the pain that it provoked blocked out my thoughts. I covered the scars because I knew it wasn't a normal thing to do and other people wouldn't understand. Self-harm became the time with myself when I could let go of all those pent up emotions that I felt I couldn't release any other way or tell anyone. The more I did it the harder it was to cover and the more people asked questions. In the end I just became defensive and cold towards people and they backed away. This served the opposite purpose to what I craved; love and affection. It was a way of not allowing myself to be loved. I deserved to be punished.

As the self-harming went on it progressed to other forms, using knitting needles, glass and knives. The more you did it the more you had to do it. The pain produced each time became less so you had to hurt yourself more to get the same effect. You also start by making marks on your skin then gradually go onto small cuts that only bleed a little. A new feeling comes with the blood. You move to another level because the blood has different feelings associated with it; it has the feeling of cleanliness and purity, actually getting rid of the feelings. You watch the blood flow and feel relaxed, not wanting it to stop. Through meeting other people that self-harm I haven't felt that I have a connection with them because everyone's self-harm is individual. I stopped self-harming for 4 years until I became increasingly more stressed and didn't know what to do with it. My self-harm has now become more dangerous, losing more blood and cutting deeper. I know that I have stopped before so I must be able to do it. It's just a matter of finding that reason to stop or replacing that empty feeling with something else.

Anonymous Service User (March 2007)

I was the age of 8. I went into Social Services care and I lived in a hostel. I had a room up there: room number 2. It was nice. Back along it was OK. But the owners left and another couple took over. They tried to make me believe in Bible lessons and if I didn't they would punish me. I stayed a good couple of years. I was away from my Mum and Dad for 14 years.

I was on my way to church but never got there because I had a nasty experience in the community from a man and afterwards the couple from the hostel sent for the old bill and I went to hospital and then Langdon hospital as informal patient. I can't remember too well because it was a long time ago. A patient asked me for cigarettes and I said I didn't smoke and I was feeling low at the time. I had to go and get my arms stitched up and they wouldn't let me out and I don't think I did it myself. I remember falling off the chair afterwards; I didn't mean to do it. Now I feel better and I do a lot to help other people and I am very busy with meetings and it's the main thing that keeps me going. I get my support from Springboard, the Joan of Arc Room and the Women's Network. It means a lot to me.

Anonymous

A Reflection on Self-harm

I am a 22 year old student who has self-harmed on and off from the age of 14. I recall the first time it happened, I was going through a difficult time, was depressed, school and family relationships were stressful and incidentally in my mind I had begun to think about traumatic experiences I had suffered as a child, to which I was previously oblivious to or at least the memories I had not been troublesome. However, although looking back I am aware of perhaps why I was so troubled my thoughts and feelings have always been very disconnected and I didn't know where my impulsive anger, anxiety and low mood had originated. I would be gripped by sudden overwhelming yet indescribable feelings that were intolerable and often accompanied by mounting tension. I simply did not know how to deal with them and although sometimes expressed as argumentative or violent behaviour, for example demolishing my room, this was unacceptable to others leading to shame and annoyance at myself for being so destructive and my distress being invalidated and reprimanded.

Thus, I soon found relief in directing this anger towards myself. It seemed logical as there was no external source that I could identify as deserving my retaliation and I was ashamed to have this 'unnecessary' anger which served to increase my sense of self-loathing. Further, I found that the act at least temporarily, seemed to ameliorate the problem. This I believe is what most people find so difficult to comprehend about self-harm and when I am not in that frame of mind even I find it hard which again feeds into the self-loathing and hence cynical nature of self-harm. I think partly being brought up with a punitive parenting style whereby negative emotions are either invalidated or else punished has made me automatically feel like I deserve to be punished: first, for feeling so out of control and secondly, for what I have already done to myself. It gives me a sense of control; I am able to do something about the seemingly unsolvable, intangible, confusing yet demanding emotions. Sometimes it was not so much about the overwhelming feelings but about breaking through a similarly uncomfortable complete numbness.

The mind is somehow shocked out of whatever state it is in and forced to take note of a tangible, urgent bodily sensation and into reality. This not only projects the feelings into a single focus but turns the intolerable, unsolvable problem into something more tolerable and solvable, as well as releasing calming endorphins. This 'fixing' the problem not only occurred during or after the act itself but I found even by just thinking about the fact that I had made the decision to self-harm and about how I would go about it brought immediate relief, I was going to do something about it.

As I got older there were long gaps between my episodes of self-harm that seemed to coincide with the breaking of a natural ability to exist in total denial,

seeing life through rose-tinted glasses and enabling me to be a generally contented, happy individual. I would flip between periods of denial and periods of depression. As the years passed this ability to flip out of denial waned and the depressions got longer and more severe. In conjunction with this a painful reality would engulf me and the self-harming behaviour escalated. This escalation was in part due to the fact that after a while I became desensitised to the more superficial scratching and lashing out at myself which lead me to resorting to the more painful, dramatic and permanent act of cutting. Seeing gaping wounds and blood became more important that the pain eventually shocking myself out of reality and back into numbness It was as if a dam has sprung a leak and needs covering urgently before the whole wall crumbles and I am finally exposed to a heavy tidal wave that would engulf me and from which I could never escape; but the dam was no longer salvageable and I sunk further into the numb depression that has for the last two years become my life.

As the depression worsened and I developed suicidal tendencies my self-harming became more about dying than trying to survive anymore and I began to cut arteries instead of my thighs. After I was admitted to psychiatric hospital, I was encouraged for the first time to try and express how I was feeling in the moment and very gradually I became more aware of my emotions and that talking to people I could trust actually helped. I was still quite uncomfortable with discussing how I felt as I was so ashamed and found it difficult to bypass my automatic reaction to shut off and suppress my emotions out of conscious awareness, but as an alternative I found by writing I was able to not only express myself better but that it served to almost transfer the thoughts and feelings from my head onto paper, as well as delay the impulsive urges until they had stopped peaking. This healthy expression which does not invalidate how I feel, has led to a dramatic reduction in my self-harming, though presently the dam is still there and the reasons behind my depression not fully appreciated or dealt with. But I am more accepting of myself and hope that through a combination of medication and psycho-therapy I will begin to be able to grasp and cope with whatever lies beneath.

Anonymous

Out of Harm's Way

I didn't know that what I was doing when I took the first overdose at the age of fourteen would have a label. For me it was the only way I knew of eliminating the pain of being picked on at school and the hurt from knowing that I was not 'good enough' or 'worthy'. I wanted to be ok though. I wanted to be able to live without having to be in constant emotional pain; an emotional pain that riddled my body and mind. Now in the general hospital, the hurt I had felt before I took the tablets was replaced with new problems which, although were very emotionally painful, gave me a break from the hurt which had brought me to take the pills. Ashamed of myself, feeling mean and nasty for having caused pain to my parents I went home and went back to school saying to myself I would never take an overdose again.

Two weeks later I returned to the hospital. This time I thought I was going to die. I thought I wanted to die but I was so scared to die alone. I needed comfort. I needed somebody with me to hold me and comfort me as I died. I could see no other answer to my pain but death yet I was terrified. My stomach was pumped out and nobody offered to hold me or comfort me. I went back home wearing another layer of guilt and shame. I was fifteen and alive.

Without consciously being aware I had learnt how to beat myself up and upset the rest of my family. I had found a new way of coping with that pain that riddled my body - that pain that today I see as being fear, insecurity, self doubting, not feeling worthy or deserving of life itself and all the elements that make for days in and days out of everyday life. Things like recognising feelings and being given a safe place to feel, feelings of love anger, sadness, joy, frustration, loneliness.

I didn't know people intentionally cut themselves. When I found out after being admitted to psychiatric hospital I could not understand it. It seemed stupid. What was the point of scratching their arms with glass? It looked horrible - a criss-cross of cuts up their arms. As a seventeen year old I thought, 'What a strange thing to do'. Some of them had stitches. I learnt that it was real bad if you had stitches. This was the culture of the adolescent unit I was in and the attitudes to self-harm at the time. We saw it as' really bad' because nobody taught us anything else. Nobody talked to us about why somebody might be cutting themselves it was all kept quiet so the adolescents came to their own conclusions.

The first time I cut I was angry. So angry I have come to realize that I had every right to be angry. At the time I had never been taught how to deal with anger in a positive way. I tore open my arms with a razor blade and my anger was replaced with shock and horror at what I had done to myself. The shame of that incident was to last for many months as the wounds healed. For years as I agonized over whether to wear short sleeves in the summer and still struggle as to whether I wear short sleeves or long sleeves today.

I became obsessed with swallowing glass that I would pick up in the street. I would study the quality of each piece I picked up. Good quality glass was dirty and jagged - this helped to enhance what a dirty disgusting person I was. Overdose upon overdose, cut upon cut. People fed up with me. Eating to vomit. Overdoses of painkillers were replaced with daily overdoses of laxatives. No longer committed to the psychiatric hospital I had committed myself to ten long years sitting on and vomiting in the toilet. No arms to be stitched and I had mastered my own way of emptying out the contents of my stomach. This time though it proved to be life threatening rather than life saving. All the time I was in the bathroom, I had only to concentrate on one thing - vomiting or shitting. This numbed me. I was still hurting, now both physically and emotionally but I also felt I had some sense of control although in reality food, weight and laxatives had control over me. It ruled every second of my life. For a good ten years I used this way of self-harming as a way to just get through each day. I didn't consider it self-harming for a long time. To me it was something I had to do in search of that ever elusive state of happiness through starvation. Of course the happiness that I was seeking would not be available to a body starved of nutrients.

I soon discovered alcohol for my next way of coping, or should I say self-harming. Alcohol provided me with an escape from feeling emotional pain. Just as the overdosing and cutting and starving had provided me, initially with a way of coping with my turmoil of unattended emotions, so alcohol became my friend, my controller, my jailer, and my enemy. All those who loved me were angry, hurt and confused. It was the end of the road for a lot of people's patience and tolerance. I still did not know how to cope. I had help from a lovely lady who 'had been there' with her own experiences of drinking and she nurtured me through the early days of not drinking – eleven years later we still talk regularly on the phone, neither of us having drank alcohol for a very long time.

Self-harming, in the form of cutting and overdosing, while experiencing voices and visions had many similarities but also lots of differences. The reasons and the drive to cut and overdose were influenced by a very dominant voice and although the outcome of harm was similar, the process of getting to that place was very different than when I was self harming without hearing a voice. Without talking to me, nobody would know this. The road to death seemed sealed only this time I didn't see it as death; I saw it as doing something I was being told to do. I saw it as doing the 'right' thing. Without an awareness of how suicide affects the family left behind I would not be here to talk about self-harm.

For me today self-harm is the fast road to taking myself to the edge of death. Self-harm and suicide are not the same thing. Self harm and suicidal actions are not the same thing. So what is the difference? For me the difference is how I feel or if I don't know how I feel, what is going on in my world when I am about to make that cut, take that overdose etc. I have been lucky enough to survive suicide attempts.

Acting on voices telling me to cut myself and harm myself in ways, which, while not being the intention proved to be life threatening. To talk about ‘luck’ seems rather strange when I look back over my days of self-abuse.

There have been times when I have hated each moment I’ve had to breathe. When I've hated having to self harm – I have cried because I don’t want to go through hurting myself, I have pleaded with myself not to do what ever form of self harm I was ‘doing’ at the time. For me it has not just been a case of stopping harming. I have come to the conclusion that I cannot afford to harm myself for I know how much it hurts and fucks up those who love me.

I have been lucky to have some very special people around me who have supported me in a non judgemental way. People have talked to me about feelings and I have seen how those around me deal with feelings in everyday life. Those people have shared with me how they cope in ways that don’t harm themselves or others. As babies we learn to walk and we usually start to learn ways of coping with and expressing feelings in a healthy way. I did not do this as a child. I had nobody to teach me. I have had to learn this process as an adult. In respect of learning to feel my friends, among family workers, social workers, therapists, children and my husband have been my teachers.

Today I cannot afford NOT to express my feelings in an acceptable way. If I don’t deal with what I am feeling on a day-to-day basis it might cost me my life and that is not a risk I am willing to take. Today I take pride in the prospect of growing old gracefully. Life is not always easy but today I don’t need to harm myself to escape form emotional pain. I never would have believed you if you said I would stop harming, let alone have a life in which I feel I have a right to. I don’t harm myself and I live like I’ve never lived before – I feel whole and at relative peace with myself. To me, that is not luck it is a miracle. If you are in sadness and pain through self harming allow other people to believe in you when you cannot believe in yourself.

Elaine

The First Cut is the Deepest

I have never cut when I've been sober: always when drunk and something inside hurt so much I felt the only way to let the pain out was to draw blood. As a teenager, I was in love with a dead woman and after drinking, I would carve her name into my arms and legs. Eventually, I had her name tattooed on my back. In my early twenties, I was bulimic and a drunk. After a drunken binge, I cut myself worse than I had ever done using a razor blade. I was taken to Casualty and a Psychiatric Unit.

Throughout my 20s and 30s I harmed myself when I was drunk and ashamed, after a row, a binge or after sleeping with a one-night stand and cheating on my ex-fiancé. Sometimes, I stubbed cigarettes out on my arms and chest or cut my arms. On a couple of occasions, I shaved off all my hair.

I became involved with a man who broke my heart. After rows with him I would burn myself with cigarettes and allow him to strangle me during sex. This relationship ended with me going to jail - after rejection after rejection, cruelty and mind games, I ended up cutting *him*. In prison though, I never self-harmed. I noticed that most of the girls had tell-tale scars inching up their arms and sometimes their legs. One girl even scrubbed the skin off her face with a scouring pad!

When I moved to Exeter, I was cutting-free for a long time but after I'd been there for a while, I cut my wrists when drunk while thinking about that man. When I thought I'd lose my home and saw no way out, I went and to a graveyard with a bottle of vodka and some razor blades. If it wasn't for a homeless girl finding me, I would now be dead.

I don't cut myself anymore. There are other ways to deal with pain without drinking and self-harm. I hate the scars and the burns that deface my arms but I wear them as a reminder of what I've been through and how I survived.

Anonymous

Seeing The Blood ……
(Reflections on a mental health nurse's work with people who self injure)

When Ed turned up for his weekly counselling that day, he looked grim and agitated. The usual pleasantries forgotten he launched into a familiar rant: *'If only I could get hold of a firearm I could blow myself away'*. He talked on, shaking, slowly producing a pack of fresh blades from his jacket pocket. Predicting what was about to happen I swallowed hard and tried to stem my feelings of impending panic. Ed wore countless scars about his body. He carried on talking to me in a jittery sort of manner. I felt the excitement on wondering whether I should hit the panic button before things got out of hand but I stayed in my seat quietly maintaining my counsellor's stance, trying to listen carefully to what he was saying. When I first saw blood trickling from his hand I gently asked him if he could desist. His eyes flared at me as he started a second cut, the blood coming to the surface in tiny globules. I went into nurse mode: how deep does this look? will it need stitches? Sudden relief. It only looks superficial. I stare at some of his scars again. He remains grim, still shaking. After another couple of scratches I start to relax a bit, thinking it'll be alright. The blood starts to drip on the floor. *'Try not to get too much blood on the carpet please Ed, This is the consultant's office!'* I can't believe I just said that! Still shaking, Ed firmly draws the blade slowly from his thumb to his wrist, this time with a determination about him, such that the flesh parts, exposing bone, though very little blood. Shit! What on earth do I do if he carries on like this? Suddenly the whole scene changes. Ed gently pulls out a large white handkerchief and presses it firmly against his hand, the white turning to crimson in barely seconds. *'That'll need stitching I expect'* I say. Then I can hardly believe my eyes.

Ed's whole being is suddenly calmed. It was as if he just mainlined on a narcotic. The shaking was gone, the ranting stopped, he uttered a few apologetic noises and sat still. I felt as if my heart had stopped! I listened to Ed for about ten minutes as he talked of the anniversary of his best mate, killed in action, blown away when he'd been standing right next to him. When Ed stood to leave I sensed some kind of gratitude from him. I told him to make sure he went home via the local accident department to get his wounds seen to. He just left. Later on, I had time to think about this traumatic incident and de-brief myself a little with the help of a colleague. Several other people I'd worked with had described their need to see the blood. Ed needed me to see it too. He needed to know if I could stomach it, or if I would reject him out of fear or perhaps disgust. He returned for a session the following week almost as if nothing peculiar had happened! Whereas I'd had flashbacks, panicky feelings and a couple of sleepless nights to contend with.

Cindy came to see me as she had many panic attacks. She feared the feelings would lodge themselves in her causing her to lurch from one panic to the next without respite. She began to disclose abuse after several months of counselling and I immediately doubted whether I could cope with what she wanted to talk about. As a nurse, I monitored her mood and the frequency and severity of her self-injurious behaviour. She conveyed, without graphic

description, how she had to cut unseen parts of her body, so that her partner wouldn't notice. I sought more intensive supervision from a senior therapist as the feelings she somehow projected onto me were causing me such angst. Was I being too seductive? Was I in danger of holding her 'secrets' in the way her abuser had? Did she need to exert her power over me by appealing to my 'shadow side' as Jung described it. Was I too voyeuristic to contain her pain, self-loathing and masochism? (I suggest that all those who counsel people whose self-injury reflects pain suffered at the hands of an abuser ask themselves these questions and take to supervision). Cindy wanted to kill herself, but her daughter functioned as a buffer against acting on this desire. But at times, the death impulse could only be countered with self-injury. The pain of her healing wounds and seeing the blood both seemed to somehow relieve some of her psychic pain and anguish and her grief for her lost childhood. When numbed into a state of depressive apathy, a sharp pain acted as a wake-up call, proving that she was still alive and could still feel things. But worst of all she expressed was the shame of what she endured. Sometimes after telling me of incidents too awful and humiliating to repeat, such was her shame that she could barely wait to leave the building before getting out her blade and seeing more blood - dear, dear blood on the carpet again!

When reflecting on how I have come to be doing such work, I realise that it has not been my choice. Invariably, in counselling the distressed, either the individual feels they can risk trusting (that is they transfer positive feelings onto the person offering help) or they can accept help but always with strings attached so that they need not try and tackle material too painful or shameful to risk sharing with someone about whom they are unsure. This has sometimes been my experience. Where a relationship has developed soundly enough that the risk of disclosure seems worth taking (Cindy, at the age of 28 had never disclosed her 'secret' to anyone!), as counsellor I have little choice but to accept such trust without abusing it myself. This needs much soul-searching and close supervision: the two things that I have found especially helpful.

Brenda Roberts has explored such issues carefully. She likens the situation to that in the myth of Perseus and the Medusa. In the story, Perseus must slay the monster without looking at its face. He managed this by making himself invisible and advancing on the creature backwards, using the reflection in his shield to direct his attack. What if the traumatised client, in his quest to slay his demon, uses his counsellor as his shield in order not to have to face the past head-on? It seems reasonable that in the dreadful struggle to face up to such horrific feelings, trying to avoid resorting to the emotional safety valve of self-injury, in the heat of the battle the client might fail to distinguish between the trauma and his reflective shield. This may result in an attempt to smash the shield and sense the triumph of victory, at least in the short term. Perhaps this explains how, sometimes just when I thought someone was trusting me to tolerate their grief, usually when their symptoms and self-injury had abated somewhat, all of a sudden a calamity ensues such as an overdose or attempt of suicide. When this is experienced, invariably it feels like I have been attacked and have failed as a useless counsellor.

Gwen Adshead also has much valuable advice. She reminds us that if the counselling seems to be going well, it may just indicate that the client has emotionally withdrawn for a spell. Frequently this is followed by an intensity of emotional turmoil, the 'fight or flight' response takes over and the intensity of feelings expressed bears little relationship to what seems to have been going on. Unfortunately it can also induce panic in the counsellor who may then respond by trying to control the situation in some way. This inevitably fails. But if I can maintain a cool, empathetic listening ear, in most cases the client will experience this as soothing in ways that he or she may never have experienced as a child. The critical thing is that I try and stay alongside, whatever the traumatic past or present holds and try to remain like a mooring jetty. In this way my client can cast-off when ready, knowing that if the sea gets too stormy he or she can return and tie up for a while before venturing out again. In this way the inevitable detachment may be managed in a way that can hold at least some control in how the counselling will end. Careful negotiation and planning is crucial at this time. Having said that, my experience has usually been that however well planned, this seldom happens just how I would like it to happen. But perhaps that is the point?

As far as I know Cindy and Ed (aliases to protect their identity) are now navigating their lives independently. Whilst they may not have slain all their demons, I think they came to realise, at least to some degree that despite what they may have been told their demons came from without and not from within.

Will Baker
(Self Harm Unit, Torbay NHS Trust)

A Journey alongside Self Harm

What follows are bits of my journey. The summer of '69 was going well for me. Jim Vallance and Bryan Adams were 15 years away from writing the song, but if you had talked to me then I might have said it was the best year of my life. I was free of school at last, I'd got a scholarship to Oxford, and I was appearing on the London Stage: big, big deal for an 18 year old. I can't remember how things got out of hand. I had had mood swings for several years, perhaps all of my life. I was on top of my little world, but in Camden Town tube station I believed that I had a brain tumour and it was the end for me so I might as well end it.

Well I didn't, but I could have. Staring into a void, or down from a platform edge onto parallel lines is liable to motivate you one way or another. In the end I found a different way to understand my experience. It wasn't the only reason I became a clinical psychologist but it played its part. I was curious about continuing to be, and about people who chose not to be. Less stark but more intricate is the complex world of emotions. Like all young people growing up I had my struggles, and around 1969 I often managed my emotions with drugs.

I found it very difficult to contemplate myself, and therefore anyone else using self harm to handle emotion, or communicate in any way. Conceptually and emotionally I had no-go areas.

The next part of this journey takes place in the 1970s in Essex and East London where I carried out research into medically serious suicide attempts (arguments about the relevance of intent and what you should call an act are a continuing theme). This involved getting to know people who had severed tendons, taken amounts of paracetomol that should have killed them, and most poignantly, people who had drunk weed killer and whose lungs were dying. As a psychological therapist part of the task is to put oneself as close as is practical to the position (emotionally, in terms of thinking etc) of the client. This group of people gave me a master class in human individuality which academic literature, and in particular textbooks, tend to reduce to categories.

In 1980 I was in Kidderminster, North Worcestershire, and helped to set up one of the first dedicated self harm services. The orthodox psychiatric assessments were replaced by an assessment and therapy team trained and supervised by a team of two clinical psychologists and two psychiatrists. The team included the hospital vicar, the senior nurse on what we then called the general side (this was one of the first hospital units in a District General Hospital), a range of other general nurses, social workers, the junior psychiatrists, Community Psychiatric Nurses, the Art Therapist, all doing the work voluntarily on top of their normal jobs. It is unlikely that you could repeat this model in today's NHS.

The Kidderminster Self Harm Service lasted for over twenty years closing only when the Hospital's A&E Department closed. In common with most services the Kidderminster one did not try to attend to self harm in the community that does not involve A&E.

Here in Devon I have worked as clinical lead to both a DBT (Dialectical Behaviour Team) and OASIS (the Overdose and Self Injury Service). DBT is an intensive therapy for people who have an extreme difficulty in managing their emotions and are actively self harming. DBT works very well in terms of getting people onto a stable platform. Unfortunately DBT in Devon, up to this point, has not had the support and investment to keep all the teams going, and we could do with more resources to build on the good platform that DBT can provide (see also page 36)

DBT is an intensive therapy and will always be a minority option. On the other hand North Devon District Hospital A&E receives between 600 and 700 people who overdose or self harm per year. Oasis offers an assessment and therapy service. There are one whole time and one half time psychologists and one therapeutically trained Occupational Therapist in the team. They cope by collaborating with the Crisis team at the Assessment stage, and for that one third of people who are already linked with mental health services they negotiate the most appropriate response. Therapy is individually tailored and time limited to

three months. For many people the contact is shorter. The clientele is defined by coming to A&E, but OASIS have set up an interest group in which the interested parties consider issues to do with self harm in the wider community. OASIS has a teaching role, in particular taking the goal of culture change in A&E Departments with respect to people who self harm seriously. This is a tiny team continuously faced with the prospect of being overwhelmed by trauma and numbers, but it is a start. It is not in a position to visit people in their homes, and it does what it can to deal with the fact that most people come to A&E outside orthodox working hours.

At this stage of my journey the key is to establish systems that respect people's individuality, both client and therapist, and to help to open doors which they may or may not choose to walk through. As to answers raised by my curiosity? Well I can do stuff, but the big questions still hang in the air.

Marc Binns
Consultant Clinical Psychologist
Head of Department North and Mid Devon
Clinical Lead OASIS

OASIS is a PCT service clinically led and A&C supported through a Service Level Agreement with the Devon NHS Partnership Trust

Self-Harm Abuse and the Psychotic Experience

Is there a relationship between self-harm and psychosis? This is a question that has been asked time and time again and time and time again service users have said yes whilst many professionals continue to argue that there is not enough evidence to come to this conclusion. There is in my opinion evidence of a clear relationship between trauma and psychosis and further, this evidence also shows a relationship between 'traumas' and self-harm.

I guess my thinking about this has been strongly influenced by my personal experience of both voice hearing and self-harm. I was eleven years old when I was abused by a catholic priest, the abuse was ritualistic in that the priest would use lighted candles and murmured prayer as a part of the abuse cycle. He would then tell me that what had happened was my fault and that I was leading him into sin and that if I told anyone what was happening then I would burn in hell.

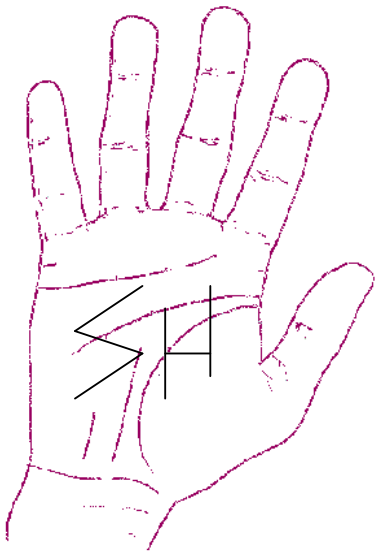
Many years later I would hear his voice telling me it was all my fault and that I should burn in hell. It should not come as any surprise then that I used to burn myself and when asked why I was doing this would reply that the voices were telling me to. My answer was unfortunately taken as gospel without anyone asking the real questions that were required in order to understand what was happening to me.

None of the workers who were working with me at this time explored the possibility that there was any causal relationship between my life history, my voices and my self-harm. The fact that this exploration never happened within the system is the main reason in my opinion that I and many others spend such a long period of our lives stuck within the system.

When I did finally get a chance to explore things it became clear to me that my abuse or at least how I felt about the abuse was central to my experience. I had been groomed to take responsibility for the actions of the priest and feeling responsible made me feel it was all my fault therefore I was guilty of leading this 'innocent priest' into sin. Since I had been raised within the Roman Catholic Church I had been taught that sin had to be either forgiven or paid for in purgatory where sin was cleansed by fire. It was this belief that was at the heart of my self-harm. I lived for many years with a need to be cleansed and this was why I self-harmed by burning myself. The voices I heard reinforced my feelings of guilt which in turn increased my need to self-harm. What is clear to me now is that if I had not been abused by the priest then I would not have heard his voice and therefore would not have self-harmed. It is also the case that had I been asked the right questions by workers they would have or perhaps I should say should have come to an understanding of what was happening to me.

Self-harm does not happen in isolation it is time for services to stop trying to change self-harm behaviour through a regime based on an unproven view that self-harm is some form of attention seeking process or in the case of voices the inability to resist voices commanding us what to do. It is time for workers to start looking for the real cause with the person and when it is found to work together to deal with it.

Ron Coleman
May 2007



Making Sense of Self Harm

What is self harm?

'Repetitive Self Harm is any purposeful act or omission that results in harm to the person but is without any direct intent to end life and occurs more than once over time' Smith (2003). Psychiatry in DSM IV (TR) defines self injury as 'The deliberate damaging of body tissue without the intent to end life'. Clearly, self harm includes self injury but is a more expansive term.

Self harm and suicide therefore are different things, the key difference being intent. Statistically people who harm themselves are more likely to go on and end their life by suicide but that does not indicate any direct or positive link, especially if you control for life events. We know that for most people separating their motivations to hurt themselves from any possible motivations to die can be a broadly helpful part of building their future resilience and making choices.

Self harm therefore is better conceived as a survival strategy that helps the person to make sense of the world and to survive today, for this reason we should never hope or ask that people will stop unless they feel it is right to do so at this point in their life.

When training workers to build their helpfulness we at ***'crazydiamond'*** often start with the following tips that often contradict the training of professionals but come directly from people who hurt themselves or our workers.

Tips for workers to consider

i) Separate self harm from suicide, when they co exist treat them as co-morbid.
ii) Self harm is never the problem so do not focus on it when working.
iii) Self harm is a messenger that there is a problem elsewhere, help the person listen to, understand and heed the message.
iv) Do not aim for the self harm to stop, aim for the person to have more control or to make choices – and oddly enough it often stops.
v) Recovery from the problem is natural and we know how long it takes even if we do nothing so workers should be kind human and hopeful.
vi) Self harm is not simply about getting your attention, do not over emphasise your importance in your clients' lives.
vii) One of the biggest obstacles to overcome is workers and others hopelessness, it is hard for a person to find their hope when they feel desperate, workers must be the holders of hope. When workers are hopeless it is hard to raise your own expectations from being a 'cutter' to being a person.
viii) Help the person to make sense of what is happening and to make choices.
ix) Ownership of the experience is important, workers do not own clients' experiences or the recovery process.

Why do people hurt themselves?

Recent studies have suggested some alarming links between life events and the development of self harm in later life, many of these links in the research made by the person who harms themselves. Importantly adults who harm themselves mostly (85%) start to self harm during adolescence and so therefore an added problem when it comes to building resilience and finding their future is recognising the importance of time and history.

In their study Diclemente et al (1991) for instance, found that amongst adolescents in a psychiatric service who reported sexual abuse, 83% cut themselves. This mental distress is believed to be a common factor which may manifest itself in many ways. The commonest of these ways is in some form of self harm.

Defending oneself against owning the abuse and surviving through transferring the pain onto the body – the effect of which blocks intense feelings of emotional pain that would otherwise be 'un-survivable'. This is the symbolic language of self harm. “It is another way of expressing the 'unspeakable'. What words could describe the feelings that go far beyond our understanding of them, but whose power urges their release through the most guttural forms of physical expression as in self injury?

Some of the many reasons why a person may self harm:

- To survive
- To communicate
- To cope
- To feel better
- To get help
- Transfer emotional pain to physical
- To show I am different
- To belong
- To heal
- To see blood
- To check I’m alive
- To feel something
- I deserve it / punish self
- To punish others
- To dissociate
- To control something

- Or our own favourite - It is complex! Workers and others need to stop trying to find simple solutions to complex problems.

How many people self harm?

- 1.4% lifetime incidence.
- 1,400 per 100,000 population.
- It is however far higher in some populations such as psychiatric services, prisons, professionally looked after children but obviously this may be because of different life experiences.
- 12% of students in further education in the UK (16-18) self harm.
- Gender : 80:20 Female:Male (but these figures are contestable and depend on what you class as self harm i.e. if you include drugs and alcohol).
- Age of onset is a mean of 14 yrs and falling steadily according to our experiences.

Separating self harm from suicide

Self harm is about staying alive and feeling better however:-

- Self harm is not associated with direct suicidal intent
- People who self harm are at risk of accidental death
- People who self harm are more likely to also become suicidal and to complete suicide (Royal College Psychiatrist Report, June 2003)

Some forms of self harm are more likely to be lethal by accident, recklessness or carelessness; this in itself leads one logically to harm reduction as a way of surviving today whilst one builds your resilience.

Assessing risk

We have developed a risk assessment tool for workers and people who self harm to consider both the risks and the safety factors together which is called: ***SHARS*** (Self Harm Assessment of Risk & Safety: available **free** from: www.crazydiamond.org.uk). It does not pretend to predict risk, rather it balances the opinions of workers, carers and the focal person and leads to a strategy by which the focal person can manage their own safety. It is based in a consideration of what we see as the 5 domains of self harm:

- Directness,
- Intent,
- Potential Lethality / Damage
- Repetitiveness.
- Control and current distress

Self harm and children

The biggest problem when trying to help children is proximity to life events that are the root of the self harm, vulnerability of the person and control of events.

Separating self harm from suicide can also be a little more effort with younger people but the recent research of Hawton & Rodham in the UK has been very helpful in developing more understanding about self harm and children.

- Self-harm is a typically a very private act and young people rarely disclose their behaviour to an adult, or seek psychological help or medical attention.
- Self-harm is most common in children over the age of 11 and increases in frequency with age. It is uncommon in very young children although there is evidence of children as young as five trying to harm themselves.
- A national survey of children and adolescents carried out in the community found that 5% of boys and 8% of girls aged 13-15 said that they had, at some time, tried to harm, hurt or kill themselves.
- In the same national survey, rates of self-harm reported by parents were much lower than the rates of self-harm reported by children. This suggests that many parents are unaware that their children are self-harming.
- Self-harm may be the only way the young person can:
  - communicate their plight to other people
  - try to get the attention, care and comfort they need

STAGES OF SURVIVING

- Begins with a decision to heal
- The emergency stage (beginning to deal with memories and suppressed feelings)
- Remembering
- Believing it happened
- Breaking the silence
- Understanding that it wasn't your fault
- Making contact with the child inside (many survivors have lost touch with their own vulnerability. Getting in touch with the child within can help you feel compassion for yourself, more anger at your abuser and greater intimacy with others)
- Trusting yourself (the best guide for healing is your own inner voice. Learning to trust your own perceptions, feelings and intuitions forms a new basis for action in the world)
- Growing and mourning (As children being abused, later as adults struggling to survive, most survivors haven't felt their losses. Grieving is a way to honour your pain, let go, and move into the present.)
- Anger can be the backbone of healing, a powerful and liberating force
- Directing your rage at your abuser and at those who didn't protect you, is pivotal to healing
- Disclosure and Confrontations
- Resolution and Moving On

What helps?

- Assisting the person to take ownership of their self-harm
- Hope & optimism
- Working through the links between self-harm and past experiences
- Working through contributory factors – feelings around self-harm - are there differing parts of oneself, voice hearing, positive / negative relationships etc?
- Talking therapy in a group or one-to-one
- Cognitive or psychological therapies
- Distraction techniques
- Finding a safe place e.g. could be a restful room, garden or under the bed
- Drawing on events that give the self-harmer a sense of power
- Developing alliances and agreements to work together (focussing on the self-harmers experiences and goals)
- Being non judgmental and supportive
- Positive relationships
- Acceptance of the person behind the self-harm.
- Making sense, identifying patterns, owning the experience, understanding the context and links to your life story
- Making choices, building resilience and finding your future

What is unhelpful?

- Complying with labelling process
- Contracts that state help will be withdrawn if the self-harm continues
- Fighting to make the self-harm stop
- Being angry or telling the self-harmer off
- Making the self-harmer feel bad, insecure or naughty
- Giving the self-harmer a guilt trip
- Telling the self-harmer they are silly, stupid etc
- Stereotypical responses

'crazydiamond' are a collective of individuals in European countries who are trying to get psychiatry to see the wood for the trees i.e. that diagnostic labels are often unhelpful and that workers could be far more helpful if they concentrated on supporting people in their recovery. 'crazydiamond' provide training and development for health and social care in the process of recovery using the THRIVE manual.

References and further information are available on request from:
mikesvoice@aol.com

Mike Smith & Marion Aslan

www.crazydiamond.org.uk

NSHN: *Hope and Support for Self-Harm*

The National Self Harm Network (NSHN) was established in 1994 and has since that time been campaigning for the rights and understanding of the National Self Harm Network. Over the years, the organisation has changed and developed its services - responding to the ever-changing needs of the service user. In recent years, the organisation has received charitable status, which has had a marked effect upon the types of service that we can provide - moving towards a support and information service. The ethos of the National Self Harm Network is essentially to reduce isolation by providing education, compassion and understanding to people who self-harm, their friends, families and professionals. We run a website at www.nshn.co.uk where individuals can contact us or access further information and will endeavour to reply to all e-mails and letters as promptly as we are able to.

NSHN is run by a committee of volunteers who all have personal experience of self-harm. This means that the organisation remains service-user focused, and is directed by people who are motivated and passionate about helping people who self-harm. We understand that self-harm is fundamentally a coping strategy that enables individuals to deal with certain periods of difficulty in their life. The experiences and feelings that drive self-harm are different for each individual, however, the common theme for individuals is that they are unable to express, understand or manage their emotions. They need compassion and understanding, patience and care to overcome their difficulties and we endeavour to help people on this journey.

For some people self-harm can be about taking control of the inner feelings, and for others it can be about anger and frustration. There are a lot of things that can happen to people that can lead them to harm themselves. It is important to try and remember that what is painful for one person may not be the same for another person. Bullying and abuse are often common experiences amongst people who self harm and a lot of research has been carried out to explore the types of experiences and feelings that people who self-harm have been through. Other people self-harm as a means of punishing themselves, because they hate themselves so much. In every case of self-harm, the individual is experiencing overwhelming emotional stress or distress that they do not know how to manage in any other way and the self-harm is a coping strategy that they turn to when they feel they cannot cope in any other way. It is not about dying, but about staying alive.

Self harm is often a very private activity and fear of judgment and shame can often exacerbate the isolation that an individual feels. The more isolated the individual becomes, the more likely it is that they will feel more out of control and alone - feelings that often drive self-harm. The main activity of any organisation supporting people who self-harm is to address this isolation by encouraging the individual to develop an understanding of their own behaviour

and to feel less isolated and alone. Many people who self-injure feel that they are the only one going through this experience. We therefore feel strongly that one way of helping people who self-harm is to encourage the individual to talk about their difficulties to others who have self-harmed or to services that can help them to feel cared about and understood.

Often, people who self-injure also face terrible stigma. There are many negative labels that are applied to people who self-harm, the most common being that self-harm is 'attention seeking'. NSHN will always try to address this misconception by raising awareness about self-harm. Many people who self-harm never talk to anyone close to them about their self-harm; their behaviour is silent and private and is never about seeking attention from others. This negative label often arises out of a lack of education and level of training amongst the individuals who come into contact with people who self harm. Self-harm is *not* attention seeking, nor is it manipulative as one may read in some texts - it is merely a way for an individual to manage their own feelings. NSHN will always advise friends, family members and professionals to help these groups of individuals to understand self-harm in the hope that they can then support the individual who is harming in a more compassionate manner.

Commonly, people find the thing that is of most help is someone who can accept that they are in distress and not judge them. This may come from a professional such as a GP or an organisation or from a friend / family member. For some, counselling or long-term structured support is the most beneficial means of help yet for others the support of an understanding friend can be enough to help them through the difficult period. The worse thing that people can do is tell someone they must *stop* self-harming, as this might just make them feel like they have to hide their problems.

The first step for anyone getting better is to acknowledge their difficulties. There is always a way forward and there are people who can help. On a personal note, I would like to extend a message of hope to all the individuals who feel distressed and alone. I became involved with NSHN a number of years ago driven by personal experience and a strong motivation to help others with similar difficulties. In the past, self-harm was a huge part of my life. I felt alone and desperate but with the right support, my coping strategies have changed. My life looks quite different now and the same is possible for every individual who suffers in this way. There is always hope but the first step is to seek support amongst individuals who care and understand.

NSHN will continue to provide support, information and training to people who self-harm, and will be there to help people move their lives forward in a safe and supportive way. Best wishes, from me and all at the National Self Harm Network.

Caroline - Secretary and Director, NSHN
PO Box 7264, Nottingham, NG1 6WJ

Liaison Psychiatry Service: Linking Self-Harm and Care

Self-harm is one of the most common reasons for presentation to Accident and Emergency Departments and is one of the five most frequent causes for admission to a hospital bed for both men and women in the UK. Self-harming behaviour accounts for around170,000 hospital attendances per year in the UK.

People will all have their own motivations for self-harm. One example being the use of self-harm, often poisoning or cutting, as part of a coping strategy for dealing with intense emotional pain. For some, the self-harming behaviour can create an addictive pattern of behaviour from which it can be difficult to break free. Although some people engage in very dangerous acts of self-harm, death is not the desired outcome rather it is a survival strategy; often however, people will admit to there being an element of testing fate. Sadly, statistically, the risk of completed suicide is heightened by the number of times self-harm behaviours are repeated. It is therefore important to develop services that can meet and manage patients making use of emergency care. The key requirement is to provide accessible mental health services which enable people with self-harm problems to engage and discuss in a non-judgemental way, the motivation behind their behaviour.

People who are using self-harm to cope with life can, through counselling and other forms of psychotherapy, be helped to replace a risky set of behaviours with healthier ways of coping. Examples of psychological interventions for the treatment of self-harm include problem-solving therapy, brief psychodynamic interpersonal therapy and dialectical behaviour therapy. People presenting with self-harm and who are also experiencing serious mental health problems tend to need the opportunity to be cared for within specialist mental health services. Many people with self-harm behaviour have anxiety and depressive disorders; this large group of people is usually treated within primary care or the non-statutory sector.

The National Institute for Clinical Excellence (NICE) Guidance regarding the management and prevention of self-harm in primary and secondary care was published in July 2004 and addresses treatment in the first 48 hours following an act of self-harm. The Guidance makes recommendations that apply across the whole health community, wherever people who self-harm present for help. The NICE Guidance advises that every person who self-harms should be offered an assessment of the psychological and social factors specific to the act of self-harm. It is emphasised that respect, understanding and choice should underpin the assessment process; people who self-harm must of course be treated with the same care, respect and privacy as any other patient. In addition, clinicians should ensure that service users who self-harm are fully informed about the service and treatment options available and are given time to talk through preferences. Health-care professionals should be fully aware of the likely distress associated with self-harm and should provide emotional support and help if necessary to relatives and carers of those who have self-harmed. The NICE guidance also recommends that healthcare staff coming into contact with people who self-harm in any setting, for example ambulance crew, should be provided with appropriate training to equip

them to understand and care for people who have self-harmed. People who self-harm should also be involved in the planning and delivery of training to staff.

One example of a service that works with those who self-harm is the Liaison Psychiatry Service at The Royal Devon & Exeter Hospital (RD&E). The Liaison Psychiatry Service offers a range of services to the RD&E Hospital for those patients admitted for medical treatment who have additional psychological disorders or mental health problems; this includes the treatment and management of those patients presenting with self-harm and attempted suicide. Annually there are in excess of 1,000 self-harm presentations to the RD&E; this includes the group of people who self-harm in an attempt to end their lives. In line with the NICE Guidelines for the treatment of self-harm, all patients presenting with episodes of self-harm to the District General Hospital are offered an assessment which incorporates biological, psychological and social aspects. The Liaison Psychiatry team also has a commitment to the ongoing education and teaching of medical and nursing staff within the RD&E and works towards developing a positive model of mental health promotion within the hospital.

Fundamental to the approach of the Liaison Psychiatry team is its aim to use the mental health assessment following self-harm as a therapeutic intervention in itself. Clinicians employ a problem-solving approach in an attempt to help the patient understand their current problems in the context of their experience of previous life events. A whole *community* approach is required to improve services for those who self-harm or are potentially suicidal. Help needs to be available at the right time and in the right place. Healthcare services need to engage those who are at risk of self-harm in self-awareness and prevention of risk behaviours.

Helping to drive change locally is The Devon Interagency Forum for Suicide and Self-harm. The Forum was conceived of early in 2004 in anticipation of the NICE Guidance on the early management of people presenting with self-harm. The lead for development of the forum came from the Liaison Psychiatry Service. The service recognised partnership with a range of helping agencies both in the statutory and voluntary sectors and decided to bring as many groups together as were interested to a conference in April 2004. The event revealed the scale of the self-harm problem in Devon from the perspective of health, social care, children and young person's services, fire, police, ambulance, schools, national parks, transport, service users and carers. Annual conferences have followed and key priorities for Devon have been shaped. The range and authority of the membership and groups supporting the forum have enabled a commitment for action and work has begun on delivering a supportive programme of service evaluation, research and training. The next conference is planned for late 2007; service users are welcome to attend and attendance is free of charge. A Forum newsletter will be published later in the year. For further information, please contact the Liaison Psychiatry Service.

Jo Hammond
Liaison Psychiatry Service
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UK wide Self Injury Support

Over the past few years the issue of self-injury (or self-harm as it is more commonly known) is slowly making its way into the public eye. From the character of Lisa on the popular evening soap 'Hollyoaks', to an admission by Dame Kelly Holmes about her self-injury prior to her double gold medal winning performance at the Athens Olympics. Understanding and awareness of the issues surrounding self-injury are still questionable, with derogatory articles about self-injury still published in the national press. For those working with and supporting people who self-injure this is of course the tip of the iceberg.

The Bristol Crisis Service for Women is a national charity that has been supporting women who self-injure since 1988. Support is provided through the only self-injury focused helpline in the country, an information service with a range of self-help and educational resources about self-injury and also a selection of training options for professionals working with those who self-injure.

There are always powerful reasons why people hurt themselves. Many people cope with their problems in ways that are risky and harmful to themselves. Some people drink or eat too much, smoke, drive too fast or make themselves sick through overwork or worry. Self-injury, although it is more shocking is very like these 'ordinary' forms of self-harm.

The Bristol Crisis Service's definition of self-injury is 'self-injury is any form of self-harm which involves causing pain or injuries to one's own body' and can take many forms. Self-injury almost always begins in response to painful and difficult circumstances in a person's life. Often these circumstances stem from childhood, although some women begin hurting themselves in response to distressing adult experiences. The type of difficult and painful experiences from childhood that can lead to self-injury include sexual and physical abuse, emotional neglect, parents who are ill or who have drug / alcohol additions, chaotic home lives and a lack of communication. In adulthood, women may start to self-injure after being raped or sexually assaulted, having abusive partners or partners where communication is very difficult. Incarceration can also lead women to self-injure.

Bristol Crisis Service for Women provides 3 months (Open College Network) accredited training for helpline volunteers, who become skilled in taking calls from women in distress. We train them to develop empathy, compassion and genuineness, and to understand issues that effect women's mental health. 40 female volunteers provide a non-judgemental listening service for up to an hour, the helpline is open all year round on Friday and Saturday nights from 9pm to 12.30am and on Sundays 6 to 9pm. In 2006, 2,200 women and young women rang the helpline for support. Reasons for calling included childhood sexual abuse, rape, eating issues, relationships, isolation, self-injury, mental health issues, overdosing and suicide, amongst other things.

Women as young as twelve years call the helpline, but ages vary and women in their 50's and 60's call us for support. Calls can be very harrowing to take,

and we offer our volunteers a peer support service, so that they always speak to a more experienced volunteer after completing a helpline shift. Some volunteers have been volunteering on the helpline for more than six years, but most have been with us for between twelve months and three years. Callers sometimes give us feedback:

"I had been struggling with my emotions all week at work, and the need to self-injure. It helped very much to be able to express my feelings and talk about my self-injury during the call." *"….I felt held by the helpline counsellor. They were really very very empathic and afterwards I felt really calm and listened to."*

We hope that the Bristol Crisis Service for Women will continue to provide support to women who self-injure across the UK. Please do pass our helpline number and opening times to women who might choose to ring (see pages 29 and 42).

Women in Prison who Self-Injure

Fiona Macaulay discusses the issue of self-injury in women's prisons and how she worked with prisoners to create something that women can use in their cell as an alternative to self-injury.

If you read any publications relating to women in prison it doesn't take long for self-harm to be mentioned at some level. A department of the government responsible for safe custody - The Safer Custody Group has produced various reports over the past decade highlighting the high rates of self-injury within women's prisons across the UK.

The increased incidence of self-injury in the women's estate is stark. 30% females held in custody were reported to have self-injured, compared with 6% of males. Despite the fact that females account for only 6% of the prison population, they account for a quarter of all individuals who self-injured and nearly half (46%) of all self-injury incidents (Safer Custody Group 2003). This is because women are more likely to self-injury repetitively, especially if it was a coping mechanism that women used before going into prison.

One of the main reasons why rates of self-injury in women's prison are so high is because the prison population contains a disproportionately high number of vulnerable women. In prison, 70% women have mental health problems, 20% have been in care as a child, compared to 2% of the general population and 50% report being victims of childhood sexual abuse or domestic violence (Women in Prison 2005). In addition, many women are separated from their children, having to live under the controlled regimes of the prison service and may find being in prison a very frightening and disorientating experience. As self-injury almost always begins in response to painful and difficult circumstances these factors link directly as to why women in prison use self-injury as a coping mechanism.

Within the prison service, the type of establishment has a clear link with the

number of incidents of self-injury. Usually it is prisons which have the most transient and uncertain populations that have the highest rates of self-injury. This may be because these prisons tend to have more limited regimes and less opportunity for prisoners to form relationships with other prisoners and staff. Remand prisoners are especially vulnerable. In 2003, remand prisoners accounted for 33% of prisoners who self-injured, but only accounted for 11% of the prison population (Safer Custody Group. 2003).

The Howard League for Penal Reform (2001) highlighted the consistent theme that women were never asked what they wanted or what would make a difference in terms of the frequency and severity of their self-injury in prison. One of the most important factors for many women was the need for a positive, accepting attitude to their behaviour. However, for most this wasn't apparent in the prison system or out in the community. With regard to practical changes that would make a difference to the amount women self-injured, change of regime, providing alternative coping strategies or activities that would counteract boredom were all suggested. These were especially apparent at times of crisis when they didn't have access to other people or activities.

At the present time, there are a number of self-injury intervention programmes taking place in women's prisons across the UK. They tend to differ in length and intensity but all focus on trying to give women more of an understanding of their self-injury and offer alternative coping mechanisms.

Giving women an understanding of their self-injury and alternative coping methods were two of the main features of 'The Pain Inside', a book produced by the Bristol Crisis Service for Women. The book was put together with the help of a group of women prisoners. They were central in saying what should be included and how the resource should look and feel. The book is divided into four main sections; information about self-injury, alternatives to self-injury, puzzles and art and a letters and diary section. The aim of the information is for women to try and understand their self-injury, enabling them to recognise their triggers and to implement intervention strategies before they self-injure. (*The Pain Inside* is currently out of print and funding is being sought for the cost of re-printing).

The sheer nature of the prison environment and the issues that women face suggest that self-injury is going to be an on-going feature within women's prisons. The support women receive in prison and attitudes towards self-injury however can have a huge impact and the role of prison staff should never be underestimated. Ensuring that women have access to self-help books such as 'The Pain Inside' can empower them to learn about their self-injury and enable them to make choices about using alternative coping strategies.

One of the recommendations from the recent Corston Report stated:

"The government should announce within six months a clear strategy to replace existing women's prisons with suitable, geographically dispersed, small, multi-functional custodial centres within 10 years".

Only time will tell whether this report has any impact on the women's prison service and whether an alternative system is created.

Self-Injury and People with Learning Difficulties

This exciting new research is being conducted by a partnership between Bristol Crisis Service for Women and the Norah Fry Research Centre at the University of Bristol. The research is funded by the Big Lottery, and has full NHS Research Ethics Approval.

The purpose of the research is three-fold:

1. To find out more about the experiences of people with learning difficulties who self-injure, and their carers/supporters

2. To explore in what ways they have been supported by the services and professionals with whom they are involved

3. To identify ideas, and then produce resources, for training and policy development, which would enable them to get the positive support they need in this area.

We would love to hear from you if you:

- Know of any people with learning difficulties who self-injure who we could interview about their experiences. There are no distance limitations on this we are covering England, Wales, Scotland and N. Ireland.
- Would like your contact details to be kept by the research team, who will then send you regular updates about the progress of the study.

For further details, please contact us:

Pauline Heslop, Norah Fry Research Centre, 3 Priory Rd, Bristol, BS8 1TX, Tel: 0117 331 0987, pauline.heslop@bristol.ac.uk

or

Fiona Macaulay, Bristol Crisis Service for Women, PO BOX 654, Bristol, BS99 1XH. Tel: 0117 927 9600. fiona.bcsw@btconnect.com

Finally, we'd be grateful if you could let other people know about the project and pass our information on to anyone who might be interested.

Fiona Macaulay
Project Worker
Bristol Crisis Service for Women
(References available from author: fiona.bcsw@btconnect.com)

Beyond Fear and Control

Founded in 1980, 42nd Street has a long and established track record of providing services to young people under stress and experiencing mental health problems. Self harm has been a key concern and for over 10 years 42nd Street has been working around the issues; providing individual interventions and groups, training to other professionals, producing publications and resources and campaigning for increased awareness.

Young people have been involved in and sometimes have led this work reflecting 42nd Street's commitment to and expertise in young people's participation. The organisation has demonstrated a strong track record in engaging '*hard to reach'* and '*minoritised'* young people as well as young people who usually struggle to access services.

When working with young people who self harm, 42nd Street aims to work in a holistic way. Young people may not always consider their self harm an issue and it is important to find out the meaning self harm has in their lives. It has therefore been an imperative to start where young people want to start and not to push the issue of self harm.

Young people who self harm tell us that they do so for many different reasons. Many use it as a coping mechanism to deal with a variety of problems and issues they face growing up. Some use it as a way of coping with the lack of control they feel in their lives. Others want to combat feelings of numbness and remind themselves they are alive. For some it is punishment, or a way to deal with abuse. For all, self harm is part of their lives and holds differing significance.

We accept that young people are experts in their own experience and that 'problematising' their self harm is not very helpful for them. We try and work with young people in a way which nurtures identity and sense of self. Young people who self harm want to be seen as young people first and to be listened to and understood. Their needs for these basic human responses are no different to anyone else's.

There are many ways young people can self harm and although cutting is one of the most common, there are many other ways. Some young people may self harm in ways that are seen as more socially acceptable. Is drinking large quantities on a daily basis self harm? The meaning this behaviour has for young people is always an important place to start.

Self harm and issues surrounding it such as suicide can raise a lot of anxiety, anger and confusion amongst carers and professionals. It is still something that is little understood and stigmatised within wider society. This can be particularly significant when working with young people because issues of risk and control become particularly important. We know from young people the

importance of listening and using less controlling methods of intervention. However, sometimes the risks posed, can make people close to the young person take control. Balancing risk and the right of the person to have control over their body can raise very fundamental instincts and values.

As workers, it is always important to be aware of one's own feelings and views about emotive issues that we come face to face with. Being self aware, means you are able to be honest about the feelings self harm brings up for you and in doing so, be more equipped to offer the right type of support to someone who self harms. It can be distressing to see others hurt themselves, especially if we care for them. It is not helpful to deny these feelings in an attempt to get past them. Only by facing our own fears can we support others who are facing theirs.

Whether this approach works or not, is for the young people to answer. Recovery is not necessarily the stopping of self harm and young people need to decide for themselves what they would like out of the support offered. The young people who attend 42nd Street talk about safety, acceptance and feeling in control as important aspects in moving on with their lives and helping them resolve some of their problems. Our goal is to enable young people to feel empowered to change their lives and feel better in coping with them.

Self harm can bring up fundamental questions about what is going on in our society to make our young people want to hurt themselves in order to cope with their lives. It challenges us all to consider our own behaviour for ways in which we hurt or sabotage ourselves. Are we not all self harmers at one time or another?

Maryam Arbabi
Community Mental Health Manager
42nd Street
Manchester
http://www.fortysecondstreet.org.uk

Learning about Self Harm

If you had told me that one day I would be talking to people about the experiences of self-harm and the ways which workers can help people who self harm I would have never believed you. I wouldn't have understood what you meant by self-harm. The concept of somebody harming themselves seemed ridiculous, weird and scary and to be honest with you, I don't think I would have even wanted to know about it. So what has changed?

It was understandable that I saw myself as ridiculous, weird and scary when I embarked on my own path of self-harm. Other people saw me as that too and they did not know what to say or do for the best. Some people were able to

support me in ways which I don't think they were aware of - they would still worry whether they were doing the right thing or not.

Today my understanding of self-harm has come from personal experience and talking to other people who have harmed themselves. It has also come from people who care for and come into contact with those who self harm: friends, family, doctors, nurses, police, social workers, and those who work with young people. My attitude to self-harm has changed through personal experience, which has been an emotionally and physically painful road to travel on. I have also learnt a lot about self-harm and do not want that learning to be in vain. People want to help, they want to care and if they don't they should seriously be thinking about changing their job, role or attitude if they are coming into contact with people who are self harming.

How do you help? That is the problem. What is the right thing to say? What is the wrong thing? There certainly are a lot of wrong things you can say to somebody who has self-harmed and the appropriate words will be right for one person and not another. If you want to help then take an interest in training days and up-to-date views on self-harm. Be prepared to listen, accept and acknowledge different views and ways of being and working with people who self-harm. This is not always easy to do when you might have already been taught a particular way of working. Based on the fact that as people we usually do things because we want to help, not hinder, then it should go without saying that we want to acknowledge different ways of helping somebody who is self harming - if it is help that they want or need.

A lot of interesting articles, documents and reports have been written on self-harm. Research is continuing in this area. The research and development department at Wonford House Hospital in Exeter has been successful in a bid to fund a two year research project into the use of text messaging as a way of supporting people who self harm (see page 34). This needs to hear the voices of those who self harm to produce the best results possible with the outcome of providing another choice in how we like to receive support. I am part of the research team and I am able to turn my negative experiences into positive ones. Training is another way in which I reach out to people. Looking at the training days that I have delivered on this subject, it has proved heartening to be able to provide valuable input on the way people treat and are treated.

A very special training day that I delivered with other service users was ground breaking in that the people we were teaching were the nurses from the Accident and Emergency department at the Royal Devon and Exeter Hospital. Being in A&E produces all sorts of emotions and insecurities both in the people who are there to be treated and in those who are delivering the treatment. I was prepared for a lot of apprehension from us delivering the training and those receiving it. Self-harm can be a very difficult subject to discuss. In the feedback forms regarding the question 'what were you expecting from today?', the reply was:

'I was dreading today. In spite of this I have 'enjoyed' the day. It has been useful to me – I feel it will affect my practice'

What I feel was developed that day was a safe environment for ALL to talk and express themselves. Away from the hustle and bustle of A&E and nobody needing to be treated for self-harm injuries, conversation flowed to everybody's advantage. Also we were all there as equals, human beings in our own right having conversations and respecting each other. When people were asked what was the most helpful aspect of the day some of the replies were:

'To talk to people who self-harm when they are not in crisis'
'Open discussions'
'Discussing why people who are suicidal actually turn up in the emergency dept.'
'An opportunity to ask questions which I have always wanted to ask'
'Service users are a good way of getting a topic like this through'

When asked what would people take away from the day the replies warmed our hearts as trainers:

'I will take with me a more confident approach to patients who self-harm'
'Listening and kindness is the key'
'I wont be afraid to talk to or listen to self-harmers'

For me it was a very special and memorable day and it needed everybody there to make it special. I have personally delivered self-harm training to other groups as well. This I find just as rewarding although the debriefing process is a little different when I deliver alone! Believe it or not, I do get nervous when I am about to teach. I think the day I feel relaxed and laid back talking about such emotive subjects is the day I should step aside and not teach. One particular day when I seemed even more nervous than usual I delivered an afternoon of self-harm training to Ambulance staff and A&E staff. It was a small group of people, which has its advantages and disadvantages. Feeling that I had delivered a rather appalling talk I was forced to take a long hard look at myself when amongst lots of very honest and positive feedback one particular comment stood out for me. When asked 'how did you feel about the afternoon' the reply was:

'it was the best lecture I've had in four years'.

I feel honoured by such a comment and I look forward to having further conversations with people who want to receive training and find out more about self-harm.

Elaine Hewis
evhewis65@yahoo.co.uk

txt4SHS: Text for Self-Harm Support

The National Institute for Health Research was established in 2006 as part of the Government's 'Best Research for Best Health' strategy, to encourage internationally recognised, leading-edge research focused on the needs of patients and the public. In October last year, it held its first competition for funding under the Research for Patient Benefit (RfPB) Programme. Funding was awarded by regional committees to high-quality research projects that offered a real chance of improving health, healthcare and the patient experience.

A collaboration between the Peninsula Medical School, the University of Plymouth, Devon Partnership NHS Trust and the Liaison Psychiatry Service at the RD&E was successful in winning one of these prestigious awards.

The study, led by Dr Christabel Owens at the Peninsula Medical School, will develop and pilot the use of text-messaging as a means of providing psychological support to individuals who engage in repeated self-harm.

Why this study?

Self-harm affects a large number of people. At least 142,000 visits to A&E departments each year are because of self-inflicted injury or overdose, but we know that these are only the most serious cases and that less than half of all self-harm episodes result in a hospital visit. Many people who attend hospital for self-harm become suicidal at some point and may try to take their own lives. The management of self-harm in A&E Departments and the provision of appropriate aftercare have been identified as a key area for action in the National Suicide Prevention Strategy.

Little is known about how best to support people once they leave A&E. Follow-up telephone calls and postcards have both been tried and preliminary studies showed that they were effective. A lot of people now feel more comfortable communicating by text. Texting is not as intrusive as the telephone, it allows people to feel in control of information and it seems to encourage people to be more open and honest about how they are feeling. We know that many young people use text-messaging as an informal means of peer support. We want to develop a way of using text-messaging to deliver structured psychological support to people who self-harm, and to see whether they find it helpful.

What are we going to do?

There are two main phases to the study. The first step will be to develop the text-messaging service. We will be working closely with a wide range of people, including those with experience of self-harm, service users, carers, representatives from voluntary agencies such as Samaritans, and health professionals.

We will be using focus groups to help us to get the details of the text-messaging service right. We want to hear your views on the type of messages that would be helpful to you when you feel like self-harming. We particularly need to know what sort of language to use, how to word the messages, how often to send them etc.

At each stage of the development process, we will ask groups of people who have experience of self-harm what they think of the 'product'. We will listen carefully to what they have to say and modify the messages, or aspects of the messaging service, accordingly.

When there is agreement among group members that all aspects of the messaging service are safe and acceptable, we will conduct a preliminary trial. This will form the next phase of the project. For the trial, we will recruit people in the A&E Department who are there because they have self-harmed. Those who agree to take part will be divided into two groups. This is done by computer so that it is pure chance which group someone ends up in. It is called 'random allocation'. Those in one group will receive the text-messaging service, and those in the other group will not. We then monitor and compare their progress for several months, looking at how many times they self-harm, how often they go to A&E, how well they score on various questionnaires etc.

This will give us an idea of whether the texting service is helpful to people. If it looks as though it might be effective in helping people to self-harm less often, then we will use the results to help us design a much bigger randomised controlled trial (RCT).

How can you get involved?

The study has been designed with the help of a service user (Elaine Hewis), who is a full member of the project team. She will be looking for other people who would like to get involved. If you would like to know more, please contact Elaine:
e-mail: evhewiss65@yahoo.co.uk *or* telephone 07843 060890.

We will be running the focus groups in July and August. Keep an eye out for the postcards that we will be distributing around Exeter that will give the dates and details of how to take part. If you would like some of these to distribute, or any other information about the study, please contact Tobit:
e-mail: tobit.emmens@devonptnrs.nhs.uk *or* telephone (01392) 403421

Tobit Emmens

Dialectical Behavioural Therapy

In 2001, whilst working as a Community Psychiatric Nurse (C.P.N.) within the Honiton Community Mental Health Team (C.M.H.T.) I was lucky enough to be offered a place on a registered Dialectical Behavioural Therapy (D.B.T.) training course along with my colleague, Kim Gould. Kim and I have continued to offer a D.B.T. service to people with a care co-ordinator in the Exmouth or Honiton C.M.H.T.s.

D.B.T. was developed by Marsha Linehan, a Professor of Psychology in Washington, USA, and was originally developed for clinically suicidal individuals. D.B.T.'s targets are to:

- Decrease life threatening, suicidal behaviours (suicidal attempts, high risk suicidal ideation, plans and threats)
- Decrease therapy interfering behaviours (i.e. missing or coming late to appointments, not returning telephone calls)
- Decrease quality of life interfering behaviours (i.e. substance dependence, homelessness)
- Increase skills in dealing with emotions, to tolerate distress and to deal skilfully with relationships

After receiving a referral, Kim or myself will meet with the person referred for an assessment. If it is felt by both client and the assessor that D.B.T. would be helpful, the client is offered between 4 and 6 pre-treatment sessions (approx). These appointments are on a two-weekly basis. The goal of these sessions is for the therapist and client to arrive at a mutual commitment to work together towards helping the client to make changes that they would like to make for themselves and in their life with the aim of making a life worth living. Agreement on committing to these goals of decreasing life threatening, suicidal behaviours are crucial at this point.

Leading on from pre-treatment, treatment can commence. This is offered for 12 months and consists of weekly, individual sessions with an individual D.B.T. therapist and also weekly 2-hour group skills training with a facilitator and co-facilitator.

In D.B.T. we recognise that people who self harm see this as a solution to overwhelming emotions rather than a problem per se. A primary goal is therefore for people to learn alternative solutions and this is where skills training comes in.

Skills training is necessary when solutions to problems require skills not currently used. There are four skills modules taught and they are:

- core mindfulness skills (helpful in decreasing confusion about self identity)

- interpersonal effectiveness skills (aimed at decreasing interpersonal chaos and improving communication skills)

- emotion regulation skills reducing those intense emotional spikes that heat up so quickly but can take so long to cool down

- distress tolerance skills including survival techniques (these help in getting through a crisis and in becoming more emotionally resilient)

Skills training is not group therapy, it is more like an adult education class. The individual therapist is responsible for helping the client to replace unskilful behaviours with skilful behaviours in their everyday life. In D.B.T. we have a set assumptions of which guide our work. These assumptions are that clients:

- Are doing the best that they can
- Want to improve
- Need to do better, try harder and be more motivated to change (I know that this sounds like a contradiction point, but what it's saying is you're doing the best that you can and you can do better as you haven't reached the limit of your own personal growth yet)
- May not have created their own problems, but have to solve them anyway
- The lives of people with a diagnosis of borderline personality disorder who self harm or are suicidal are unbearable as they are currently being lived (given this fact the only solution is to change their lives, this is where D.B.T. comes in)
- Must learn new emotion skills and behaviours in all relevant contexts of daily life.

We encourage clients to make contact with the individual therapist outside of individual therapy sessions if experiencing difficulty in applying D.B.T. skills in every day life. The therapist will offer coaching, cheerleading, support and joint problem solving skills. People experiencing active thoughts of suicide or self harm are encouraged to telephone to ask for help in not acting on these thoughts and to develop a survival plan.

Clients are required to attend both individual therapy and group skills training. As a D.B.T. therapist, I am required to attend group consultation (supervision) on a weekly basis for two hours. Within this consultation team we use D.B.T. strategies to help find a solution to problems which might have arisen in individual therapy over the previous week.

In summary, there is a great deal of research evidencing the efficacy of D.B.T. It is not, however, a suicide prevention programme, the goal rather is to help people to develop a life worth living. If anyone would like further information on D.B.T., I have research articles and information sheets which I am happy to share.

Sarah Challis, C.P.N.
Churchill House, Honiton
Tel. 01404 540100

Hidden Harm

Working in mental health services, it is clear that our use of the term *self harm* is deeply misleading. Over many years, people in mental health services have consistently spoken of harm done *to them*, usually as children, usually by adults, for which *self harm* has become a way of surviving, *Self* harm misrepresents the nature of harm suffered and the source of that damage.

As children, we need to be provided with safety in order that we can develop and survive. When our carers and community are unable, or do not, provide this safety, as children we can be very much at risk of experiencing damage and harm. This harm may be emotional cruelty, violence, sexual abuse or neglect and may leave us as children with an overwhelming struggle: how to live in danger or with damage - beyond any resources available to us as children.

Living with serious damage from adults / carers / neighbours / strangers challenges our survival as children. Children have to use the resources available to them to survive. We may, as children, try to make an internally 'safe place' or safe thought or safe toy that may create some feeling of comfort or familiarity in an unsafe / damaging world. We may try to create routines and patterns that give us some predictability amongst all that may seem unpredictable and out of control.

We may also try to understand why this harm is happening / has happened to us. As children, we tend to feel responsible for bad things that happen. We may blame ourselves, feel very ashamed, very afraid, very trapped, very sad or angry. These feelings can be overwhelming for a child. We may discover as a child that harming ourselves makes the feelings go away for a while; that harming ourselves may help numb the fear, the sadness, the danger. Self harm may feel comforting; it may feel soothing; it may feel punishing. As children, harming ourselves may become a way of surviving damage and danger.

** "The cuts are a visual expression of my distress when I am lost for words, my cuts speak for me... they say – look, that is how much I am hurting inside…"*

"It's a silent scream: It's about trying to create order out of chaos…"

"I'm sad about all the scars but they are also really important … I can look at them and know that I am not making it all up…"

"Cutting was my only release from all the unbearable chaos inside…"

Damage from childhood often remains unseen in adulthood. The harm experienced in childhood may not be spoken of, may not be visible, may remain hidden. We may experience further damage as adults in relationships of violence or abuse or lack of care. We may continue to have many feelings from childhood that are still difficult to bear or to speak about. Harming ourselves may continue

to be a way of surviving powerful feelings of sadness, shame, anger, self blame; a way of managing disturbing memories and flashbacks. As adults, this harm to ourselves may become noticed if we need to get help from our G.P. or A&E. We may have friends or partners we try to speak to about it. We may look for help from mental health services.

The challenge for us working in mental health services is to understand self harming as a way of surviving. Too often in mental health services self harm *per se* becomes the focus of concern and change. Childhood damage - harm experienced *by* the person - remains invisible and unseen. This can create a painful process in which mental health services try to reduce self harming strategies that are part of surviving childhood harm. We need to understand in services self harm as a way of managing very difficult feelings, memories and experiences of abuse and damage.

To begin the process of healing, we need to be able to work safely to hear the distress of hidden harm. It may feel very difficult for someone to begin to speak after so many years of silence and hidden pain. Writing, painting, drawing may offer safe ways of expressing painful feelings of shame, blame, sadness or despair. We need to work together to develop new strategies to manage the damage and harm - to comfort painful distress, to begin to safely express sadness, loss, rage; to painfully struggle with shame and self blame. This need not be in isolation. Survivor groups offer the possibility of sharing and learning from each other.

Self harm will not be needed when there is less harm to survive; when there are ways for painful feelings to be heard safely; to be expressed safely; when it is possible to live with more comfort and safety in our bodies. Tackling the mental health and health effects of abuse and violence is now a major goal for the Department of Health. In addressing these connections, we can work towards ensuring mental health services can work safely and well with this often hidden harm.

** Quotations from Women who Hurt Themselves, D. Miller (1994)*

Gilli Watson
Consultant Clinical Psychologist
Devon Partnership Trust

Quotations on the subject of self injury

(source: www.jenniferboyer.com *with permission*)

Damaged people are dangerous. They know they can survive. Josephine Hart, '*Damage'*

Better to inflict pain on myself than to let other people do it. Tracy Thompson, 'The Beast: A Reckoning with Depression'

I was forever staring at the tender blue veins along the inside of my wrists, fragile twigs trapped under ice. Maud Casey, 'A Better Place to Live'

A scar is what happens when the word is made flesh. Leonard Cohen

Once again, I wanted to kill something in myself, wanted to bleed it out until I was left with the bare, clean baseline, the absolute zero from which point I could rebuild a better version of myself. Caroline Kettlewell, 'Skin Game'

I felt white, drained of blood, cared for, purified. Peaceful. Margaret Atwood, 'Cat's Eye'

And I am still alive - what though, my damnation is eternal. A man who deliberately mutilates himself is truly damned, is he not? I believe that I am in hell, therefore I am. Arthur Rimbaud, 'A Season in Hell'

When everything feels like a movie, you bleed just to know you're alive. Goo Goo Dolls, 'Iris'

These are the screams within
these are the life streams bleeding from skin
Patrick Jones, 'The Eloquence in Screaming'

How will you know I am hurting,
If you cannot see my pain?
To wear it on my body
Tells what words cannot explain.
C. Blount

I find cutting myself attractive…I find it sexual. Richey Edwards

I eat and I dress and I wash and I can still say thank you. Puking, shaking, sinking, I still stand for old ladies, can't shout, can't scream, I hurt myself to get the pain out. Manic Street Preachers, 'Yes'

Such beautiful dignity in self-abuse. Manic Street Preachers, '4 Stone 7lb'

Have you ever felt the need to slit your wrist, let all feelings of guilt and depression bleed out, then sew yourself up to be happy again? Heather Hubbard

When I cut myself I feel so much better. All the little things that might have been annoying me suddenly seem so trivial, because I'm concentrating on the pain. Richy Edwards.

A short play: **'A Nice Present (Presence)'** by peter.
(2 characters: SI, G)

Act 1 scene 1

G: Hi, how are you doing?

SI: Pretty pissed off actually. Feels like something is hurting within me.

G: Cheer up. I have a present for you. You like a bevvie don't you?

SI: Sure, I do like a drink.

G: Me too, my friend. There you go - a nice can of beer.

SI: That's cool, thanks man.

G: It is a beautiful can of beer, don't you agree? Let's crack it open.

(they both drink from the can in turns)

SI: This beer is really tasty man, I'm feeling much better than before.

G: The beer is beautiful.

SI: You know, I'm glad that you're here with me. If I had been alone, I don't think I would have seen the beauty of the can, I wouldn't have appreciated the beauty of the beer or understood the beauty of your gift to me. I think that I may have trashed the can and cut myself with it. I thank you for sharing your beauty with me. By the way … my name is Self Injury … What's yours?

G: God.

SI: *Whoah*, OK God, thanks. The next can is on me. Respect, man!

THE END

Self Harm Useful contacts:

The **Better Services for People who Self Harm** project have a useful website: www.rcpsych.ac.uk/selfharm This website also includes a questionnaire for people to fill in who have self-harmed about the quality of the treatment they received.

Bristol Crisis Service for Women
PO Box 654, Bristol BS99 1XH
Helpline: 0117 925 1119 Office/Admin: 0117 927 9600
www.users.zetnet.co.uk/bcsw/

National helpline: voluntary organisation set up to support women in distress, particularly those who self harm. They also offer talks and training to professionals. BSCW also has a list of self-harm self-help groups around the country.

Lifesigns - Self Injury Guidance and Network Support. A charity run by directors who have experience of self-injury. Does not give advice but provides support on-line and provide information. www.lifesigns.org.uk

A new **MAZE** website offers an independent and confidential advocacy service for 6 - 19 year olds who are experiencing emotional or mental distress.
www.mazeadvocacy.net
National Children's Bureau: young people and self-harm information resource
www.ncb.org.uk/projects/selfharm

National Self-Harm Network (NSHN) P.O. Box 7264 Nottingham NG1 6WJ Resources and Information for People who Self-Injure, Health and Mental Health Professionals, Friends, Relatives and Advocates. **info@nshn.co.uk**
www.nshn.co.uk

Providing signposting for worried parents: www.parentlineplus.org.uk/

Samaritans 08457 90 90 90 www.samaritans.org or jo@samaritans.org

SASH (Survivors of Abuse and Self-Harm) 20 Lackmore Road, Enfield, Middlesex EN1 4PB, sashpen@aol.com

Self Harm Alliance National survivor led helpline. Source of Support newsletter, available from PO Box 61, Cheltenham, Gloucestershire GL5 18YB
www.selfharmalliance.org

Self Injury And Related Issues is an information site maintained by a counsellor and trainer. www.siari.co.uk

YES (The Youth Enquiry Service) in Exeter is a good point of contact for younger people. Tel: (01392) 331666

For information about the National Inquiry into self harm among young people, visit:
www.selfharmuk.org

Blue Pain

begin
again
at the start
when my heart
she was breaking,
(keep it together)
Inside, my sanity
wavered and walked out:
left me
stranded and alone.

Lifelessness of depression
stretched across a bed
in solitude,
the slumber of day,
the slumber of night;
the sleep that lasts forever:
I want a sleep that is forever.

Never did I realise
I was alive,
as I struggled
through minutes, hours, days,
and wept into mornings
in blue pain.

Mirrors were empty:
I did not exist.
fractured,
I tore away
from myself,
and cut my arms
to remember
I was alive.

cut - I am alive,
cut - I am alive.

AR

Rejection

So painful and hard
It bounces off my heart like rain on a hot tin roof
It eats me like acid burning my soul
I let it in for it's all I know
…. I reject my very soul and I give it no home to go

To be at home is to be myself… to feel safe and secure
To be away from myself is to bear such pain and conflict
To not know where I belong
To be lost
To loose sight of myself
Rarely to meet up with myself in decades of fears
Imprisoned by self … destruction running rife… so heavy
On a life that needs to be loved and cherished, destroying my soul
Which is pitiful and cold
So painfully imprisoned in a body so unwelcoming

In silence there is growth
No spoken word can disturb the silence of growth
The internal, where true growth takes place
Needs the spoken word to remind it that true peace exists

There is life in death and death in life
And true growth cannot be stunted by self
If true self is acknowledged.

Elaine

Layers

She tries to cut away at the layers
Peeling and stripping at the pain
Each stroke a caress of the memory
A parting of those who said they cared.
An innocence, lost with the fiery touch
Compounded with screaming goodbyes
A crazy world where nothing makes sense
Lost in layers.

Self abuse

Abused, used
Torn from a mind
Innocent

Darkness
Tipped into a space
Of colours and
Freedom

Locked in a world of
Solitude
Where she played not
Touching what was
Real.

Awoke with the pain
Self destruct
Why – she cried
Bleeding

Ed

My Life and My Need to Self-Injure

Having been a survivor of sexual, mental and physical abuse I thought I had boxed it, tied up, and pushed it to the back of my journey. The red and colourful angry balloons soon escaped the packaging and they burst with different emotions: pain, guilt, anxiety, anger, self-blame, frustration, self-hatred. Where did these feelings go? - inwards, inwards, inwards. To cut made the feelings real. To cut was to stop the pain - internal pain from getting too much. To cut myself was to control the bad feelings. To cut was to cleanse myself from what I was experiencing. To self-injure is a way of saying to the rest of the world I'm hurting, hurting inside.

Lucy Stevens
(May 2007)

!Self-harm!

As I put the glass up to my wrist and pull down as hard as I can I feel the adrenalin of my blood dripping onto my leg. I wipe the blood away but the satisfaction is not so great anymore. Need a better satisfaction. More blood needed, more fuckin' blood. I suddenly fear that death would be a greater satisfaction for me.

Hole

I am in a hole
I can't get out
I can't breathe hardly
Breathing is getting faster
Faster, faster, faster
The hole goes deeper
Breathing gets faster
The hole is at its' finish line
My breathing gets slower
Slower…slower……slower
Blackness I see… Still no light
Feeling numb Breathing stopped
The hole has stopped

Lucy Bennett

Darkness

As darkness falls
I fall
As darkness grows dark
I grow dark
As darkness fades
I fade
When darkness is angry
I'm angry
When darkness shows pain
I show pain
When darkness is dark
I'm really dark
When the sun is out
I'm still in my own darkness