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Getting even

**Making sense of mental ill health
through
writings, narratives,
myths and misunderstandings**

by

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**A thesis submitted in partial fulfilment of the
requirements for the degree of**

PhD in Social Anthropology

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I, Salma Siddique, hereby certify that this thesis, which is approximately 115,364 words in length, has been written by me, that it is the record of work carried out by me and that it has not been submitted in any previous application for a higher degree.

12 April 2005

I was admitted as a research student in September, 1998 and as a candidate for the degree of PhD in September, 1999; the higher study for which this is a record was carried out in the University of St Andrews between 1998 and 2005.

12 April 2005

I hereby certify that the candidate has fulfilled the conditions of the Resolution and Regulations appropriate for the degree of PhD in the University of St Andrews and that the candidate is qualified to submit this thesis in application for that degree.

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ABSTRACT

In this thesis I explore mental health and mental ill health from different angles, starting with fieldwork I did at an alternative crisis project for women in England.

After working for several years in a mental health crisis setting and having a personal experience of mental ill health I became aware of the importance of reflexivity. Reflexivity emerged as my central concern for anthropological and ethnographic research as well as mental health care practice. I realised that only through practising reflexivity can one develop an empathic understanding of the world.

I look at attachment theory and a systemic approach, both of which were central in the conception of the alternative crisis centre .I also look at how the women were assessed and supported during their time at Miles Terrace.

The task of looking at some individual women has led me to a discussion of negrescence and self-harm, and ultimately leads me to a narrative way of knowing. This narrative way of knowing has caused quite a paradigm shift in general medicine, and I discuss narrative ways of knowing the other as well as narrative competence on the part of the health care practitioner. Furthermore I stress the importance of the creative use of narratives for communicating empathy and ethics, through which particular attention can be focused upon the use of reflexivity by a team engaged in narrative therapy.

I have examined how an understanding of mental health is constructed in the eye of the beholder from all different vantage points. The points including that of an ethnographer, carer, individuals with experience of mental ill health, of doctors and medical students. I conclude from my experience in and outside the 'field' that meanings can only be realised through the reflexive appreciation of the self and other over time.

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DISCLAIMER/RECLAIMER

I deliberated a long time whether I should include a glossary of terms with the contentious subject of mental health.

Meaning is always assigned, and as such is always political. Especially so in the field of mental health, which is “invisible”, which makes it much more susceptible to the insidious ways in which power will seep in and create stigmatisation. Labelling is a powerful notion in mental health, once a diagnosis has been assigned, once a signifier has been selected to match whatever is perceived, it will stay on your record.

Psychiatric labels always have a Frankenstein effect to them, our gaze is that electrical surge that gives Mary Shelley’s monster life and humanises it. But the western gaze has fused doctor and monster; not the monster that is called Frankenstein, but rather its creator. But it’s the monster that is conjured up in our minds.

The words that have been created in order to combat other labels, created out of a deep reaching awareness of the power they wield, and also created out of a helplessness to deal with the other labels.

The current politically correct labels that refer to both ends of the continuum of people’s mental states are mental ill health on the one hand and positive mental health on the other. When people are closer to the mental ill health end of the spectrum, the label that has been assigned to them is ‘service users’.

The problem with this is that many of the very people for whom these services have been set up, never relate it to themselves, as they are not familiar with the terminology. More than one person with experience of mental health problems has told me they passed signs with the words ‘service users’ every day, not realising it refers to them. They think it’s for drug users.

A glossary signposts, that’s its job description. In mental health, there is no clear path, no single way to arrive at an understanding, in many ways more so than in every other field.

Sylvia Plath once asked "Is there no way out of my mind?"

A few months ago, when I was despairing over the outside conditions, the epistemic inequalities of the system, weighed down by the weariness of the world, I found myself at a fork in the road and someone strongly gestured me on to the road into my mind, on to the road of reflexivity. Up to that point, I had looked at mental health as something that needed to be levelled at a societal level, that had to be deconstructed from the outside. But when you are on a reflexive road, whatever there is on the outside, unless you yourself are prepared to meet the other at eye-level, there is no getting even.

In Ruth Behar's words "Follow me if you don't mind getting lost."

Be a mind tourist.

NOTE ON ETHICS AND CONFIDENTIALITY

For ethical reasons I am not using the real name of the women's crisis centre where I spent nine months as a research project worker.

I chose to refer to the crisis centre as Miles Terrace. The word terrace evokes in me the lives of many different people side by side, while it is up to them how much further they want to take the connection that had been created by physical proximity. And Miles conjured up a the mileage of people's journeys as they were travelling along the various stages of mental health and mental ill health. And besides, I like Miles Davies.

The women who had come to the project in acute crisis as well as the staff have been given pseudonyms. The 'partial stories' that each of the women share from their perspective as women using the service or women practicing care at the project have been fused together. As a result, each woman's experience becomes a mosaic of experiences of a number of women . I wish to further demonstrate that for the anthropological experience, both in and outside the 'field', meanings can only be realised through the reflexive appreciation of the self and other overtime, which includes reflecting upon all the emotional baggage that has been brought along in the journey.

The manager of Miles Terrace had invited me to the project for the sole purpose of undertaking this ethnographical research. Consent was sought from the project to undertake the fieldwork. I was given the support and guidance by the women whose stories I was attempting to make sense of. Every effort has been made to ensure the accuracy and currency of the information brought together here from a wide variety of sources and experience. Ultimately these partial stories and encounters have been filtered through and understood by my own limited life experience. The Danger has been that the anthropologist might theorise the women's behaviour much the same way as the psychiatrist would. The attempt here has been to avoid that route.

I intend to return many times to Miles Terrace to continue the conversation and laughter.

PREFACE

I have been working in mental health since completing my undergraduate degree in Social Anthropology in nineteen ninety-six. In various capacities, I have worked with people who have used mental health services, and also with the people who create, run and work to improve these services. In addition to my hands-on experience I also have 'sit-on-committees' experience of mental health services in Britain. On such committees, I have seen in action the different narratives that comprise the discourse about mental health. And I have also had the experience of learning that the very points about which I wish to raise awareness, the very points that had produced my (now former) position as a minority officer in the first place, were often not of any interest to other committee members. What I am attempting to say here is that I am all too familiar with the dominant model according to which mental health is perceived in this country.

Faced with the immediate necessity of synthesising my knowledge into the academic context of a PhD thesis did scare the wits out of me. There are so many things, where to begin, how to say it? There is of course the issue of institutionalisation, which grew out of a desire to control the members of society and which gave rise to the discipline of psychiatry in the first place, which then leads to topic of possible alternatives to institutionalisation. Indeed my fieldwork took place within a structure that was created as an alternative to hospitalisation for women who were in acute mental health crisis. The sister issues of institutionalisation, control and protection of society inevitably lead to the question of the legitimisation of such control, and not only the legitimisation, but also its effectiveness. Approaches dealing with

mental health issues range from a psychopharmacological line of attack to cognitive behavioural therapy, both of these being backed by biomedical Neo-Kraepelinian and biopsychosocial conceptual models and procedures. These models are in turn inspired by the question of what psychiatry actually is – what do we in fact know about mental health? In the West, psychiatry is classified as a science, but we may well ask just what does that mean? How far do you get with the ‘hard’ facts of mental illness, and how many of those are there in the first place? To only look at the biological bases of mental ‘disorder’ is incredibly limiting. For instance, at what point does the mind and soul enter the equation - a question which brings us to a mind-body split that continues to inform a multitude of aspects of Western thinking about society, and the relationships which comprise it. This almost absolute mind-body polarity is however quite particular to the West, and the fabrication of such a Cartesian duality manifests itself in particularly interesting ways in certain psychiatric conditions such as somatisation disorders. On the other end of the spectrum of psychiatric disorders are the culture bound syndromes, which highlight the fact that culture can never be completely eclipsed from a classification of disease: mental illness, to some degree, is informed by how the self is constituted in interaction with others in society; it pertains to the concept of a person, about the identity of the person. And this of course includes all sorts of identities, those of gender, sexual orientation, ethnicity, religion, culture, age, you name it. My original focus was going to be the cultural one, but the specialisation of transcultural psychiatry is in so many ways a product of a much broader and complex way that mental health works... and all the threads of the richly textured rug that covers the field of psychiatry and mental health are so intricately interwoven that I simply did not know which thread to pull on first. How could I isolate and organise all those different strands and arrange them in a feast of

appealing and easy to digest portions, while I was choking on their entirety?

There was of course the fieldwork that I had conducted over a period of nine months. As mentioned, I had been working as a research project worker in an acute mental health setting, which constituted an alternative to hospitalisation. As a research worker I occupied an awkward position, right at the intersection of social roles - on the one hand I was a member of staff, while on the other I was there to talk to the women residents about what it was like to be in the crisis house, what it was like to be in acute crisis. In other words, I was meant to be their chum. However, the demands of working in acute psychiatric care, the frustrations, the in some way undefined and contradictory nature of the role of a project in an alternative setting brought me very close to the line that separated me from them, the line that differentiated the service providers from the service users. But how do you in fact define such a line? What does such a line really separate? The normal from the abnormal, the healthy from the ill, the good from the bad, the wheat from the chaff... so some narratives would have it. While acute mental health work does bring you to your limits: through your institutional power you are still in a strangely untouchable position, where despite coming close to the line that separates health from illness, there is ultimately a strong sense that the health is on the side of the healer and the illness resides with the ill, and ultimately the health worker is safe from it, from mental ill health – even though the staff at the crisis project of my fieldwork had been recruited to reflect upon the diversity of the population, which included the former use of psychiatric services. This double standard made me question certain aspects of the way in which psychiatric care was set up.

There always has to be a line for any knowledge to be organised and understood. This line is never there to begin with. Someone comes along and decides for reasons that seem important at the time that this is where it should be drawn. And then, after a while, someone else comes along and debates the line. And suggests it would work much better 5cm to the right. Then someone else thinks this is rubbish, where it really should be is 74inches to the left. And this carries on until someone else comes along and suggests to scrap the line altogether. This then has the disadvantage that it leaves all apprentices of that body of knowledge with no guidance whatsoever, and brings us back to square one. In psychiatric terms, one important line that organises what we know what's out there mental-health-wise so we can understand it, is the DSM, the Diagnostic and Statistical Manual of Mental Disorders. Currently in its fourth edition, this psychiatrist's bible had undergone quite some shifts as to where exactly it drew the line between mental health and mental ill health, and, which is of equal importance, where and how it delineated one type of mental illness from another. So before zooming in on any psychiatric particularity, I would have to look at the diagnostic lines and assessment axes of the DSM, the Diagnostic and Statistical Manual of Mental Disorders that was the first to create one important strand in the psychiatric narrative. It was a narrative of science, where the neo-Kraepelinian categories chopped mental health into a finite number of disorders best understood as biological in origin. Kraepelin's system was based on the 'medical model'- as used by medical doctors in diagnosing physiological disorders.

Today's classification system, The DSM IV (Diagnostic & Statistical Manual, 4th revision) is based on the Kraepelinian system, and many of its problems have been passed on from the Kraepelinian system. Kraepelin's use of the medical model in diagnosing psychopathological

disorders has the implicit assumption that they are similar in nature to physiological disorders. It has come to light that this assumption is deeply problematic. Such compartmentalisation then enabled the pharmaceutical industry to pick up or take over the issue of social control that had once been within the realm of an asylum. Which brought my search for a suitable starting point full circle.

I was paralysed in the face of how inextricably interlinked the staffs' mental health was with the residents. I was overwhelmed with the sheer wealth of material that I had taken in over the past years. None of those issues are going to be new for the seasoned ethnographer who collects data in a very systematic way and organises it so that every point is perfectly cross-referenced and fully contextualised. It wasn't that I had no material, rather I had so much that I simply didn't know where to put it, in which one of the folders I had created on my computer it should go. Everything was so interlinked, all my pieces of information pertained to, in a superglue kind of way, to all my other points. How could I possibly tear them apart? And the more I looked, the further my horizon retreated away from me, and the act of creating an order of my own that would make sense to others through the act of writing became ever more daunting. This is not helped by the fact that I am dyslexic. I realised that the challenges for me in organising material and having clarity about the written word as mirrored in the chaotic nature of mental ill health.

Looking at that ball of sticky threads that were stuck together, I realised that the creation of the DSM, the Diagnostic and Statistical Manual of Mental Disorders, had been a kind of ethnography in its own right, with the result being a mental health manual that could be used cross-culturally. The DSM is used cross-culturally, and in many ways, it does the job it was designed to do. But in many other respects, its lines and

axes had been arranged in ways that left big chasms yawning in between. And along came the critics that lobbied to move the lines again. And as the arrangement of all lines and axes was man-made, every new edition of the DSM produced ever new critical movements that sought to go beyond where one had stumbled.

So if I wanted to produce a psychiatric ethnography of my own, ideally I would wish to incorporate any such ethnographic shortcomings and include in my monograph not only the current state of mental health but along with it a critical and post-psychiatry all in one. On top of all that it should be evocative writing. This brings me back to my actual fieldwork in a crisis project that offered women an alternative to hospitalisation.

The whole point of doing fieldwork in a psychiatric crisis centre was to get close to the experience of mental illness. And I got very close. But in addition to the residents' vibrant, terrible, dramatic and above all absorbing narratives, there was another angle from which I experienced mental health, and that was of course from the perspective of the provider of care: the diametrically opposed point of view, vis-à-vis which mental health is perceived in the first place. It was in the position of the care provider that all sorts of institutional narratives colluded. There was not only the narrative of institutionalisation, but also those of the pharmaceutical industry, the medical model, systems therapy and the biopsychosocial model, and also the narratives of nosology, the psychiatric classification of diseases, the narratives of religion, spirituality and myth making, and all these narratives came together in my experience of the residents, my experience of my position as a mental health worker - and my experience of who I myself was with in all these multitudes of narratives. So it wasn't that I was short of bricks for my bricolage. And it is precisely this vibrant narrative intertextuality

that underlies transcultural psychiatry. Psychiatric conditions do not necessarily look the same in different places. Nor do they necessarily look different. As always, there is the issue of cultural competence, but that alone will not necessarily get you any further. Or, in the words of Bruno Bettelheim, *Love is Not Enough* (1950); Aaron T Beck, the founder of cognitive therapy, stepped it up a gear with *Love is Never Enough* (Beck 1988). It is only by looking at the multitude of different narratives that come together in the field of mental health, that one can begin to understand why things are the way they are here and another way there. And why it leaves you in this and that state. It seemed that in order to really do it justice, the complex field of mental health can only be understood when looking at it from multiple angles simultaneously.

But in addition to all the epistemic narratives and discourses that locate mental health within certain dynamics of power, there are all the other, more literal narratives, the guttural narratives of people who have an actual experience of mental ill health, the ones that I had originally set out to understand. And as I was wondering how much of those gut narratives I had taken in really, I began to realise why I was racing around in ever more twirling epistemic circles. I had gone into an acute crisis setting, all ready to explore the illness narratives of the women who were in the project, armed with paper and pencil and my dyslexia. But above all, I had come into the mental health setting armed with my anthropological theory, which I produced whenever things got tricky. It is one thing being aware of dominant discourses that shape the way an institution operates in society, but it's quite another to get out the theory when what is required, as far as I could see, is really nothing but oneself. But the full self, the self that is open like a parachute so it can work, so it can do the job of realising its humanity through others.

Last December, after I had been wielding the theory at the acute crisis project, I was given the opportunity to see that all the while I had been fighting my way through the jungle of mental ill health and psychiatry, my parachute mind had been closed. Or rather, not the parachute mind but rather the parachute heart. I don't mean this to be sappy, but for me, the moment when the GP told me that I myself was in acute crisis, was probably the most defining one I had in all the past years. And I realised that all the epistemic knowledge in the world meant nothing in the absence of empathic knowledge. Or rather, I began to see that all the empathy that I was so convinced I had had in abundance for all the women with an experience of mental ill health, did in fact only go so far. So instead of the institutional narratives of epistemic dominance, I began looking at the way the actual narratives of the women in crisis had unfolded in relation to myself. I began to see that unless I really took a good look at myself, my shadow would always blot out whatever interesting things might otherwise find their way into an ethnography, your undisclosed biases seeping in at the seams. And a reflexive kind of ethnography posed the exact same challenges as reflexive mental health practice. Exploring the benefits of reflexive practice, I began to see how the systemic theory at the basis of Miles Terrace, the crisis project of my fieldwork, could be, and is taken further. From an anthropological observation I now found myself on a journey to a psychiatric understanding of the self – of myself. An understanding that no longer spun around various epistemic and DSM axes, an understanding that went beyond a phenomenological appreciation of the matter, an understanding that could only be achieved reflexively. The ethnographer's way forward lies in offering oneself up to the world, letting it seep in, rather than always having this or that theory ready.

Returning to my ethnographer's block. After I had been paralysed in the face of how incredibly interlinked everything was, I realised that it didn't really matter where I started, that ultimately, all ways would lead to Rome, which incidentally happens to be the seat of the World Psychiatric Association. The only thing I would ever have to do was make sure I took myself with me. Love might not be enough, but if there is no empathy, you might as well not bother. So this is a journey towards an empathic appreciation of mental ill health.

My mental health journey began with agency work in a crisis project in the mid-1990s and reached a peak of direct exposure in 1999/2000 during my nine months at Miles Terrace. But traipsing around an alternative to hospitalisation for the best part of a year did not do the trick to kick me out of my aquatic bubble into the world of empathic listening. That took a crisis of my own. Or rather it took someone telling me I was in crisis.

Like the last stage of Cross's negrescence model, the framework in which I had conceptualised mental health had been enriched by a whole new level that put things into a more human perspective. I had been a vegetable; now I was on my way to being a mineral. Also, my crisis was couched in a structural transformation of my own life: I quit my job and started a new one. Still in the same field, but in a different place. But there were some parallels in the physical place.

On reflection, had I written my thesis at any other time it would have been a different thesis. But had I not written it in the middle of coming to terms with even my own mental health situation, there is no way I would have ever come close to coming to terms with anyone else's.

PROLOGUE – FIRST STEPS

In 1996 I joined a nursing agency in South East England keen to work in various mental health settings. At first, the agency said I had to be signed up for a little while, before they would send me into hands-on mental health job, and they therefore started me off on a number of clerical jobs. One of those initial clerical jobs was in a local GP surgery, where I had to reorder all the patients' case files. While I was ordering the files, I got a call from the agency, someone couldn't come to do a duty on a ward, would I step in. Of course I would.

It was an acute psychiatric ward, a locked ward, a close observation—patients are put under close observation when there is a risk of self-harm. The hospital was a tower block, with the reception at the front, and the locked ward was on the first floor. I showed my ID and was given the patient's case file to read. I was told I had to sit there for 40 minutes keeping an eye on them; this meant I was sitting in the doorway looking through the door into their room. The patient was a black guy in his 20s. I began talking to him and as I got to know him, I quite enjoyed his company. The black guy wanted to walk around, so I walked around with him. Amongst the people we passed, one guy was quite drugged out, and as we approached him he said 'flesh is grass'. This absolutely freaked me. But everyone who saw the horrified look in my face started laughing, and my close observation guy was protective of me, and asked the flesh is grass guy not to say that to me again.

My close observation guy wanted to go out and buy cigarettes. This was against what the staff had in mind for him, and he got quite confrontational about it. But before the situation could develop into

anything more severe, some members of staff came and pinned him down, asking me to join in. They gave him an injection, and the rest of the day I sat outside his room while he slept. When the staff had asked me to help control him, I was holding down his ankle, while other people held down other parts of his body, and I could feel the energy running through his body. It freaked me out that we would do this to a human being. He was struggling until he fell asleep. I was stunned that no attempt had been made to talk to him, that the staff had immediately launched into the short cut of physically pinning the guy down. I was not going to do that again.

So I went back to reordering the files in the GPs surgery. Someone from the nursing agency phoned me and told me they had very good feedback on me from the hospital and wanted me to do more work on the wards. I told them I was not ready for it. Would I work in residential places instead? I was fine with that.

A few days later I had finished filing the patients' case files at the GP practice, and I was asked to do a night duty on a ward. I was told it was nothing like I had done before, I could just take in a magazine. I was excited and anxious at the same time, as I turned up at the central South East England hospital. Again, I had to watch someone, this time together with a male nurse. The guy I had to watch was called Rory, he was Irish and in his 50s. He was in a side room by himself, and he had an obsession with drinking water. Generally, drinking water is a good thing, but if you drink too much, it messes with your electrolytes and throws off the chemical balance of your body, which is just as bad as dehydration.¹

Rory was very pleasant and we were chatting away. At one point the male nurse got up to make a cup of tea for himself and me, and Rory wanted to go to the toilet. I didn't see any harm in that and let him go. When the male nurse got back with the cup of tea, on hearing I had let Rory go to the loo, he ran to the loo and pulled the door to the cubicle open, where Rory was drinking the water out of the toilet bowl. The nurse put an arm underneath Rory's shoulder, picked him up and took him to his room. I was given strict instructions not to take my eyes off him.

So I sat there, talking to Rory, as he got up and started licking the condensation of the window. So I explained to him that while there is usually nothing wrong with drinking water, drinking too much was very bad for his system, he wouldn't be able to lift his arms if he drank too much. But it's only water, Rory nevertheless replied..

This experience made me think about the different ways in which people understand how the world works; everybody has their own set of ideas. No matter how much I tried telling Rory that if he carried on drinking he was harming himself, he'd always complain about being thirsty. He showed me adverts in magazines about how drinking water had nutrients. This is a characteristic shared by many mental patients: many would digest very commonsensical messages from the media but then take them to an extreme. Some people, for example, would hear about how good eggs were for you, and suddenly they would do nothing but eat eggs.

A month later I was asked to cover someone's shift at Miles Terrace. Sarah, the woman at the agency had phoned the night before and told me that they could not get anyone else to cover the shift. She said that the

people who worked there were strange, some of the workers were openly lesbian, and there doesn't seem to be any order, and everybody seems to just let it all hang out. "Could you just go there one day to that shift?, they take new people regularly". I was worried about not fitting in. Don't worry, they'll tell you", Sarah said. It's difficult to go back there twice. After Sarah's little summary of Miles Terrace, I was so anxious about the next day that I couldn't sleep at all that night.

The next morning I got on to the tube, and as I got out of the station, my steps got slower and slower and by the time I reached the project I was 10 minutes late. If they're so pernickety, they won't want me to do anything today and they won't ask me to come back, I thought to myself. I knocked on the door, a bald headed woman with army fatigues, a white vest and tattoos up the side of her arm, dog tags round her neck opened the door. She smiled broadly. I freaked - why was a resident opening the door? You must be Salma from the agency, come in, we haven't started handover yet, the bald woman said. So she wasn't a resident after all. I was ushered into a room on the right hand side which was the office, where a number of the staff were sitting in a semi-circle swivelling about, and the manager welcomed me with a notepad and a pen.

Handover was when one shift ended and another started and any information about the residents needed to be passed on. I was feeling quite anxious and self-conscious, and tried not to make much eye contact. Each of the staff went through their list, did they take their medication, did they go to their appointments, what time they returned if they had been out, and any other issues to be followed up by the next shift. Once that was done I was given an induction by Nat, the bald woman with the tattoos who had opened the front door. Let's start the

induction in the garden, she said, I'm desperate for a fag. We left everybody behind and went downstairs, into the basement, through the kitchen and the lounge. There were several people sitting in the lounge, and a big goldfish tank and a television. Nat said hello to everyone and introduced them to me and me to them, telling them I was the new agency project worker. She also told them not to give me a hard time.

On our way to the garden, Nat asked me to tell her about myself. This induced considerable anxiety in me I wondered what do you want to know about me? Noticing my discomfort, she told me not to look so worried. She only wanted to know where I was from, and what type of work experience I had had. However, before I could respond one of the residents came up to Nat and started talking to her. She was telling her how she was having a shit time and her partner wouldn't let her visit her child, and Nat was quite comforting and understanding. I was thinking to myself that bald-headed Nat didn't look like the sort of person who's had or ever would I have children. And I noticed how my own first judgments had slipped into a somewhat distorted initial assessment of Miles Terrace².

I was quite comforted by what Nat was saying, and as Nat smoked her roll-up, I could see what connection she had with the residents. She smoked roll-ups, as did many of the residents, and kept the tobacco and cigarette papers in a rusty tin.

Quite a few of the residents had rusty little tins. When they wanted to smoke, locating the tin on their body became quite a ritual, one which appeared to give them a certain sense of comfort. The minute the residents got bad news or couldn't get their way in a one to one meeting, they would reach for their tin, and even if they knew they couldn't

smoke, they were sitting there, rolling their cigarettes, knowing the meeting would eventually come to an end. The minute they had finished rolling their cigarettes, I often noticed how they started to be agitated. So when I met with the residents, the minute I saw them reaching for their tin, I'd speed up to say what I had to say before they had finished rolling their fag. This was their way of saying things need to stop, this conversation needs to come to an end soon, I don't like what you're saying... and rolling up their cigarette to me was the code for the things they couldn't just say. Not because the setting wouldn't allow them to express themselves freely, but because of the manifold ways human beings express themselves. Because there were things in their minds that wouldn't allow them to say things, or because they didn't even realise there was something they had to say. Another way of communicating distress was counting change in their pocket.

If this place was such an excellent alternative to a hospital, then why could people not say more directly what they had to say, I was thinking. Instead they regressed into a particular kind of coded talk.. I had been told that this was an alternative project that tried to eradicate the difference between the service provider, be it the doctor, the nurse, the occupational therapist, or us, the project workers, and the service user, the patient. Instead of erecting constraints of a power relationship, Miles Terrace was to be designed in a way that would allow the creation of relationships that would break down authoritative roles and power dynamics. In this way people would be able to communicate directly, as equals. The project workers came from all walks of life, and represented a broad spectrum of society, as did the residents, and thus the object of equality was quite an ideal. As I noticed the women frantically reaching for their rusty tins, and counting the change in their pocket, I was wondering how much of such an ideal could ever be realised.

The house was kitted out in Ikea style. It was a Victorian period house, on four floors. Three of the floors had bedrooms, four bedrooms on top and the middle floor, all with own bathrooms and there were two family rooms. On the walls there were beautiful paintings that evoked a very middle class feel, there were lots of plants, and the overall atmosphere that had been created was very homely. It was easy to see the rationale behind the expectation that a homely environment would make one feel safe, and would make it easier for people in crisis.

I thought, yeah, things really work at Miles Terrace. The place is nice, the staff are nice. The women had a key worker assigned to them, with whom they had one to one sessions. The key worker made sure they got up in the morning, that they had a routine, a purpose. What an amazing place. But soon I picked up on the fact that there were boundaries that worked against the realisation of egalitarianism in the treatment process.

And after doing a few four months stints of agency work during the summer and winter breaks, I decided to investigate such problems more closely, and do my postgraduate research at Miles Terrace. And when I returned to Miles Terrace in December 1999, I had "research project worker" written into my contract.

PART-ONE: MILES TERRACE IN HEALTHCARE

CHAPTER I:NO PLACE LIKE HOME

As an introduction to the intent of Miles Terrace as a specific project in mental health, I provide here an extract from the project's information pamphlet:

MILES TERRACE - STATEMENT OF INTENT

“Miles Terrace” is an alternative to hospital admission for women living in the South East of England, which has now been offering a service since the mid-nineteen nineties. This service recognises the need for women to have a safe space in which to recover from their crisis and focuses on the issues that cause mental problems for women. It was inspired and supported nationally by government recommendations and by work such as the Stress on Women campaign (Southampton Mind) 1994.

The service is managed by the Regional Health Services Trust and is funded by the Mental Health Challenge Fund and contributions from the two local authorities, via the Health Authority within the North East via the Health Authority.

It also has the benefit of a management Advisory Group which consists of women who have used services and women who work in mental health organisations within the region. This group contributes to the project maintaining an alternative focus, which ensures an open system of communication with other women and provides another forum for action to be taken on feedback received. It gives an objective opinion on the service and assists in keeping it open to development.

Service

The service aims to offer a safe and respectful space for the individual needs of women. This includes having a staff team that reflects the local population in terms of race, colour, sexuality, class and previous experience of using services.

The model of service provision is based on a systematic approach which values and recognises the importance of relationships, the context of a situation and the variety of intervention which can be offered to assist a person. The service aims to see a person through a crisis to a satisfactory place of safety, enabling them to move forward in a positive way.

Referrals

Referrals are taken over the telephone only and the project does not welcome potential users coming to the house unannounced.

The project can be contacted 24 hours a day by anyone wishing to make a referral on behalf of themselves or another woman. Information at this stage will focus on the current crisis and the likelihood of hospital admission if an assessment is not offered. An exploration will take place regarding other support systems which may assist before a crisis project will intervene.

Assessments

Women are offered an assessment if staff feel they are able to offer some information or advice that may be useful and they have established that at this stage the referral fits with the criteria for the project i.e. offering an alternative to hospital admission. The assessment meeting is a further exploration of the current crisis including issues in regard to

risk to themselves or others. Staff will also liaise with other professionals working with women and can, with the woman's permission, consult her personal contacts re family and friends. The assessment is facilitated by senior staff who are skilled and experienced, using a systemic model. Risk assessment is a crucial factor at this stage of the process.

If a place is offered, women can be given a place immediately, if a place is available. Women are offered a placement for up to four weeks.

A place at Miles Terrace

Once a resident at Miles Terrace, women will have workers allocated to them on a shift basis and two members of staff as named workers who will work more intensively with the particular women. Women will always have a senior member of staff supervising any work offered to them. Senior staff, in turn, are supervised by the Project Manager. Where possible, women will be offered a choice of worker e.g. a black or lesbian worker.

The project offers a respectful and peaceful environment which assists in reducing tension and anxiety and promotes self-esteem. The team offers further assessment, crisis counselling, planning around the management of self-harm, eating, drinking, drug abuse, and a general commitment to women when they feel unsafe. They also work in a very focused way on planning support services and liaising with other professionals to activate existing support systems. The aim is to enable women to go home as soon as possible with a system in place.

Children

The project can accommodate up to four children at any one time but only two children per adult as the children share their mother's room. Women maintain full parental responsibility whilst at Miles Terrace but the project aims to be as supportive as possible to the parent. Sessional crèche workers are available when needed, up to three times per week.

Miles Terrace philosophy is that women can, given the chance, maintain responsibility and control over their situation with support. At Miles Terrace women make agreement plans with staff, detailing who is going to deal with the different aspects. Women often are documented as the person responsible for taking a lead in a specific area.

GP Services

Women have access to a local GP, who visits the project throughout the week. The GP will offer women information on medication, prescribe any that is necessary and explore any physical health needs they may have. Any changes in medication are often made in consultation with the women's CPN or own GP. A visiting pharmacist also offers a group or individual sessions if women want to explore further the implications of taking medication.

Liaison with other professionals

As the project covers such a large area it is vital that it has access to professionals working in all sectors. It therefore works very actively alongside community workers and encourages very regular contact whilst women are resident at Miles terrace to provide continuity and enhance effective discharge planning. GPs are all informed in writing within the first few days of entry to the project.

All women staying at Miles Terrace are covered by the Care Programme Approach and will have an assessment to establish whether a key worker is appropriate at this stage.

Sessional workers provide a variety of groups within the project such as massage and acupuncture. The staff team offers two support groups a week which women can attend for six weeks after leaving.

Miles Terrace has, so far, been successful in offering a safe place where women can recover from a variety of problems including feeling suicidal, actively self harming, having psychotic experiences and reacting to a variety of stresses including the effects of both physical and sexual abuse.

Feedback

Provided by leaving questionnaires, discussion in house meeting and via the advisory group. Evaluation of the service is monitored by stats which look at number of referrals, assessments, admissions, ethnicity of users, location and previous use of services.

Jane McNamee Project Manager

HISTORY OF THE INSTITUTIONAL BACKGROUND TO THE CREATION OF MILES TERRACE.

Home is not where you live but where they understand you.

Christian Morgenstern, writer (1871-1914)

It should be said at the outset that Miles Terrace was one of the first residential crisis house catering exclusively for women. The inspiration for a residential alternative to acute hospitalisation per se came from the idea of the crisis house which had been pioneered in the United States as non-hospital residential care (see Bedell & Ward 1989:533-535, and Fenton, Mosher, Herrell & Blyler 1998: 516-522).

For some people with serious mental ill health, hospitalisation as part of acute psychiatric care can be very dislocating personally as well as socially. Not only because the person is ripped out of their usual environment, but also because the service offered in a hospital might be not ideal. Particularly in inner city areas, where there is a high psychiatric morbidity, beds are notoriously over-occupied (a bed crisis) (Dratcu 2003: 83-86) and dissatisfaction with conditions on acute wards abounds (see Milmis Projects Group 1995: 276-280).

In 2000, Owen, Sashidharan and Edwards (2000: 169-171) surveyed the attitudes of mental health providers and purchasers in the UK towards home treatment for acute psychiatric disorders. According to their survey, all purchasers and 97% of providers were in favour of the principle of acute home treatment. According to Holloway (2000:161-162), this confirms the paradigm shift that has occurred over the past 50 years in mental health care away from institutional care of the mentally ill. Owen, Sashidharan and Edwards (2000): 169-171) cite a policy

document, which aspires to a "safe, sound and supportive" mental health service³.

This is not to say that all hospitals are bad, and there will certainly be situations where a hospital is the only place to go. But often, community services can provide an excellent, sometimes even better alternative. It is important to bear in mind that often, the first port of call for people with mental health issues is primary care; consequently, especially areas with low resources are best served improving primary care, with specialist back-up. Areas with medium resources may additionally provide out-patient clinics, Community Mental Health Teams (CMHTs), acute in-patient care, community residential care and forms of employment and occupation. High-resource areas may provide all the above, together with more specialised services such as specialised out-patient clinics and CMHTs, assertive community treatment teams, early intervention teams, alternatives to acute in-patient care, alternative types of community residential care and alternative occupation and rehabilitation (see Thornicroft & Tansella 2004: 283-290).

One of the main deficiencies of mental health services in the UK is their inaccessibility for patients at times of crisis (see Rogers, Pilgrim & Lacey 1993). Of even greater concern is the fact that the duration of untreated psychosis prior to first presentation to mental health services is often long (see Lincoln, McGorry 1999:51-79) and time to treatment of severe non-psychotic disorders, such as obsessive-compulsive disorder is even longer (see Holloway 2000: 161-162). Particularly in inner cities, pathways to mental health care often involve the criminal justice system or unnecessarily dramatic presentations to accident and emergency departments (see Burnett, Mallett, Bhugra, et al (1999): 475-483). This is however more often the case for men than for women.

A crucial factor with regard to hospital admission is the fact that it is 24 hour. As Holloway states, in 1997 two-thirds of the purchasers did not yet provide access to the community mental health team throughout the 24-hour period.⁴ Holloway points out that there are certain practicalities to consider: “Quite how one could provide 24-hour access to me, my trainees and the three hard-pressed community psychiatric nurses who comprise the de facto community mental health team serving my catchment area is an interesting issue which deserves clarification from the Department of Health (Holloway 2000: 161-162).”

And on goes the struggle between constraints of resources and the specific needs of the individual. Particularly the needs of women in acute mental distress may be not met by existing mental health facilities. Usual issues are a lack of privacy, the fact that assaults are common and an atmosphere that causes arousal is normal. ⁵ People in mental health crisis are vulnerable as it is, but women patients are additionally vulnerable to sexual harassment and assault⁶. To illustrate this point, I quote a first person account from the March edition of the journal mental health today:

“Helen has experienced mental health problems for the last 15 years, resulting in a number of admissions to hospital. She has never been offered an admission to a women only ward. During one stay in hospital a male patient became very interested in her. He came into her bed space, which was only surrounded by a curtain, sat on her bed and began talking intensely about his feelings towards her. Helen was very scared. When, after some time, a member of staff arrived Helen was told very severely that she should not have men in the female dormitories.

Helen believes her experience and the attitude of the staff are not uncommon. “Women are very nervous. Single sex dormitories with curtains are no good, and a bedroom can be even more dangerous. It would only take a second for a man to get in. There is no security.” She believes that staff must engage with patients if there is to be any improvement. “Women don’t trust the nurses and so they don’t talk to them. Wards revolve around punishment, not care. There is never anything to do, and the good nurses never stay long. People become frustrated and the only nursing interventions come from dealing with the aggression this causes (George 2005: 15).”

Many of the women at Miles Terrace had had similar experiences in mixed wards. While being in a mixed ward can be anything but therapeutic for women in general, it is particularly inappropriate for women from some ethnic or religious backgrounds where segregated living is prescribed. As a woman from such a Muslim background, I can only emphasise this point. While I was working at Miles Terrace as a research worker, my accommodation was in a mixed nurses’ residence, and I would take every care to run across the hall to the bathroom, throw on my clothes and run back at times when I was sure that no one else was around. And I was the care provider, with no experience of personal abuse, so what must it be like for the user of psychiatric services, many of whom had experienced childhood sexual abuse or domestic violence.

Gender-sensitive approaches to the psychiatric needs of women that explores issues such as motherhood, parenting, sexual and physical abuse, social support, physical well-being, side-effects of psychotropic treatment and personal and professional relationships have proved

successful (see Seeman & Cohen 1998: 674-677; and Ramsay, Welch & Youard 2001: 85-92)..

Kohen (2001: 329-334) points out that women with mental illness exhibit fewer behavioural disorders and much less aggression towards others than do men. There is a general understanding that women seem to be more appreciative of social support and may make better use of psychological input.

One important point regarding women in care is the fact that they might be the primary carers of children who also have to be taken into account. For women with children, acute admission to the psychiatric ward means that alternative child care arrangements have to be made, often at short notice and sometimes involving placement of the children in the care of social services. A women-only crisis unit which could provide a safe place for those who would otherwise require hospital admission and which could provide facilities so that children remain with their mothers reduced some of the pressure.

There are a number of single-gender acute psychiatric wards for women with severe mental illness (Kohen 1999a: 31-33, and Kohen 1999b: 570-571). In such centres motherhood takes priority in the assessment of the needs and management of the patient.

In-patient mother-and-baby units (MBUs) are either with or without community, domiciliary or specific out-patient services linked to them. Units that have a community service link and can follow women in their homes are much more likely to be successful than those that consist simply of acute psychiatric beds and cots for the babies (Kohen 2001: 328-334). When there is no community service attached to the women's

unit, the in-patient team has to fight with the mental health management to acknowledge the need for a community mental health team (CMHT), which would contribute to the in-patient work (Kohen 2001: 328-334).

Inappropriate admissions to MBUs and problems in establishing guidelines have however unfortunately led to difficulties in both admissions and discharges. The result was under-usage and untenable vacancies, which in turn have led to bed closures⁷.

Although most of the hostels that admit women with severe and enduring mental illness may not fit the criteria for residential care alternative to hospital treatment, they are well established, perhaps even the best recognised and most widely distributed facilities of their kind (see Kohen 2001: 328-334). Since the 1990s there has been steady progress towards community treatment of acute mental illness and women-only community placements are becoming more common (see Fenton, Mosher, Herrell, & Blyler (1998): 516-522).

Admission rates of women to psychiatric beds have also been reduced by day hospital facilities with a priority for women with personality disorders that offer cognitive-behavioural approaches. Furthermore, community day units attached to CMHTs with a strong psychology input have been successful in serving women with personality disorder (see Kohen 2001: 328-334).

The crisis house model has enjoyed some success in the US, and has also been supported by groups of users of mental health services in the UK (see Sayce, Christie, Cobb & Slade 1994). Nonetheless, the provision of such services has been very slow in the UK.

In 1992, MIND, the Mental Health Charity in England undertook a consultation exercise with MIND Link and 230 local Mind associations, on the subject of crisis and acute services. From the responses to that survey, the following checklist for new services was compiled: "The case for change, on the basis of user and local MIND views as well as other research, is powerful. People overwhelmingly want a range of non-hospital crisis services. There are also significant themes which emerge both from criticisms of acute units and from hopes and fears for new crisis services which can help guide purchasers and providers engaged in setting up new services" (Sayce, Christie, Cobb & Slade 1994).

In their chapter on Users' Perspective on Emergency Needs, Sayce, Christie, Cobb and Slade (*ibid.*) identify the following characteristics that patients were most likely to value in a new service:

“

- (As a first principle) it does not do harm.
- it is as effective as possible.
- it offers autonomy, including a choice of treatments, a choice of worker and a right not to be intruded upon.
- it gives opportunities to talk through underlying causes of distress, and adopts a holistic, rather than mainly medical, approach.
- it helps people with their problems where they arise, and does not necessarily cut people off from normal life.
- it offers safety, including safety from abuse for women, black people and others; and including some genuinely safe containment in crisis houses - or in hospital-type care for the minority who want or need that.
- it takes place in people's own environment or in environments geared towards mental health needs.
- it manages people's dependence on others when in a crisis with sensitivity - for instance, by ensuring people can withdraw from the

service gradually and be linked into other help, such as self help or longer term professional support.

- it can offer anonymity.

- it safeguards resources from the hospitals for support for mental health service users.

- it respects the support that users offer each other” (Sayce, Christie, Cobb & Slade 1994).

Any potential pitfalls of non-hospital crisis services identified by users could be tackled by following the above principles - and by ensuring that the new services are developed by or with users of existing mental health services.

In 1996, one year after the establishment of Miles Terrace, the Mental Health Foundation began identifying and establishing models of good practice in crisis services. Their Crisis Service Development Programme assisted the establishment of user-led, voluntary sector crisis services and assessed the success of these. The programme was underpinned by the philosophy that the voluntary sector, in particular groups representing service users or minority ethnic communities, has a vital role to play in the development of crisis services. The funded projects were two residential crisis houses, one of which also operated a ‘crisis sponsor home’ programme in which local people took someone in crisis into their own home; two ‘safe houses’ providing weekend and evening support, and three telephone helplines.⁸

As part of the programme, The Sainsbury Centre for Mental Health undertook a formal evaluation of two of the crisis houses⁹ together with one other¹⁰. The resulting report¹¹ recommends UK-wide investment to help establish community-based crisis services for people with severe

mental health problems to use wherever and whenever they need them. It also stresses the need to build on the positive experiences of the small number of innovative community-based crisis services, frequently run by the voluntary sector, which focus not only on medication and containment but on supporting people to recover.

As already stated, Miles Terrace was the first residential crisis house catering exclusively for women. Dora Kohen (2001: 328-334) points out the gender differences that have been established in the frequency, clinical expression and outcome of psychiatric disorders in women. Women have higher prevalence of depression, dysthymia, seasonal affective disorder, generalised anxiety disorders, panic attacks, phobias and deliberate self-harm (Meltzer, Gill, Petticrew (1995)¹². Schizophrenia also develops differently in women. Perinatal psychiatry is an exclusively female area, and most eating disorders occur in women.

While these epidemiological findings do not constitute qualitative research, they still serve as interesting contextualisation of the gendered climate in which Miles Terrace operates:

Depression

Women are almost twice as likely to develop major depression than men. According to some studies, depression affects over 20% of the female population (see Kessler, McGonagle, & Zhao 1994: 8-19). Mild but chronic forms of depression and dysthymia are considered to be higher in women, although it is accepted that studies on mild depression and dysthymia are difficult to interpret because of differences in definition and problems of reliability. Kohen points out that certain

women's mood abnormalities such as premenstrual dysphoric disorder may contribute to the higher prevalence of depression.

Generalised anxiety disorder is more prevalent in women, and the risk of panic disorders is three times more common in women (Bourdan, Boyd, & Rae 1988:227-241. Women are also more likely to experience post-traumatic stress disorder (Robins, Helzer & Weisman 1984: 949-958).

Deliberate self-harm

Deliberate self-harm (DSH) is an index of social deprivation; it is closely linked with unemployment, overcrowding, substance misuse, physical and sexual abuse during childhood and domestic violence. There is a higher prevalence of DSH in women of all ages and the proportion of women in need of hospitalisation for DSH is on the increase (Hawton, Fagg & Simkin 1997: 556-560).

Perinatal psychiatric disorders

The prevalence of post-partum psychosis is about 0.2% and that of postnatal depression 10–15% (Kendell, Chalmers & Platz 1987: 662-673).

Women and forensic psychiatry

In 1996, half of the 3000 women in UK prisons warranted a psychiatric diagnosis (Maden 1996). Thankfully, the different needs of women with psychiatric diagnoses in the criminal justice system are well recognised by the special hospitals and secure units, which either have or are in the process of establishing specialist women's units.

Eating disorders

These syndromes are predominantly seen in women, with a male-to-female ratio of 1:10. In Britain the incidence of anorexia nervosa is 7 per 100 000 population, which may mean 4000 new cases per year. 90% of individuals suffering from bulimia nervosa are female, and the incidence in young women is 52 per 100 000 (Turnbull, Ward, & Treasure 1996: 705-712). Binge eating disorders have a female-to-male ratio of about 3:2 (Levine & Marcus 1998:).

Drug and alcohol dependence in women

While women had traditionally been regarded to be less likely than men to misuse alcohol and illicit drugs, recent studies suggest that this gap is closing. The male-to-female ratio of alcohol dependence in the Epidemiologic Catchment Area (ECA) study (Helzer, Burnam & McEvoy 1991) was 5.2:1, compared to 3:1 in the US National Comorbidity Survey (Anthony, Warner, & Kessler 1994: 224-268), which has been mirrored by the British Household Survey (Thomas, Walker, & Wilmot 1998)) indicates that there has been a gradual increase in alcohol consumption by British women and that the proportion of women drinking over 14 units per week had increased to 14% in 1996.

The Psychiatric Morbidity Survey (Meltzer, Gill & Petticrew 1995) shows that men have a higher prevalence of drug dependence (3%) than women (1.5%).

Severe mental illness

While incidence and prevalence of schizophrenia, psychosis and bipolar affective disorder, the so called 'severe mental illness', is no different

between the sexes, there are specific demographic, clinical and outcome differences. Schizophrenia appears at younger age in men (Murray 1994: 6-12) (and perinatal insults to the central nervous system appear to affect more men than women O'Callaghan, Gibson, & Colohan 1992: 1256-1259). Men also exhibit more premorbid behavioural problems that have strong predictive value (Foerster, Lewis & Owen 1991: 171-176).

Women with schizophrenia have better premorbid, sexual and social competence (McGlashan & Bardenstein 1990: 319-326). The course of schizophrenia in women tends to be more benign and remitting, with a more favourable social adjustment (Flor-Henry 1990: 211-227).

Admission variables are different for women and men, with women having lower levels of rehospitalisation and shorter length of stay (Angermeyer, Kuhn & Goldstein 1990: 293-307).

Difficulties in social and interpersonal interaction, which are associated with higher relapse rates, show a marked difference. Women show lower rates of sensitivity to and lower responses to expressed emotion (Vaughn, Snyder & Jones 1984: 1169-1177) but higher risk for suicide (Mortensen & Juel 1993: 183-189), though rates for completed suicide are higher in men (Moscicki 1994: 152-158; also in Holmshaw & Hillier 2000, and Kohen (ed.) 2000).

FACTS AND FIGURES AT MILES TERRACE

A statistician uses statistics as a drunk uses lamp-posts - for support
rather than illumination,
Andrew Lang (1844-1912),

During my time as a research worker, an evaluation of the alternative crisis service of Miles Terrace was carried out. According to the findings, the service was able to respond quickly to referrals and appeared to be functioning safely. Overall, the project appeared to be succeeding in providing a safe alternative to hospital admission for women with severe and enduring mental health problems.

Just to paint in the profile of the service users, let me list statistics:

In the first three years of operation there have been 620 admissions and 44 children have stayed at Miles Terrace. During that time one woman has committed suicide while staying at Miles Terrace and there have been two suicides shortly after discharge. There have been two episodes of damage to property and no major violent incidents. Referrals came from a wide variety of sources and the majority of assessments took place within 24 hours. 78% of referrals who were admitted to the alternative crisis project were seen within 48 hours, which makes the project a viable resource for service users in acute psychiatric crisis. In contrast with mainstream acute hospital admission only now is there an opportunity to carry out systematic research

Miles Terrace can however not be considered as an alternative to an acute ward in an emergency situation where use of the Mental Health Act was deemed necessary. As the project is funded by the local mental health trust which means that

The average age of women who came into the service was 39 years (the youngest being 20 and the oldest 72). The average length of stay was 19 days, with the shortest stay lasting 1 day and the longest 50 days. Out of the sample population, 19 women were given extensions beyond the 28 days that were the project's target.

The most common reason for admission was suicidal ideation and/or self-harm (47%) followed by relapse of psychosis (23%).

The most common diagnosis was depression (53%) followed by schizophrenia (16%) and bipolar disorder (15%).

Six women were recorded as misusing alcohol or drugs in addition to their primary diagnosis. Eighty per cent of the women were previously known to psychiatric services and 78% had at least one previous admission to a psychiatric unit. Sixty-five women saw a doctor during their admission and of these 10 (15%) saw their sector doctor, 50 (77%) saw the house GP, four (6%) saw their own GP and one (2%) saw a doctor in casualty.

The ethnic background of the sample population showed an over representation of African Caribbean women and fewer Asian women in our sample as compared with the local population.

Initial indications from these data are that the women admitted to the project are suffering from severe and mental health problems and a substantial number have had previous contact with mental health services. The low rate of serious incidents seems to show that Miles Terrace is able to provide a safe environment for those presenting in acute crisis.

MORE DETAILED DESCRIPTION OF THE SERVICE

Having covered some background and some statistics, I would now like to fill in some more details that concerned staff and residents on a more practical level, details that structured the day to day running of the crisis project.

There were three shifts at Miles Terrace, with a half hour handover period smoothing the transition. During handover, the staff just about to start their shift were filled in on what had happened with regard to each woman that was currently at the project, and any overhanging bits of work were discussed.

Handover for the morning shift started at 7am, and the shift lasted until 3pm. As a lot of the practical running of the shift was dealt with during this time, it usually was a busy shift and required a minimum of four staff, two out of whom were ideally seniors. Maria, the Greek administrative secretary would come into Miles Terrace for a normal 9-5.

The late shift began with handover from the previous shift at 2:30pm and would last until 9pm. At 8:30pm the workers who were on the night shift would come in. Each shift was co-ordinated by a senior member of staff, who would temporarily act as a team leader. Due to the demands made by a 24 hour cover, a senior member of staff was not always available, in which case another member would be nominated to co-ordinate the shift.

There were 17 members on the staff team in the following hierarchy:

The highest Administrative and Clerical Grade was A&C 6. An A&C 6 would take on a management role within the project. In addition to coordinating shifts an A&C 6 would key work up to four people. They would also allocate tasks to the support staff. A&C 6 members of staff were referred to as seniors.

The next grade down was A&C 5. A&C 5 presupposed some management experience and could key work two people at any one time. I was the only A&C 5. More importantly however, I was the only project worker who was there in a research capacity. Everyone on A&C 4 was a support worker, a junior.

A key worker was the main point of contact with regard to a woman who was in the project. It was the name of the key worker that would go on to the person's file. If any agencies or external staff, nursing staff, wards, people from the social work department, from housing called about that woman, the key worker was the person who would liaise with them.

Every day, the key worker would meet with the woman for one-to-one sessions, in which her progress was discussed. When the key worker felt that the woman who was to be discharged did not have a support team, a case conference was held and the woman's case was discussed with a multidisciplinary team including a social worker, a psychiatrist, the GPs, nursing staff, an occupational therapist, counsellors and therapist.

While there was one particular (male) GP that covered Miles Terrace, no set psychiatrist had been allocated to the project, because it was felt that this would feed into the medical hospital model.

Many of the women who were serial mental health patients, with a history of repeat referrals to Miles Terrace crisis service, had a psychiatrist in the community or in a hospital. In those cases, we would work with those existing contacts.

Miles Terrace had been designed as a single sex service that offered a safe space for women in mental health crisis. While all project workers were women, it could not be guaranteed that all external staff were female. Every effort was made to hire female massage therapists, survivor's poetry workshop facilitators, social workers, etc, but there were cases and time where it was not possible to recruit a woman. The GP, for instance, who came to Miles Terrace twice a week, was a man.

On admission, every woman was allocated two named workers with whom she would plan her care. Some women were already known to mental health services and many of them had a history of repeat admissions into Miles Terrace. Generally, such service users were referred to as revolving door patients, which was a term that clearly stems from a hospital ward setting. The staff at Miles Terrace were very sensitive to any colonialist connotations that would come with a certain terminology and would never use the word patient when speaking about the women that were in the project. The revolving door women often had community-based key workers who remained involved with their care.

With regard to women that were new to the service, a decision was made as to whether a community based key worker needed to be allocated. If it was decided that there was a high likelihood the woman would require ongoing case input from psychiatric services, a referral was then made to the sector community mental health team.

Many problems in mental health care stem from the fact that the care cannot be easily accessed, either because the people who would need it simply don't know about it, or because the pathways to care are lumbered with stumbling blocks. Miles Terrace had been conceived with easy access in mind.

Admission to Miles Terrace was a two step procedure. The first step into the project was the referral. As stated in the pamphlet, the women can refer themselves. It has been shown that women are more likely to recognize a psychiatric problem in themselves than men (see Horowitz 1977: 169-178). Also, as women are also more likely than men to see their GPs with psychological and emotional problems (see Briscoe 1982; and Corney 1990: 365-368. the pathway to Miles Terrace is an easy one.

If the staff decided that a referral warrants an assessment, it would pass on to the next stage. Miles Terrace operated its own assessment procedure. As stated in the pamphlet, one important criterion was that the acute problems experienced by the women were so severe that in-patient admission would otherwise be indicated. Another crucial factor was risk assessment. Women who were thought to be at risk of violent behaviour, who appeared to need constant supervision because of a high level of risk, and women who were misusing drugs and alcohol to such an extent such that they needed detoxification under medical supervision, were not admitted.

THE SYSTEMIC APPROACH

One main difference between the residential care offered by the alternative crisis service of Miles Terrace and a hospital was that an assessment at Miles Terrace did not involve labelling the woman with a medical diagnosis. Instead, an assessment would explore the woman's current situation using a systemic model. The staff at Miles Terrace were well aware of the fact that approaching the women's mental ill health from the angle of the social networks around them is markedly different from a traditional medical line of attack, which locates a pathology in some 'essentialist', innate aspect of the person (see Haw 2000). Also see Kohen (ed.) 2000). A systemic approach places the emphasis on examining the current situation and focuses on identifying and resolving the triggers to crisis and perpetuating factors. A variety of interventions are used and can involve group and individual work, medication and variety of complementary therapies including homeopathy, acupuncture and massage. Particular efforts are made to maintain supportive community links where they exist and to identify and strengthen the woman's own coping strategies. In doing so, throughout the woman's stay at the project she is encouraged to take an active part in resolving her own situation, which includes self-medication as soon as possible. The ethos of the project was to reduce the 'unnecessary' reliance on staff.

System theory was first proposed in the 1940's by the biologist Ludwig von Bertalanffy¹³. Rather than reducing an entity (e.g. the human body) to the properties of its parts or elements (e.g. organs or cells), systems theory focuses on the arrangement of and relations between the parts which connect them into a whole. This particular organization

determines a system, which is independent of the concrete substance of the elements. Thus, the same concepts and principles of organization underlie the different disciplines (physics, biology, technology, sociology, etc.), providing a basis for their unification. By focusing on the overall system, Von Bertalanffy hoped to reinspire a unity of science, which had split into isolated disciplines and counter reductionism. This systemic approach took hold in fields all across the board, from cybernetics through mathematical modelling to family psychotherapy.

Until the systemic approach hit family psychotherapy, the field had been dominated by what can be called a psycho-educational approach. With regard to approaching schizophrenia this meant educating the family members about certain aspects of the disease as to improve the management of the disorder. Such an 'intramural' treatment might work in chronic cases, where the disorder can be controlled by organising a miniature lunatic asylum within the surroundings of the family (Boscolo 1996: 81). In acute cases, in particular with first time schizophrenic episodes and hospital admission, such an approach could have a very negative influence insofar as the labelling as schizophrenic introduces powerful ideas regarding diagnosis and prognosis of the illness. According to the systems therapists, it was the labelling of the disturbed person as schizophrenic that called an irreversible and chronic disease into reality: introducing an authoritative diagnosis of schizophrenia creates dangerous expectations and resignation.

Systems theory is now well utilised in family therapy, social services and child and adolescent services and has its revolutionary roots in the Milan school of family therapy. In the early 1970s, the Milan based analysts and psychiatrists Mara Selvini Palazzoli, Luigi Boscolo,

Gianfranco Cecchin and Giuliana Prata were dissatisfied with the limits posed by psychoanalysis. Psychoanalytic thinking did not locate things firmly enough in their contexts. Palazzoli & Co were studying the actual communication patterns of families with schizophrenic members. Thoroughly bored with looking at families in a Freudian kind of oedipal sort of way, they began looking outwards. Rather than in the psyche, they were interested in the structural games that families played and in their reluctance to change behaviours. By looking outwards, the Milan group effectively brought about a paradigm shift from an intrapsychic to a structural focus with regard to family therapy. The heyday of ego, id and superego was drawing to a close. Instead, communication which can never be separated from the cognitive and the emotional was beginning to receive therapeutic recognition. And as communication within a family is of particular importance for most people, the Milan 'gang' started off with developing family therapeutic methods. No more talk about mother, father, sister, brother; instead the whole family was put into a room, together with the therapist, and had to actually talk to the latter and to each other. The goal of therapeutic interventions was no longer to get the individual and their psyche to change, but rather to influence their communication patterns. In 1978 the original Milan group published *Paradox and Counterparadox: A New Model in the Therapy of the Family in Schizophrenic Transaction*¹⁴. Two years later, in 1980, Luigi Boscolo and Gianfranco Cecchin left the team. Another two years later, Mara Selvini Palazzoli together with Giuliana Prata founded the "Nuovo Centro per lo Studio della Famiglia", the new centre for family research, which was joined later by Stefano Cirillo, Matteo Selvini and Anna Maria Sorrentino. 1985 Giuliana Prata left the group to found the "Centro di Terapia Sistemica e di Ricerca", Centre for Systems Therapy and Research.

Systems therapy had been inspired by the groundbreaking work of the Palo Alto group under Gregory Bateson in the 1950s and 1960s. But the Palo Alto focus on actual communication was no more than an outsider interest until it was taken up and developed further by the Milan group around Mara Selvini-Palazzoli in the 1970s Palazzoli, Boscolo, Cecchin, & Prata (1978). The ideas of the Milan Associates have in turn been developed further in family therapy and social work, but they have also been fed back into the communication theories that originally gave rise to them, and were taken up by constructionists and the post-modern movement (see Burr 1995). Notions of power, culture and the use of language are central to all these ideas, and also a matter central to the discussions of this thesis

One therapist who has offered some relatively recent contributions to systems therapy is Evan Imber-Black (1987: 5). In her consultation model for dealing with families and larger systems who have become embroiled with one another, she offers models for longer term work with those families who must engage with larger systems across significant portions of their life cycle. This also addresses problems of labelling, stigma, and secrecy in families.

At Miles Terrace, the staff team were fully aware of the importance their social systems played for the women who had come into the project in acute crisis. But a crisis project with a maximum stay of 28 days offers limited scope for an exploration as to how to restructure those systems in a way in which the women would not come back before too long. My case histories will explore this issue.

Systemic thinking encourages a more expansive and inclusive exploration of what might be useful to offer as a service provider. It also

allows professionals to develop awareness of the discourses operating, which are impacting on the presenting individual. If we think in terms of the family as a metaphor for the organisation then we have a role in creating changes not just with the family but 'playing an expansive function, one that challenges a status quo supportive of economic and social suffering for a significant portion of the population' (Imber-Black 1987: 5). It allows for the focus to be on the relationships that exist between people, the relationship to work of class, race, and the potential climate and power, culture, politics etc. It encourages us to work with people and take into account the multiple contexts the person is operating within and the context created by our relationship (i.e., we cannot be objective but can take a different stance, (curiosity) and look at how we as part of that context are going to impact on them.

It encourages the workers to think creatively and not become stuck fighting for the truth of a situation and who the 'expert' is. Everyone has different accounts (stories) to tell and all the stories can enrich the possibilities for moving through a situation. As workers we are there to connect with the person and assist them to create new possibilities and stories for themselves in order to go on.

In crisis work, there are often stories of stuckness, negativity and truths which limit the views of all concerned about how to move forward. Systematic theory encourages the professional to take a 'curious' stance (see Cecchin 1987: 405-413) to allow them to think creatively and ask new and interesting questions which may lead to fruitful places. The belief is that life is constantly changing and reconstructing each moment in relationships. Therefore everyone has opportunities to change and learn, the idea being to find the ways to allow this to happen. Social

constructionists would argue that to 'not change' is not possible because life is occurring all around you and in relation to you.

The crisis project aimed to incorporate the useful aspects of most existing models of service, maximising the benefits of different service options without excluding others. There are important methods and tools within this theory of system such as the 'reflecting team' (see Andersen 1987: 415-428). This encourages conversations to be held in front of others and then the others talk about the conversation they have heard. It provides new perspective and voices to be heard. At Miles Terrace this method is adapted during the assessment session. The team aims to work in twos or threes and all times to bring different 'perspective voices'. They work together to create an hypothesis about what is happening and what might be best to offer the person. It important not to 'fall in love' with our own ideas which we then fight for instead of sharing our ideas to be used or not.

The systemic approach used at Miles Terrace focused primarily on social factors of the illness. According to Groddeck, who wrote more than half a century ago, there are two essentially different causes [of illness], an inner one, *causa interna*, which the man contributes to himself, and an outer one, *causa externa*, which springs from his environment. And accepting this clear distinction, we have thrown ourselves with raging force upon external causes... And the *causa interna*, we have forgotten. Why? Because it is not pleasant to look within ourselves (Groddeck 1949).

In my investigation of manifestations of mental health I will explore later more fully Groddeck's internal causes. They were hiding in an unexpected place. I was only able to see them when the need for reflective practice forced me to examine these connections.

ACCOMMODATING ME

I started my fieldwork December the 6th, 1999. Having worked at the project before made it easy to settle into a daily routine. I liked the early shifts, because that way I finished before 3 o'clock and I could write my notes up.

I stayed with a friend for a couple of weeks before I got my own accommodation sorted out. I moved into a nurses' residence which was in an old Victorian building with about 35 rooms. Appropriately, the residence was attached to a psychiatric hospital. On the outside, the residence looked very impressive. On the inside, it had long narrow corridors, high ceilings and stone floors and it felt very quiet and cold. At the end of each corridor there was a kitchen, and there were communal bathrooms.

The rooms were very bare, with little wardrobes and a table and sink, and it had the institutionalised feel I knew well from university accommodation. It felt very transient. None of my colleagues were in the residence. I had just come down for a limited amount of time, whereas they were local, in various stages of buying a property, getting married and various other processes, but most of them lived nearby. Miles Terrace was only about 20 minutes by bus.

The house was predominantly full of male nursing staff, who often came back in the evenings, opened a can of beer and sat in the lounge and watched the telly. Most evenings the atmosphere was quite pleasant and jokey. I found it quite hard to engage though, as two or three people on my floor worked in the same hospital and knew each other. After it had been established that I was not a nurse but a research project worker, the

nurses lost any initial interest they might have had in me and I ended up feeling very excluded in that accommodation. Over the months I found out that quite a few of the people who stayed in the hospital accommodation had been there for more than a year, mostly because flat prices were so expensive, and it was the cheapest staying in a residence. Even though I came from the institutionalised setting of university accommodation, I found living in the nurses' residence quite difficult. To be fair, my warden's flat at St Andrews was a long way from my room in the nurses' residence. With its plastic mattresses, small rooms and furniture from the 1950s, the nurses residence did not seem all that different from a secure ward.

It didn't help that I was getting blotches on my skin. One of the staff members at Miles Terrace, Lee, the 'feisty-in-your-face' African Caribbean woman, said she thought I had bed bugs and suggested I should call the manager to fumigate the room.

The residence manager did come and the room was fumigated while I was staying at a friend's place for a few days. The blotches never returned. But it didn't help to make the residence feel more like a home.

I always had a little transistor radio, which I would listen to while the nurses would hang out together and cook, watch soap operas, drink beer.

Coming from a sheltered Muslim background, I would try to avoid bumping into people on my way to the shower, and would time my shower visits so that I knew no one else was around. I also began to avoid getting into casual conversations with the other residents, after some of the conversations had become quite argumentative; particularly the male staff living there were quite challenging of what I was doing,

not challenging as in engaging my knowledge, but rather in so far as they looked down on anthropology. And after doing exhausting shifts at Miles Terrace, I did not want to get into verbal fights. But with me running across the hallway to the shower, quickly getting changed, running back, making a conscious effort not to have breakfast in my accommodation and instead picking up something on the way to Miles Terrace, I slowly realised that I was impoverishing the social dimensions of my life, that I was losing something. Over the months that I spent working at the crisis project and living in the nurses accommodation, I spend a lot of time 'in my head'.

**CHAPTER II: REFLEXIVE RESEARCH REFLEXIVE
PRACTICE EMPATHIC UNDERSTANDING**

The notes I handle no better than many pianists.
But the pauses between the notes –
ah, that is where the art resides.

Artur Schnabel, pianist

It is not our purpose to become each other;
it is to recognize each other,
to learn to see the other
and honor him for what he is.

Hermann Hesse

It takes two to tell the truth
— one to speak and another to hear.

Henry Thoreau

I know what I have given you.
I do not know what you have received.

Antonio Porchia

I always ask my clients what they think I said.
More often than not, it is not what I said.
Liz Wilson, Solicitor family Law (Scotland) specialist.

“Anthropology [...] is the most fascinating, bizarre, disturbing, and necessary form of witnessing left to us at the end of the twentieth century. As a mode of knowing that depends on the particular relationship formed by a particular anthropologist with a particular set of people in a particular time and place, anthropology has always been vexed about the question of vulnerability” (Geertz 1995). As Clifford Geertz says (1995), “You don’t exactly penetrate another culture, as the masculinist image would have it. You put yourself in its way and it bodies forth and enmeshes you.” Yes, indeed. But just how far do you let that other culture enmesh you? As Behar suggests (1996), our intellectual mission is deeply paradoxical: get the “native point of view”, pero por favour without actually “going native”. Our methodology, defined by the oxymoron “participant observation”, is split at the root: act as a participant, but don’t forget to keep your eyes open. Lay down in the mud in Colombia. Put your arms around Omaira Sánchez. But when the grant money runs out, or the summer vacation is over, please stand up, dust yourself off, go to your desk, and write down what you saw and heard. Relate it to something you’ve read by Marx, Weber, Gramsci, or Geertz and you’re on your way to doing anthropology¹⁵...”Nothing is stranger than this business of humans observing other humans in order to write about them” (Behar 1996).

In this chapter, I explore my own bewilderment during the fieldwork process, and the development of my slow awareness of the 'disturbing' impact of my own personal engagement with the 'subjects' of my research to both the 'data' I collected and my initial interpretations of it. The main point that I wish to make is that fieldwork can never be a 'disengaged' , purely 'objective' process: rather, the nature of personal engagement must be understood as a crucial aspect of our research observations. Thus, after fieldwork, to run to the nearest social theorist

that takes your fancy for 'methodological' guidance is to distort at the very start of writing up your material the results of the 'data gathering', observational process of the research project. The researcher must first of all understand the relationship of 'self' to the process of her or his research, and its results. This presence of 'self' and its effects are in themselves not a matter of 'good' or 'bad', but rather something that must first be recognised and then well understood, for reasons both personal and academic. The process may well be painful.

DISENGAGEMENT IS IMPOSSIBLE.

There I was at the acute crisis service where I had been working as an agency worker for four summers. But now, my contract said 'research project worker', which set me apart – it set me apart from myself in the past when I was an agency worker, and it set me apart from the other staff, as I was the only one with researcher in front of her name. It also put me into a category of my own administration-wise, as I was the only person with A&C grade 5.

But even though now I had been elevated to the level of research worker, the same work I had been doing for four summers as an agency worker still needed to be done.

The results of this was that I constantly found myself torn between the two roles of researcher and health worker. As a newly minted postgraduate student, the role of researcher was very much the one that I identified with most, it was a role that filled me with pride, a role from which I derived an academic identity, and it certainly was a role I used to present myself.

It was also a role that the other staff were quick to comment on, especially at those times when I was shocked at some thing or another, and my sheltered background was compared in stark contrast to their more streetwise ways.

The acute mental health crisis setting of Miles Terrace provided me with plenty of opportunity to be shocked.

It started on the first day, in fact.

On my first day as a research project worker, I was told quite causally about the death of a woman who used to come into Miles Terrace. I had worked with Idi on a number of occasions in the recent past, and now she had been found dead on her doorstep.

In a matter of fact way I was informed that Idi's funeral was the following day and that any staff member was free to attend during handover. During the half hour of handover, the staff of the previous shift briefed the staff of the shift that was just about to begin about any issues. Handover was typically abrupt, but to me the information about admission and discharge of new women was insignificant compared to the fact that Idi, who I'd been working with only recently, had died. I made a comment about how I was beginning my time as a research project worker with a baptism of fire. 'Shit happens' was all that came back.

Over the following weeks, information would dribble in about her death; Idi had died as a consequence of a heart attack. I remember her as a colourful, charismatic character, who even at her lowest point of

confusion and frustration, had an amazing ability to pick up the threads of a conversation with the people she had encountered in her last stay at the project. I had been assigned Idi to work with fairly often in the past, as the other workers found her '*too needy*'. I remember thinking how difficult I found it to be with the staff at those times, how unfairly I thought they were on Idi, just feeding into her inferiority complex by dumping her. And now she was dead and I was appalled with how indifferent the staff were, how they had shut down to cope with the situation, how desensitized they had become.

Those were my thoughts at that time.

So there I was, back at the crisis project, in my special category of research project worker. Seeing the other project workers deal so casually with something so big as the death of a woman who had stayed at the project on several occasions in the past adjusted the lens through which I would see them much of the time of my fieldwork. And the lens I used was an anthropological one I was at Miles Terrace to find out about mental health from the women who had been admitted to the project in a state of acute mental health crisis, but on day one I had managed to turn my lens on my colleagues as well. And my lens was not on eye-level. I was looking at an angle. And I was not looking upward. To use Clifford Geertz's cute little phrase, I was straining to read their culture "over their shoulders."

So there I was, in my special category. I was a member of staff, but I really had come to Miles Terrace to conduct research on the women in crisis, and sometimes I would find myself siding with the women. Other times I would side with the staff. In terms of institutional power my

position was of course always on the side of the staff. And yet, I often found myself between camps.

SUBJECTIVITY AND THE BETWEENNESS OF OURSELVES AND OTHERS.

This was in fact not something that was new to me; it was not the first time I had found myself in an in-between place. As Kirsten Hastrup has argued (1987:52-4), "Fieldwork is situated between autobiography and anthropology. It connects an important personal experience with a general field of knowledge. The connection itself is of generative impact upon the reality of anthropology. Like other individuals, anthropologists are also continuous with the space they constitute (Ardener (1987:39-40).)" The subject of autobiography is crucial to my own story about understanding my own subjective status within the fieldwork situation.

At my very white middle class university, I had always been the only Black person, visibly black person, particularly in a discipline with a colonialist history as anthropology (See, for instance, Asad (1975) on the colonial gaze of anthropology).. Also, I was a vegetarian. This might not sound like it's such a big deal, but growing up in an Asian family of 6 as the only kid that does not eat meat did set me apart, and certainly provided me with quite some unpleasant memories of having to sit at the table until I'd finished, my father throwing little chunks of chicken at me. Also, me the fact that I was gay did not go down too well with my traditional Muslim family. These were just some of the in-between places I had found myself in so far.

Moreover, it struck me that the place where I was doing my fieldwork was an in-between place par excellence: not only was it a crisis service for women in acute mental health crisis, but it was also a cutting edge,

state of the art alternative to hospitalisation, the first of its kind in this country. There seemed to be too many of these 'in-betweens' all at once!

The most important in-between place I found myself in was in between my role as a project worker and my role as a researcher. Most other differences had been levelled, specific effort had been made to ensure that the staff at the crisis service reflected the population of the multicultural and otherwise diverse catchment area in terms of ethnicity and other factors. I did not stand out in terms of ethnicity or sexual orientation. And as far as I was aware, no-one had expressed any interest as to whether I was a vegetarian or not.

Kirsten Hastrup notes (1987:52-4) another in-between: "Due to the fundamental simultaneity between discovery and definition in anthropology, the reality experienced in the field is of a particular nature" (Hastrup 1990: 5 (1). As Tedlock remarks (1983:323), it is not the unmediated world of the Others, but the world between ourselves and the others that is experienced. Our results are deeply marked by this betweenness and there is no way, epistemologically, to overcome its implications. The ethnographer in the field is the locus of a drama which is the source of her anthropological reflection (see Dumont: 1978, and Hastrup 1992). As Rabinow states (1977:5) (also see Hastrup 1987, 1992), "to eliminate the experiential nature of fieldwork is to stick to a radically inappropriate view of the anthropological practice – with which we have been all too familiar in the modernist era (See Rabinow 1977, and Hastrup 1987, 1992).

Fabian (1985) has stated that the condition of fieldwork is fundamentally confrontational and only superficially observational; self and other are inextricably involved in a dialectical process. In fact, and

quite contrary to positivist wisdom, the main lesson of anthropology in general is that the absolute distinction between subject and object is an artefact of Enlightenment and modernist thought, a distinction generally denied within non-modern societies traditionally studied by anthropologists(see, for instance, Dumont 1986).

While I was theoretically aware of this modernist artefact of subject/object divide, I would not get an opportunity to really cross it until I started writing up. I am hardly the first ethnographer to realise that it is not the act of fieldwork, but the writing up of ethnography where it professionally at. Quite apart from personal career-making, the inducement to produce ethnographic texts actually stems from the fact that they are not mere records of experience, they are means to it. In Tyler's words (1986:138) '*experience became experience only in the writing of ethnography*'. It was not until I had started writing up that I would begin to see some very profound parallels between anthropological research and mental health practice, i.e., both are highly subjective enterprises. Moreover the importance of understanding the nature of such subjectivity, and its importance to results, often remains unrecognised by both researcher and practitioner.

As Behar notes (1996) such parallels were highlighted by Devereux (1967:86), an ethnopsychiatrist, who "believed that observers in the social sciences had not yet learned how to make the most of their own emotional involvement with their material". Devereux insists (as Tedlock (1979,1983) also has for the anthropological fieldworker , that *what* within happens within the observer must be made known, , if the nature of what has been observed is to be understood. The subjectivity of the observer, Devereux notes (1967:84), "influences the course of the

observed event as radically as 'inspection' influences ('disturbs') the behaviour of an electron." The problem is that the observer has great difficulty in 'observing' the 'self', and its effect. As Devereux suggests, observers tend to develop 'methods', which might be better labelled as 'defences', ones that reduces observer anxiety. Behar argues (1996:6) that even saying, "I am an anthropologist, this is fieldwork", becomes a good means for draining anxiety from situations where we might feel, for instance, complicitous with structures of power. In other words, this subjectivity of the anthropological observer and of the health practitioner is important: especially, as it allows, when not recognised, for the denial of self engagement, or effect. As Devereux suggests for both mental health practice and anthropological research that there is a tendency to push inter-active experience away from the self, and certainly not be reflexive about it, in case doing so might be slightly uncomfortable. In such cases, both observer and practitioner are denying their own responsibility in their obvious acts of engagement - with either indigenous person or mental patient, whichever the case may be. I hadn't realised that that was what I was doing until a few months ago.

AN AUTOBIOGRAPHICAL NOTE.

On the morning of the 5th December 2004, I have spent a number of years working within various mental health settings. I had facilitated a group that was looking at involving service users in education and their role in supporting and developing mental health as a subject in higher education. This was something I cared strongly about, and everybody said it was brilliant and I knew I had done a good job. I went back to my office to find two emails from my boss. For months and months, my boss had ignored me and I felt not supported in my job, certainly not by him. In fact, I felt actively undermined. He called me 'you ethnics'. In the first e-mail, he said xyz was going to happen, and these were the

approaches they were going to take. XYZ was completely contrary to the work I had been doing for months and months. In the second email he announced that he had appointed an independent consultant, but the information he sent out in his name was my work. I broke down crying. And once I had started, I couldn't stop. I did manage to call my boss to say I was coming over, I had to speak to him, but I was still crying. I am not someone who cries easily, certainly not in public. But that day, I simply couldn't stop, and eventually the secretary said, look I understand what you're going through, you're not dealing very well with this and you need to go home. She gave me a hug and sent me to the railway station. On the train from home to the office I phoned the doctor whilst I was still on the train and got an appointment for later that day. The doctor was an old fashioned, well spoken locum Doctor, and when I said I didn't feel very well, I needed a sick note he asked what he should put on the sick note. I told him I was having real difficulty, personality problems with my boss and I didn't want to be at work. He said 'I won't put stress down, I'll put debility. Debility is a beautiful word, it means so many things to so many people. By the time they figure it out you'll be back on the road to good health. You don't want to get a black mark against your name, those Human Resources people are a bugger, they remember those things like stress'.

The following Wednesday I went back for another sick note. This time I saw another doctor, a woman who was in fact a lecturer in mental health, and I found it really difficult, because she didn't just want to renew my sick note, she wanted a conversation. 'Debility – what is actually going on for you? I see you work in mental health.' I told her how I had broken down and burst into tears in my office, and that I found this really humiliating and shaming. And that I thought it would be really damaging for my career if she put stress on my note.

At which point she said 'I'm quite shocked, I would expect such a lack of insight from somebody who didn't have the experience and knowledge that you have. Looking at your record and going by what you've told me that you've worked in various mental health settings, you're in a very stressed and distressed state. What is it that's stopping you from owning this experience. I don't even hear you acknowledging it'. I was just gobsmacked. She was right. I had never realised this. I had never acknowledged when something was really getting to me. And true to form, I made a joke of it, saying this was enough to send me into an existential crisis. 'Would you know what it meant if it happened?' was her reply.

I did know. It made me question my whole vocation and discipline, being an anthropologist, working in the field of mental health. In one breath, she'd managed to shatter the image I had of myself, the illusions I had of myself. I had come to her with a problem of how someone else was seeing me, how my boss kept undermining me by not acknowledging my work and using it in his own name. And now she was telling me that it was how I see myself that was the fundamental issue. I had to think about all this. She wanted me to come back in a fortnight and have a hard look at myself. 'Before you can be with other people in a similar situation, you need to be with yourself first.'

I went home and couldn't sleep that night. There I was, looking out at the world as if it was some underground aquatic thing, with me in the capsule.

I thought about the time when I was four years old, growing up in Birmingham. We lived in this place called Stanmore, with terraces of

predominantly different mixes of Asian and Black people with a few white people, of the poorer sort. Every night, around 11pm a dull noise would wake me up, and I was quite a frightened child anyway. Only later on reflection did I realise what everybody knew but nobody ever talked about, namely that the Hindu guy next door was coming home drunk and beating up his wife, you could hear him shouting or hitting her. One Saturday, I was four or five, looking out of the window, I saw one of her twin children walking along the street, and the mother was sitting in the middle of the road, crying, using the end of her sari that was thrown over her arm to catch her sobs. She was just sitting, sobbing in the middle of the street and all these Asian people were walking backwards and forwards, just carrying on with their business. I told my mother and she went out and brought that woman back into our house, where she and her twins spent the night on the couch. The next morning her husband came. Nothing was said, my mum just exchanged looks with him and my father said don't let this happen again. A few months later, they moved.

I was still in shock, in my bed. That's how I'd always existed. Things have happened to me, and I saw them happen, but that was as far as it went. I saw things happen, but never really took them on board. Months or years later, I would comment on them at dinner parties or other social occasions. But I've always worn these experiences as outer clothing, I've never let them become part of me of the fabric of my self.

The experience of standing in the doctor's surgery made me question whether I was understanding any of the things around me. What I had understood up to now. Over the next month that I was off sick, I did a lot of thinking about my fieldwork. Out of my piles and piles of books, three in particular popped into my mind: How to get your PhD (Phillips

& Pugh 1998), Doing research projects (Bell 1996), Ethnography step by step (Fetterman 1989).

I had so many post-its in the book about doing your research projects, drawing attention to the finer points about how to keep a diary, critical incidents, problem portfolios, recording and analysing, audio-recording, interaction process analysis, selecting a method, observation study checklist... Many of these things had worked out very differently from how I had planned, with my field notes ending up being eaten by a woman in acute mental health crisis.

But now, lying in my bed, unable to sleep, my heart racing, my head pounding, I realised that even the most perfectly planned project, the most detailed field notes, the highest stack of audio recordings of interviews - it doesn't mean shit if you can't say I'm a part of this. I am here, participating, making it and unmaking it. If you stand outside of your fieldwork, it's like paying five dollars and looking through a little peephole, getting instant gratification. And as I was lying in my bed, I saw large parts of my life I had lived this way pass by. The life of Salma Siddique. A \$5 peepshow.

I was off sick for more than a month, and in that time I started revisiting things in my mind, looking over my notes, and I began to see how judgmental I had been¹⁶.

That first day when I went into Miles Terrace as a research worker, the staff team had been sitting in a little circle for the handover from one shift to another, and as we were going over what had happened in previous shift, quite casually, one of the staff members had dropped into

the conversation that one of the previous residents had died, had been found dead on her doorstep.

I remember what I thought at the time when it happened, namely what a cold, heartless bunch of bastards. Quite clearly they didn't care, undecided as they were about who was going to the funeral. But if I felt so strongly about Idi's death, I now realised, what was it that kept me from going myself; After all I had worked with her the most in my pre-field research times at Miles Terrace. But I hadn't gone. I had excused myself with more important work.

What I saw now, looking back, was that the staff at Miles Terrace had to deal with a lot of deaths, a lot of trauma. When Idi had been found dead on her doorstep, the staff were not uninvolved. They discussed whether to have a collection and tried to include all the team in the decision; rather than one person commanding who should go to the funeral, the staff were free to go or not to go. After the decision was made that the staff at Miles Terrace did want to be represented at the funeral; two members attended, the manager and a senior member of team. I suddenly saw that to a certain degree, everybody was grieving, or was shocked or traumatised. I saw the way they tried to work was to include everybody in the process of their collective grief. I saw how such a collective understanding of the situation enabled everybody to play a part, a role they chose for themselves - if they wanted to go to the funeral, they could nominate themselves; if they didn't, nobody thought less of them, no assumption was made, no judgment made about how much a person had to contribute or not.

What years ago, I had experienced as harsh, cold and uncaring, now struck me as a very healthy environment. I'm not saying they were

saintly, but my perspective has lost its harsh edge. And now that I had been forced to acknowledge sides in myself that I had despised when seeing them in others, now I could begin to allow others to be human too.

I felt such a failure. It went very deep and I can't find the words to translate this feeling on to the page, but it went very deep and was horrible. I must have done poor research, I was devastated. Suddenly I realised that I had always conducted my fieldwork *à la* Colin Turnbull (1972) who watched the Mountain People from the safety and comfort of his Jeep. This was exactly what I had been doing at Miles Terrace. I had kept these women, the service users as well as my colleagues, at arm's length, with both arms. I was observing life from my aquatic bubble. There I was, in the safety of my aquatic bubble, pitying the life forms I was observing in the aquarium.

Pitying these life forms because in them I could see the very thing that I couldn't see in myself, couldn't acknowledge in myself, because they were wearing their experiences on their sleeves, while I did everything I possibly could in order to deny to myself that I had similar experiences. I rejected or couldn't bear in others what I couldn't own in myself.

Stress is a commentary on one's environment, and I had been working in an environment that gave lots of cause for such commentary. But while I was there, not one member of staff had asked me personally about my stress. And nor had I asked them about theirs. And my field notes ended up being a commentary on the commentary, rather than a commentary on the real thing. Up to that point in my ethnography, I had been describing the world starting from the tip of my nose outwards. Now it struck me that what I should be doing was to start from behind my ears.

According to Kundera (1988) "In the Unbearable Lightness of Being Tereza is staring at herself in the mirror. She wonders what would happen if her nose were to grow a millimetre longer each day. How much time would it take for her face to become unrecognizable. And if her face no longer looked like Tereza, would Tereza still be Tereza. Where does the self begin and end. You see: not wonder at the immensurable infinity of the soul, rather wonder at the uncertain nature of the soul and of its identity."

'From behind my ears'. Even though I knew I could not go back to before that moment in the doctor's surgery, I wasn't quite sure about what exactly were the practical implications of doing ethnography from behind our ears. As an ethnographer, I always had to position myself, because, as Harding suggests (1987), "the beliefs and behaviours of the researcher are part of the empirical evidence for (or against) the claims advanced in the results of research. This evidence too must be open to critical scrutiny no less than what is traditionally defined as relevant evidence." I've kind of done that now, in my haste to share with the reader what has pushed me into this direction rather than into another one.

ON THE USE OF AUTOBIOGRAPHY AS METHODOLOGY: ANOTHER NOTE ON SUBJECTIVITY.

Ruth Behar notes (1996:12) that no one objects to autobiography as such, as a genre in its own right. What bothers the critics is the insertion of personal stories into what we have been taught to think of as the analysis of impersonal social facts. But personal stories are the only way to insert that subjectivity that Devereux determined was so crucial

in order to make science more 'objective'. Although he acknowledged the subjective nature of all social knowledge, for Devereux self-reflexivity was not an end in itself. Recognizing subjectivity in social observation was a means to a more important end – achieving significant forms of objectivity and therefore truly “*true*” science(see Devereux 1967:84).

Devereux’s premise about relentless subjectivity of all social observation still leaves us with a practical problem – How do you write subjectivity into ethnography in such a way that you can continue to call what you are doing ethnography? Should we be worried that a smoke alarm will blare in our ears when the ethnography grows perilously hot and not “too personal”? This is a question that Behar asks.

If ethnography has to be written to make sense, so does autobiography too, if it is to make any sense. ‘Writing up’ is ‘making out’ – which is different from ‘making up’ (Geertz 1988:140). And yet, until fairly recently, and especially this side of the Atlantic, some people were indeed respectful of Behar’s smoke alarms and stayed well clear of anything that would even remotely resemble unauthorised autobiographies (see Okely 1992:1-2) on this topic). As late as the late 1980s, Ernest Gellner wrote (1988) against a reflexivity of even the mildest and least personal form, such as might be found in Geertz's book, *Work and Lives* (1988). Yet in the early 1970s, David Pocock had suggested a reflexive examination of anthropologists' texts in the light of their biography. He gave examples from his own work. The details remain unpublished, although the notion of a personal anthropology is used imaginatively in his forward looking introduction to the discipline (see Okely 1992:2).

According to Okely (1992:2), a popular critique has been that reflexivity or autobiography is 'mere navel gazing', as if anthropology could ever involve only the practitioner. The concern for an autobiographical element in anthropology is to work through the specificity of the anthropologist's self in order to contextualise and transcend it. Lobera notes (1987:101-118) that autobiography or reflexivity in anthropology has also been labelled narcissism. Okely (1992) points out that harsh critics of autobiographical procedures tended to embarrassingly mixed their metaphors: self-adoration, she notes, is quite different from self-awareness and a critical scrutiny of the self. Indeed, as Babcock points out (1980:1-14), those who protect the self from scrutiny could as well be labelled self-satisfied and arrogant in presuming their presence and relations with others to be unproblematic.

Aware as he is that in anthropology everything depends on the emotional and intellectual baggage the anthropologist takes on the voyage, Geertz, like Devereux, embraces the cause of inter-subjectivity with one arm only. In *Work and Lives* (1988), Geertz suggests ethnographies are a strange cross between author-saturated and author-evacuated texts, neither romance nor lab report, but something in between.

While Devereux wants to make anthropology into a better science by using subjectivity, Geertz's concern, according to Behar (1996:7), goes beyond the ethnographic process and pertains to its reception: with the power of the narrative that then constitutes some of the points at which we anchor our spider's web of meaning, with the result that if we don't see the Evans-Pritchard's complex theory of passion, knowledge and causation in action we are more likely to doubt our own perceptual powers rather than his..

Behar also points out (Behar 1996:28-29) that Devereux' dream of doing social science more subjectively so it will be more objective is greatly aided by feminist writers following the motto 'the personal is political' in the sciences, among them Evelyn Fox Keller, Sandra Harding, Donna Haraway and Hillary Rose. Particularly Donna Haraway's assertion points into the very direction that Devereux had taken with regard to the parallel Behar (1996:29) had begun to notice between ethnography and health practice: "Location is about vulnerability; location resists the politics of closure, finality" (Haraway 1991:196). Haraway's location goes way beyond saying where one is from, it is the sort of location that looks the Other in the eye – at eye level. Only at eye level can one see into the window on other people's souls. But it takes guts. It requires making oneself vulnerable.

Ruth Behar was one of the first to go where no one had gone before. She likens it to opening a Pandora's box (see Behar 1996:19). Who can say what will come flying out? Behar notes: "When I began, nine years ago, to make my emotions part of my ethnography, I had no idea where this work would take me or whether it would be accepted within anthropology and the academy. I began with a sense of urgency, a desire to embed a diary of my life within the accounts of the lives of others that I was being required to produce as an anthropologist. As a student I was taught to maintain the same strict boundary Malinowski had kept between his ethnography and his autobiography. But I'd reached a point where these forms of knowing were no longer so easily separated. And I came to realize that in much contemporary writing, these genres seemed to have exchange places, ethnography becoming more autobiographical while autobiography had become more ethnographic" Behar 1996:21)

Behar continues, but on her gendered role as an anthropologist. "As I wrote, the ethnographer in me wanted to know: Who is this woman who is writing about others, making others vulnerable? What does she want from others? What do the others want from her? The feminist in me wanted to know: What kind of fulfilment does she get – or not get – from the power she has? The novelist in me wanted to know: What, as she blithely goes about the privilege of doing research, is the story she isn't willing to tell" (Behar 1996:19)" She notes further (*ibid.*) that , after all, the genres of autobiography, ethnography and novel are just as arbitrary discourses as science and arts, none of which can be automatically privileged anymore in these postmodernist time". We can also note that Kundera, writing on the novel and Europe (1984), raises the question whether it was an accident that the novel and the hegemony of scientific rationality emerged at one and the same time?

Whichever way one tries to get at it, it is no longer difference that gets us where we want to go, but sameness. It was the exotic Other of colonialist times that anthropology owes its existence to as a discipline, but focusing on difference only gets you so far if you're trying to understand someone else. Away from difference, a fundamental shift has happened towards viewing identification as the key defining image of anthropological theory – and practice (see Behar 1996:28). And this can only be achieved subjectively, or reflexively. This can be done only through owning up to one's experience. In this regard, what lifts anthropological practice on to a whole new level does the very same thing for health practice. Making use of the fact of subjectivity makes possible not having to resort to hiding behind one's position when trying to know, understand someone, be it in anthropological or in health practice.

REFLEXIVITY IN HEALTH CARE METHODOLOGY.

As I said, it wasn't that I had never heard about reflexivity before, it was there, somewhere in the back of my mind, but until I was in the doctor's office, I had no concept of its magnitude. Because anthropology has been dealing with the other in relation with the self (albeit often unconsciously) since its inception as a discipline, it was here that this kind of thinking first featured. Regardless of whether, who, or to what degree it was taken up is another matter. In health work, reflexivity hit the scene somewhat later, but it definitely had come to stay.

Taylor and White examine (2000: vi) how professionals in the health and welfare setting make sense of and process cases. They note that in the present policy climate, "with its emphasis on performance indicators, clinical audit and evidence-based practice, practitioners across the range of health and welfare agencies have become accustomed to evaluating and justifying how they make use of knowledge (Taylor & White (2000: vi). Such methods tend, they say (*ibid*), to leave the muddled business of categorization or 'diagnosis' unexplored. The process of screening and assessment is assumed to follow unproblematically from "eligibility criteria", or from "procedural or clinical guidelines". Taylor and White do suggest that although "practitioners may know they should be reflective...in their decision making, ...they often have few ideas about how they may accomplish this, or even what it means" (*ibid.*). So-called anti-oppressive practice they suggest (*ibid.*), tends to emerge as a rather empty exercise: practitioners might "assert their knowledge about various forms of 'oppression' or 'disadvantage', or simply gloss people into categories as 'oppressors' and oppressed without understanding or interrogating how 'oppression is brought about by practitioners in their encounters". It appears from this analysis that practitioners know they

should be reflective or reflexive: let's look at what people might understand by reflexive.

According to Etherington (2004:15), "reflexivity is a skill we develop as counsellors, and I would like to include all sorts of other health workers in that definition: an ability to notice our responses to the world around us, other people and events, and to use that knowledge to inform our actions, communications and understandings. To be reflexive we need to be aware of our personal responses and to be able to make choices about how to use them. We also need to be aware of the personal, social and cultural contexts in which we live and work and to understand how these impact on the ways we interpret our world" (see Etherington 2004:15).

More importantly, reflexivity can never be static, "becoming" is a process, it implies movement, agency and continuity, there is no one state at which we have become. As Etherington says (2004:15), we are constantly changing and developing our identities, which are never fixed. As we grow in our professional lives, we make different choices at different times, and likewise, this thesis would be a different one had I written it any different time, it would have turned out very different, had I written it right after working at Miles Terrace.

One of the first UK books that forecast the course of reflexivity in health and social work was John McLeod's *Doing Counselling Research*¹⁷. In 1994, in the first edition he states that "research findings would make more sense to readers if they were truly reflexive (1994:185)." McLeod mentions six emerging strands in counselling research: a greater awareness of the relationship between research and practice, permission to be reflexive, openness to new methods of inquiry, the researcher being oriented to discovery rather than verification, appreciation of the

power relationship between researcher and researched, and displacement of an over-psychological concept of the person (McLeod 1994:189-199). Much of this was preceded in anthropology. For those who cared like in anthropology, in health work too, reflexivity had to fight off connotations of solipsism and navel-gazing. Researcher reflexivity, the way Etherington sees it, is the capacity of the researcher to acknowledge how their own experiences and contexts (fluid and changing as they might be) inform the process and outcomes of inquiry. By using reflexivity in research we close the illusory gap between researcher and researched and between knower and what is known.

Reflexivity, it is interesting to point out, is not necessarily the same as self-awareness. As one of the participants in Etherington's study puts it:

Self awareness is a term that tends to be used by people who think of themselves as a constant, in some way, or who will talk about getting to the 'real me'. Whereas for me, another dimension of reflexivity implies a reciprocity between what you experience out there and changing yourself in response to it."¹⁸

In the late 1980s, Woolgar coined the term "benign introspection" (Woolgar 1988) to refer to a form of reflection, a process of looking inwards, and thinking about how our own experiences may have influenced our thinking. According to Taylor and White (2000:6), such benign introspection lies at the basis of practising reflexivity¹⁹.

The word reflexivity is used in social science literature, whereas in health work, especially in nursing and social work, the term reflective practice is where it's at. At one level, both terms are interchangeably, namely at the level of what Woolgar calls "benign introspection", it is a

kind of reflexivity – perhaps more accurately designated ‘reflection’, that entails loose injunctions to ‘think about what we are doing’ (Woolgar 1988:22). Such reflection has produced add-on pieces to research reports that give the “inside story” about how research was conducted in the social sciences. In health work, it has led to a focus on the learning process and the keeping of learning diaries to document how particular aspects of practice have been dealt with (See Taylor & White 2000: 34). More about that later.

Such learning diaries, or add-on texts can at times have a confessional nature. Taylor and White argue (2000:35) that it has to be taken further, to an epistemic reflexivity that subjects our own knowledge claims to critical analysis.

Traditionally, knowledge was passed from generation to generation through storytelling, myths and legends. And now we have returned to valuing local stories and lived experience. By positioning ourselves within the text, by deconstructing dominant discourses and taken-for-granted assumptions about the world (see Derrida 1981), by refusing to privilege one story over another, and by allowing new stories to emerge, we have come to a ‘*narrative turn*’ in the world.

As well as gathering local stories, narrative research encourages the inclusion of the researcher’s story, thus making transparent the values and beliefs that are held, which almost certainly influence the research process and its outcomes. Etherington calls this reflexivity, while others have also referred to it as ‘critical reflexivity’ or ‘critical subjectivity’ (see Etherington 2000:27).

Etherington argues (2000:28) that before it is possible for practitioners to develop theories as they reflect on practices that are based on the knowledge from earlier actions or experiences, we need to understand the internal and external forces that propel us towards the actions we take, and how we make sense of our experiences. He goes to suggest that due to postmodernism-induced crises of confidence, our internal, tacit knowing, our intuition does not necessarily conform to rationality or rules, yet is equally important for our interpretations and decisions we make about our practice (Etherinton 2004:28-29). For these reasons, Etherington makes a strong argument that practitioners not only need to understand themselves at this deeper level, they also need to make their understandings explicit in order to go beyond and learn from them (Etherington 2004:29).

When we are able to communicate explicit knowledge of our total experiences, 'we can allow our perspectives to be transformed by discussion'. Being open to including others' views that might extend, challenge or validate our own allows us to co-construct new meanings in response to their critical reflections and our own. This critical, external reflecting allows us to check for distortions in our interpretations that might be based on past experiences held outside our full awareness, or based on indoctrination within our personal or social cultures that we may have accepted without question since early childhood.

When another person mirrors, reflects or paraphrases our words, we can notice – sometimes for the first time – what we are really thinking or feeling. When they summarize what we have been telling them we might begin to create links between ideas, stories, experiences, and relationships of which we had been hitherto unaware. When others ask us curious questions as they listen to our stories and notice our physical

presence, our body language, our inconsistent behaviours (for example laughing, when talking of painful issues) this can lead us to reflect more deeply and become more aware of lesser known aspects of our selves. Another person can reflect back to us what they can see, and so often, they see more than we can see ourselves, offering us a less conscious aspects of our selves (see Etherington 2004:29). This process was used by the reflecting team at Miles Terrace in the process of engaging in narrative therapy, but more about that later too.

So reflexivity is two-fold, it involves engaging with everything while actively working towards opening oneself to the contributions of others. Etherington pointed out the processual aspect when talking about becoming reflexive, Taylor and White (2000) use the verb 'practising' (reflexivity) over the noun (reflexive) 'practice'. They suggest that reflexivity never simply exists. Reflexivity always has to be done. Again and again and again. It is when active engagement with what's happening ceases that emotional blunting kicks in.

The exposure of self, who is also a spectator, has to take us somewhere we couldn't otherwise get to, Behar emphasizes (1996). It has to be essential to the argument, not a decorative flourish, not exposure for its own sake.

For me, making first steps on the road to reflexivity, has lifted me to a whole new level. I went into my fieldwork, both anthropologically as well as on the health worker front, armed with my theory, but not much more. This was a matter that everybody at Miles Terrace, colleagues and residents alike, picked up on.

Only years later did a doctor push me on to the path to a place where the very understanding I sought before, is possible. Only through allowing to admit my own reactions to myself, reactions that went beyond cartoon emotions of 'I'm so shocked', but rather reactions that allow me to own my experience. This insight coincided with the ethnographic process - in my case, it was not entirely kicked off through the act of writing, but it was certainly supported by it.

Call it reflexivity, call it anthropology that breaks your heart, the term that for me captures best the basis of any possible understanding is that of empathy. Like many other words, this one too means different things to different people. Karla Poewe (1996:3-4) contents that:

"empathy is the faculty that allows us to experience the happening. Broadly speaking, empathy is the ability to share in another's emotions and feelings. It is not, however, as it tends to be defined in Webster's dictionary, a matter of projecting one's own personality into the personality of another in order to understand him or her better. More frequently, the reverse is the case. Empathy has to do with the projection, in the sense of impact, of the other's personality and culture on one's own. The other's personality and culture create a happening in the open-minded or receptive researcher that requires thoughtful exploration (see Halstrup 1987:52; Also in Poewe 1996: 3-4). The result may be an increased illumination of both the other's and one's own personality and culture. Clearly, if an ethnographer wants to give expression to this increased illumination, the ethnographer is compelled to write a different kind of work from the kind that Evans-Pritchard made famous without, however, denying the important and essential, if separate role played by the latter (Schultz & Lavenda 1987: 46)."²⁰

In the early 1900s, Lipps (1902; also in Poewe 1996 vol.3- 4, note 5) based his concept of empathy on the assumption of a common humanity. This assumption, Poewe points out, is quite the opposite of that of reflexivity which depends on cultural differences and distance (even when none exist or are of minor importance) and is concerned with intersubjective meaning. By empathy, Lipps also refers to a projection of our feelings into the other, an understanding of the word that was taken up by Zweig (1997).²¹

For Karla Poewe (1996: 177-206) however, empathy has nothing to do with reproducing someone's psychological state. For her, "empathy implies reflection upon the experiences and thoughts of self and other. As for reflexivity, the conjoining of self and other through intersubjective meaning, its limitations are obvious in, for example, South Africa where black and white Christians believe themselves to have arrived at common intersubjective meaning only to discover that there is no agreement between them in action or experience to which the common meaning seemingly referred."(Poewe 1993)²² That may be, and such differences are not unlike finding myself reinforcing a different course of action from the one that one of the women at Miles Terrace would have taken. And yet, I would like to reclaim empathy as the key to understanding, as the levelling factor, that allows you to look the Other in the eye at eye level.

My ethnography has a touch of Peter Carey's *Wrong about Japan*. It turned out to be about some of the things I was too blind to see, or rather blinkered. But this is not necessarily a bad thing. Not when at some point you realise that you don't have that 360° anthropological vision you might have thought you had.

How else could Peter Carey have written a bestseller based on the same principle, in his recent *Wrong about Japan*, where his son turns out to be more streetwise than he, despite the heavy duty research he dived into around kabuki. He is however remarkably relaxed with regard to not speaking Japanese, but then, he is not a serious ethnographer, but a literary dabbler in anthropology. And like many an honest ethnographer, Carey soon notes that he knew more about Japan before he actually went there. At the same time he takes delight at the perceptiveness of his son, which had inspired the whole trip, which takes place during a school holiday after all.

In the end, he does of course get quite a few things right. But this in itself is not what makes us want to read it. What makes it the little masterpiece that I think it is, is the process. Carey returned from Japan, whereas I still work in the mental health field. So I will have plenty of opportunity to practice reflexively through empathy in the future. Which is why I highlight some of those approaches in other sections.

CHAPTER III: PARENTAL PANICS AND OTHER CRISES

What a child doesn't receive he can seldom later give.

P.D. James

Too many parents make life hard for their children by trying, too zealously, to make it easy for them.

Johann Wolfgang von Goethe

The most important thing a father can do for his children is to love their mother.

Theodore M. Hesburgh

Information Given to residents with children on admission:

Guidelines for parents and staff regarding children staying or visiting Miles Terrace.

Staff are obliged to contact children and families social work department to inform them of any child staying here. You will be told this when offered a place here.

- 1) Four children can stay with their mothers in the project at any one time. Children staying for only one or two nights will be included in this number.
- 2) Children are welcome to visit the project but must be accompanied at all times by their parent or carer. They are not allowed to play on their own in the crèche without crèche workers present.
- 3) Children must not be left unaccompanied in the project at any time. The only exclusion to this is when the child is asleep in

their room and the intercom/baby monitor is in use. Mothers must, however, regularly check on the child throughout this period. Staff will not take responsibility if you leave your child in the care of another resident.

- 4) Recognising this is stressful, crèche workers can be offered at a maximum of three sessions a week. Also in emergency situations staff will assist mothers in supervising their children for short periods.
- 5) If any of the above feels unmanageable, please talk with your named workers to look at your options for childcare if staff feel these guidelines are not being adhered to. They may ask you to consider a review of your child's stay here.
- 6) Children are not allowed in the main sitting room after 8pm. This is to allow for example other women a quieter period, to discuss issues that may not be appropriate for children and to watch programmes that are not suitable for children. Children can use the quiet room as a sitting room after this time.
- 7) We can accommodate children over six months and under sixteen for girls and twelve for boys. This is in line with the guidance for children staying in a refuge.
- 8) All these guidelines are set to maintain the safety of your child whilst they are staying in a new environment with people they do not know. We cannot guarantee or assume that all who enter the house would have your child's best interest at heart.

ATTACHMENT THEORY

One of the main factors that motivated my liberal excursion into some aspects of attachment theory, is the fact that many of the women that were granted refuge at Miles Terrace had been crippled by issues that could be traced back to incidents in their own early childhood, incidents, be it one big one, or a series of little events, that had caused their own development to go awry.

Separating women in crisis from their children often causes the women additional distress. Likewise, separating children from their parents can have an equally detrimental effect. And given that many of the problems of the women at Miles were caused in childhood, such effects were not only detrimental, but also circular. Before going into some of the observations I made at Miles Terrace, bearing in mind that it was a women centred rather than a child centred crisis project, let me outline the theory that informs this issue, namely Bowlby's attachment theory (See Bowlby 1960). Looking at personality development in the 1950s, Bowlby focused on separation. Compared to psychoanalytical approaches of the time, notable Bowlby's supervisor Melanie Klein, who looked at the child's separation from the breast rather than the whole parent, Bowlby's focus on separation had clear-cut observational advantages: either there was separation, or there wasn't. Trying to get to the bottom of the dramatic responses of children to separation, Bowlby, together with his colleague Robertson, identified three phases of separation response: protest, which they related to separation anxiety, followed by despair, attributed to issues around grief and mourning, and denial, which Bowlby and Robertson saw as a defence mechanism. All three stages proved a crucial point, namely that separation anxiety is experienced when attachment behaviour is activated and cannot be

terminated unless reunion is restored. This contradicted current Kleinian thought.

In contrast to other analysts, Bowlby saw excessive separation anxiety as being rooted in the social environment of children, such as abandonment or rejections by parents, or parents' or siblings' illnesses or death for which the child feels responsible. Having revolutionised the thinking about a child's tie to the mother and its disruption through separation, deprivation and bereavement, in his paper *Grief and Mourning in infancy and early childhood*, Bowlby (1960) took his environmentalist view one step further by challenging the prevailing view that infantile narcissism was an obstacle to the experience of grief upon loss of a love object. Bowlby's theories were informed by careful and comprehensive observation, unlike those of above mentioned Anna Freud (see especially her assumptions about the lack of ego development in infants 1923)²³ and those of the Kleinians who took little interest in the interaction patterns that he had found so crucial to childhood development. (see Klein 1988a: 1921-1945)

In 1948, having set up his own research unit, Bowlby hired James Robertson to observe children that had been separated from their mother in a hospital setting. Bowlby would have been hard pushed to find a better observer than Robertson; a conscientious objector during World War II, he worked as a boiler man in Anna Freud's Hampstead residential nursery for homeless children. Regardless of their training or background, all staff had to write notes on cards about the children's behaviour, which were then used as a basis for weekly group discussions. This way Anna Freud made a lasting contribution to the development of attachment theory, even though she didn't think too

much of it (see Bretherton 1992:759-775 on the origins of attachment theory).

After two years' of collecting data, Robertson found that he still had no audience as a theoretical scientist.. Had he been an anthropologist studying the Yanomami, there would have been no more ardent advocate fighting for their land rights. As a medical researcher, Robertson had to discover another way to shake the world of children's therapy with regard to the horrors that unaccompanied children suffered in hospital. Robertson had to shout much louder to reach the child caring community than was possible through the traditional route of publications in academic journals²⁴. The medium that he found most useful in for communicating the horrid reality of child separation in all its piercing poignancy was film. In true student fashion, with no money, no film training and no artificial light, Robertson captured authenticity at its most moving in the 1952 film *A Two-Year Old Goes To Hospital*²⁵ which depicted the plight of the child , Laura, who had to spend eight days in hospital to have a minor operation. At two years old, Laura was obviously too young to understand her mother's absence. Because her mother was not there and the nurses frequently changed, she was obliged to face all the fears, frights and pain of her hospital experience without a single familiar person to cling to. She was extremely upset by a rectal anaesthetic. Then she became quiet and was said 'to settle!' But by the end of her stay she had withdrawn from her mother, being totally shaken in her trust. Anticipating the impact the filmic portrayal of little Laura would have, Bowlby ensured that utmost care was taken to eliminate any bias, and the potential for accusations. The target child was randomly selected, and the hospital clock on the wall was in the picture frame at all times, this way serving as proof that time sampling had taken place at

regular periods of the day and the film segments had not been specially selected (Bretherton 1992: 759-775).

Now a classic, this first film study of the typical emotional deterioration in an unaccompanied young patient caused ripples in two directions, three in fact, when one counts the controversy it initially caused among the medical establishment. Beyond that, *A Two Year Old* played a crucial role in the development and popularisation of Attachment Theory, and together with Spitz's 1947 film *Grief: A Peril in Infancy*,

Robertson's first film helped improve the fate of children in hospitals all over the Western world, at a time when visiting times were severely restricted (see Bretherton 1992:759-775). The powerful medium of the moving image drove home the message that if going to hospital means losing the care of the mother, the young child will fret for her - no matter how kind the doctors, nurses, and play ladies²⁶.

James Robertson had been hooked on the issue and together with Joyce Robertson, who had also been working at the Tavistock clinic that was the backdrop to the filmic portrayal of *Laura*, pursued it further: How was it possible that what the importance of meeting the emotional needs of children that he and Bowlby had demonstrated in the 1950s was not well attended in to in child-care practice? Why was it that although we know it to be imperative that young children have stable relationships, we still fragment their care among many people when they come into hospital or other such residential settings (Robertson & Roberson 1989)?

In her paper on *The Roots and Growing Points of Attachment Theory*, Inge Bretherton (1991) came up with the answer that explains how things had come full circle, almost all the way back to Freud:

"The time has come when the psychoanalytical origins of attachment theory are coming into sharper focus. Thus attachment theory can now more clearly be seen as a theory of interpersonal relationships in the lineage of object relations theory incorporating much of ethology, but also shedding new light on and reworking from a new and more rigorous perspective the issues in which Melanie Klein, Douglas Fairbairn, and Donald Winnicott had also been wrestling." (Bretherton 1991)

Robertson and Robertson located an answer in the practical realities of care; Staff shortages and a short working week caused problems. A more important factor was however that while it was endeavoured to provide play and education, no attempt was made to meet the much greater need for mothering-type care, and child-care was disastrously fractioned. According to Robertson, this stemmed from the fact that through the everyday issues that came with distressed children, any sense of urgency and alarm in staff went either missing or dampened down. In the words of the Robertsons':

"There is a tendency for even the best-educated and the best-motivated of people working with young children to become to some extent habituated to the states of distress and deviant behaviour that are commonly found in young people in hospitals and other residential settings. Thus the medical or nursing student, who in the beginning may be seriously affected by the distress of the young patients separated from home, will in time develop a 'second skin' against being upset by these painful sights and sounds. Later encounters with similar distress make less and less impact than did the first, and to some extent sensitivity is blunted. Similarly, at more senior levels those who are all

the time associated with situations of stress for young children - the executive officer with absorbing administrative responsibilities, the child-care officer with a heavy case load - may become distanced from the problem and lose the sense or urgency which goes with full awareness." (Robertson & Robertson 1989)

What the Robertsons really are getting at is a mind/heart split that is almost as deeply ingrained in Western culture as the Cartesian cogito:

“Intellectually there may be good understanding of the typical distress responses in newly separated toddlers and of the personality impoverishment that results from lengthy experience of discontinuous relationships common in residential care and in long-stay hospitals; but because concern is blunted the reality situation has a certain psychological distance even for those working within it. Paediatricians, child care officers, policy-makers and administrators may understand very well that the behaviour of bright and disarming, deprived young children is unsatisfactory development, yet take comfort from the bland behaviour just because it is superficially reassuring and fits into the need for peace of mind (Robertson & Roberson 1989).”

It is the health workers' defence that causes them unwittingly to avert from the newly admitted child whose extreme distress is painful to see. Such a defence is by no means confined to health professions, but is a universal feature of human interactions, whenever those get too close for comfort. It is at the same time ironic and no wonder, that it is precisely in professions that have sprung from the very need to respond to distress where such defences are up and kicking, blunting emotions in a way that enables the health worker to carry on. While such defences reduce stress in an immediate way, they compound and complicate issues later on.

Robertson and Robertson acknowledge how Bowlby's language of protest and despair, their use of words that were so evocative when first encountered during training, worked in time as barriers working against the empathic pain they once aroused. Once again, Robertson had arrived at a point where the power of the written word had been exhausted, and journal articles once again became ineffective.

"Without a sufficient degree of anxiety in the professions there can be little improvement, no matter how much knowledge is available. The problem is how to bring pain and anxiety back into the experience of professional workers, but in such a way that these are put to constructive use instead of being defensively sealed off by the constant pressure in all of us to escape hurt. Our way of focusing attention on the problem was to turn to narrative film." (Robertson & Robertson (1989)

So roughly two decades after the effects of the gripping portrayal of the child Laura's ordeal in hospital in 1952 had worn off, the Robertsons decided to return to their camera work. To be fair, they had continued to use it all along it after their film on Laura, and in so doing producing a series of equally powerful and significant films²⁷. Their portrayal of 17 months old John in a residential nursery was their most famous²⁸. John was placed in a residential nursery for 9 days while his mother gave birth to his younger sibling and his father was kept by an insurmountable circumstance from staying home with him. Like Laura, John's emotional needs were not met, and having exhausted his 17 months old coping strategies, John withdrew from the busy life around him into apathy, and screams and struggles against his mother's attempts to hold him on the 9th day.

Both stories, Laura's and John's²⁹, were nothing out of the ordinary, there was nothing mysterious about them, nor anything surprising. And yet, their central issue failed to be adequately addressed in care settings. As so often, implementation is a completely different 'issues' from theorisation, regardless of however wholeheartedly the latter legitimates the former.

With regard to depression within the context of attachment theory, one of the main mental health menaces in Western society, it has been shown time and time again that a large proportion of clinically depressed long term users of medication have recurrent or unremitting depression, whereas research into the long term effects of therapy, particularly cognitive behavioural therapy, has shown that psychological treatment effects are more long-lasting and wide-ranging than those associated with drug therapies³⁰. Without going too much into the issue at this point, this suggests that behavioural patterns that most often originate in a significant childhood moment, are at the root of a great proportion of mental health issues. And yet, more often than not, children's emotional needs are not met by mature adults. Little wonder that mental health issues that respond to cognitive therapy, and by extension could be prevented in the first place, haven't gone out of fashion since. This is how places like Miles Terrace are kept in business.

In order to keep history from repeating itself, Miles Terrace crisis project was designed with the fact in mind that there are situations or life stages where women simply come as a package deal with their children, and declining two for the price of one would run counter the whole concept that inspired the crisis project.

Being able to bring one's children into the project was one of the main selling points of Miles Terrace. It was the first and only crisis centre for women that offered such a facility in the UK. While it was possible to bring children, many of the women had made alternative child care arrangement during the time of their stay at Miles Terrace.

Given that the women themselves were in crisis, taking their children with them, does not allow the mother any break. Sometimes it was difficult to reconcile the burden based upon the woman to adhere to the maternal role. Most often women would come in a very distressed state, confused, and not able to cope, and she would say I can't cope. And yet we would leave them with equally distressed screaming kids competing for attention. Other times it was an anchor for the women: life would continue, things would continue. To have their children with them helped them with the transition into the crisis centre. They were able to see the crisis as transition rather than as a breakdown. Interesting, they often use the term 'break-up' to signify such a positive transition. They had more hope of putting pieces back together, with lots of positive language around, helping them to bring the fragments back together. Seeing the children, relating to the children is that anchor in the past as much in the future of their lives, they often spoke about little Jimmy or Katie, helping them through a difficult time. Most often, the children were the main witnesses of the women's episodes of crisis or distress, and in a way the children held a complete narrative, like a photo album. And as much as the parent is in every photo, the child is in every photo and if the parents are very mistrusting of what they see they ask the child how they experience. The children did of course know their mothers well, and were much more tuned into their needs than was possible for the project workers, who spent much less time with the women³¹.

In a crisis it is often difficult to see other beings, the world may well seem turned upside down, with pink trees and orange grass, flying ships (not all that dissimilar to a Beatles album). It can be like a journey into a mythical place. And often, so the women tell me, it is their children who have an access to that world that might allow them to interpret it.

The anthropologist Van Gennep's famous ritualised rites of passage for individuals (Van Gennep 1909) have three stages, beginning with separation of a person from their group or previous status ending with reincorporation into society in a new identity or new status. The transitional period in between, the liminal state, must be as short as possible, since it is widely perceived as dangerous, people lose their bearings as to where rules collide, overlap and new contradictions are created. Any prolongation of this transition phase puts the person at risk of losing touch with the guiding principles of the society into which they are about to be reintegrated. For the children, the time at the project was such a liminal stage - a period 'in-between'.

The experience of children who have been separated from their parents is not unlike the experience of refugees. In her article about Somali refugees, Cécile Rousseau (see Rousseau, Said, Gagné, & Bibeau 1998:385) goes into the effects of the long pre-migration waits before reaching the final destination in a foreign country. During these passages the refugees create a mythology and to a great degree, it is the ensuing story-telling that helps them to manage the high measure of uncertainty and distress that comes with such a situation.

At Miles Terrace, for women who would stay at the project for the maximum period of 28 days, the situation would become frustrating. If their departure plans fell through, both Rousseau's Somali refugees

being delayed or the women at Miles Terrace becoming too unwell to leave on the set discharge day, or were about to be moved to a hospital stay, the “dream trip” often becomes “dream madness”.

ON THE DEFINITION OF "CRISIS" IN THE MENTAL HEALTH LITERATURE, AND ITS AMBIGUITIES

According to Alison Cobb,

“a crisis associated with acute distress can take different forms but essentially means reaching a point where your feelings, and possibly behaviour, are beyond control and you can no longer cope with the demands on you. The person in crisis may be despairing, or experiencing extreme sorrow, grief, fear or anger. They may think of harming themselves or fear harming someone else. They may be worn down by the pestering of voices they cannot control, or see frightening and persecutory visions. They may be convinced that they have superhuman powers, or that they are in the grip of a hostile external force. Their racing thoughts or agitation may prevent sleep, leading to physical and mental exhaustion. Or they may be immobilised by deep depression (Cobb 1994).”

Such a crisis, - a problem that could not be dealt with by a person's usual coping skills, along with the distress that came about because of this - was at the basis of Gerald Caplan's 'crisis approach' to mental health in the sixties. Gerald Caplan (Caplan 1964, 1974) was the first to introduce the word crisis into psychiatry. He had developed his concept of crisis on the basis of evidence such as Lindemann's study (Lindemann 1944:141-148) of the 1942 "*Coconut Grove*" nightclub fire in Boston, that people who had suffered severe trauma had much better outcomes if they received immediate psychiatric help. He defined crisis in the following way:

“A crisis is provoked when a person faces an obstacle to important life goals that is, for a time, insurmountable through the utilization of customary methods of problem solving. A period of disorganisation ensues, a period of upset, during which many different abortive attempts at solution are made. Eventually some kind of adaptation is achieved, which may or may not be in the best interests of that person and others.” (Gerald Caplan)

A crisis was seen as a brief non-illness response to severe stress, and crisis intervention emerged to detect maladaptive responses to crises and to convert them into effective coping and learning experiences. Caplan's concept of crisis was in line with, and limited by the theories of the day, a model of disease rather than health and mechanistic theories popularised by Freud and General Systems Theory regarding "homeostasis" and "equilibrium". These limitations were however far outweighed by Caplan's contribution in emphasising the importance of preventive care, achieving mastery of the crisis, the social, cultural and material "supplies" necessary to avoid or resolve a crisis, and his pioneering advocacy of a community mental health approach (Hoff 1984, in Rosen 1997: 633-638).

By taking a word out of the everyday and applying it to psychiatry, Caplan had inserted an element of 'can do' into the field. Everyone has crises, they are part of everyday life, and most people will recover from them without professional intervention. Like the "*Coconut Grove*" Night Club Fire however, there are crises outside the bounds of a person's everyday experience or coping resources, and it is to achieve recovery from those crises, that requires expert help.

Alan Rosen identifies 3 main types of crises (Rosen 1997:633-638):

Developmental crises, situational crises and complex crises. Developmental crises have abundantly been object of anthropological investigation (e.g., the work aforementioned by Van Gennep (1909); they occur at the time of transition between life stages, and are often culturally marked by specific rites of passage at clearly defined moments, i.e. those surrounding being born, becoming adult, getting married, becoming an elder or dying. While transition can be straightforward, developmental crises can be periods of severe and prolonged stress³², particularly if there is insufficient guidance and support to prevent getting stuck while in transit. In small-scale cultures, there is a sense of continuity and retained value in transiting from before birth to beyond death (e.g., becoming an ancestral resource). In Western societies, rites of passage between these stages have become blurred, the extended kinship networks they depend upon for clear expression have become scattered, the cultural value ascribed to such transitions varies with occupational and economic status, and events surrounding birth and death tend to be experienced as clinical termini (Rosen 1985).

Situational crises are equally intrinsic part of the fabric of life, but in a less ritualised way. Sometimes referred to as accidental crises, situational crises are more culture- and situation-specific, examples being loss of job, income, home, an accident or burglary, separation or divorce. Situational crises are often framed as loss.

Complex crises are the hardest to cope with, they go beyond normal everyday experience or shared accumulated knowledge. Complex crises include severe trauma, such as violent personal assault, natural or man-made disasters. Complex crises often reach beyond the individual and

involve and affect their immediate and extended support network, observers and helpers (Raphael 1986).

So far so good. However it is now that complex crises become interesting for psychiatry, for complex crises also refer to crises associated with severe mental illness. A presence of mental illness can increase both the number of crises a person experiences and their sensitivity to a crisis. Reciprocally, the stress of crises can precipitate episodes of mental illness in those who are already vulnerable. People coming out of emergency treatment of acute episodes of mental illness can experience post-traumatic stress syndromes similar to those resulting from a disaster (McGorry, Rosen, Carr & Pantelis 1994). Developmental, situational and complex crises can overlap and cause each other. Caplan had pointed out that the crisis resolution may or may not be ultimately favourable. This is illustrated nicely by Rosen's four subsequent crisis stages:

The first Stage is characterised by mounting tension, as a person steps their habitual problem solving responses up a gear in an attempt to maintain the usual steady state. This goes up until a plateau of disorganisation has been reached in stage two, where the person in crisis is feeling anxious and ineffectual, and indeed is ineffectual and does not quite carry through any attempts to solve whatever is the problem. Stereotypical experiences of this stage include hitting your head against a brick wall. At this stage dependence on others increases, as do ventilation needs. At the third stage, all internal and external resources are mobilised leading to maximum arousal, heightened suggestibility, increasing vulnerability to good or poor advice. Emergency methods or creative, novel solutions may be attempted, resulting in a range of possible outcomes in the next stage.

In the fourth stage the crisis can subside in a number of ways: the crisis can be resolved if the person adapts to new circumstances, which restores stability and steady state at an equal or higher level. This is the ideal outcome.

Somewhat sub-ideal is a maladaptative response which brings about superficial closure or reactivation of past crises (see Scott 1980: 66-68) or leads to recurrent medical symptoms and treatments (see Bassuk & Gerson 1980: 1513-1517). The worst kind of crisis outcome takes the form of major disorganisation, which may precipitate psychotic episodes or affective disorders in the case of an existent vulnerability (see Szmuckler 1987: 24-34).

The time that can pass from pre-crisis steady state to a re-establishment of a new steady state, which ideally is at an equal or higher level of organisation, often lasts several weeks and usually subsides within a month or two in the case of successful resolution.

Crises are by definition short-lived experiences. A crisis is a fluid period of destabilisation which will resolve with or without help: either adaptive or mal-adaptive strategies will be learned or reinforced. Crises provide an opportunity for personal growth because the individual, highly anxious in a state of flux and confusion, is more motivated than at other stable periods to confront problems and to use help to bring about desired change or new learning.

This element of opportunity is particularly relevant to the establishment and running of mental health crisis services, as pointed out by Allan (1999):

“While the Latin meaning of the term is dividing-line, in Chinese the word is represented by two symbols one of which means danger and the other opportunity³³ For many service providers and users the term has also come to be used in the context of its Chinese meaning to refer to a ‘turning point’. In this way, rather than viewing a ‘crisis’ within the negative contextual view of a disordered state with no meaning mental health service users and providers are able to contextualise crisis experiences in what is considered to be a positive, meaningful and therefore helpful way.” (Allan 1999)

It is for this reason, that the term ‘crisis’ is preferred by many mental health service users to describe what was previously known as a ‘breakdown’ or ‘mental illness’.

Despite the widespread use of the term crisis in mental health literature, the concept of crisis is a controversial one; just as the term itself defies consistent definition, so does the theory around it, theory, which in Alan Rosen’s words is "mainly theoretical speculation based on descriptive accounts, with the cultural and clinical concepts of crisis deriving from seemingly different fields of inquiry" (Rosen 1997:33)

Having come a long way since Caplan introduced the term into psychiatry which was based on a model of illness, modern thinking seeks to integrate illness into life, so that a crisis might be seen to encompass life events as well as the ‘symptoms’ of mental health problems (Wakeling1999: 547-550). A crisis in itself is not a clinical disorder. It may however lead to one, if the response is severe or protracted; a common example is major depression, or, more commonly, an adjustment disorder³⁴, which is defined as the development of

clinically significant emotional or behavioural symptoms in response to an identifiable psychosocial stressor. Adjustment disorder should be distinguished from bereavement and other non-pathological reactions to crises which do not lead to marked distress in excess of what is expected, and which do not cause significant or lasting impairment in social or occupational functioning.

Stress is not a synonym for crisis (see Parad & Parad 1992) as all people face stress as part of the human condition. The same stressor cannot shake one person and cause a crisis or even a clinical disorder in another.

In contrast to crisis theory, some crisis interventions have been subjected to rigorous empirical study, demonstrating their effectiveness with specific problems (e.g., individuals and families seriously affected by mental illness) (see Hoult & Rosen 1984: 1005-1010).

Crisis intervention can no longer be seen as a unified strategy for care, as many divergent practices in different settings have developed since its origin, from walk-in clinics to mobile home intervention, but Waldron has identified a number of common features (Waldron 1984:4283-4287). These include rapid service, intense work in the short term, and a practical here-and-now therapeutic focus.

CHAPTER IV: ADMISSION TO CARE

Gaining admission into a care setting in a state of acute crisis is the biggest hurdle to overcome. Whether admission is sought into a psychiatric ward or into a more relaxed setting like Miles Terrace did not make a difference with the women at Miles Terrace. Both processes represented phases in the crisis that were connected with feelings of being scared, anxious, nervous, intimidated, daunted and vulnerable.

If anything, women, especially women who had not been admitted to Miles Terrace before would be particularly anxious and scared of the possibility of being rejected. Even if the process of admission shoved their crisis right into their face, as it involved presenting it in detail to the staff who would take the assessment, this was the lesser evil. First timers would wrestle their way into a place at Miles Terrace with great energy. Revolving door patients who were seeking repeat admission tended to be calmer as they had become slightly more worldly wise with regard to procedures.

ROSENHAN'S 'THUD' EXPERIMENT.

At this point it is relevant to say something about how much has changed in terms of admission to hospital since the early 1970s, when David Rosenhan, a newly minted psychologist with a joint degree in law conducted his "thud" study (1996).

One day, in 1972, Rosenhan called eight friends and asked them whether they were busy the next month and fancied faking their way into a mental hospital, just to see what would happen. All eight, three psychologists, one grad student, a paediatrician, a psychiatrist, a painter

and a housewife, were free and up for his little experiment. After a careful briefing, one week before the official start of the study, Rosenhan's people went into preparatory mode, which involved abandoning most basic body maintenance tasks such as shaving, showering and dental hygiene. Once they were sufficiently scruffy, they dispersed to present themselves at various psychiatric emergency rooms in different parts of the United States. Rosenhan had picked the hospitals to cover the whole range, his choice included the McLean type red and white brick number as well as the somewhat more shoddy state-run affairs that sported urine-scented corridors and graffiti. Once the Rosenhan gang had reached their respective destinations, their task was fairly straight forward: all it involved was presenting themselves saying "I am hearing a voice. It is saying thud." The word thud had been chosen on the basis that such obvious cartoon angst had never been previously recorded in the body of psychiatric literature Rosenhan had sifted through. Apart from their name and occupation, all questions on the part of the admissions staff were to be answered in all honesty. No more symptoms were to be feigned. Once admitted, the Rosenhan people were instructed to say immediately that the thud had disappeared and they felt now fine. Rosenhan did not report on any reaction of the part of the psychiatrist at Pennsylvania's state hospital where he presented himself, nor any of the other hospitals. But everybody was admitted. And kept for a while. Everyone was given some therapy and medication. Rosenhan had briefed his gang as to how to avoid eating the medication. As it turned out, the other in-patients were also privy to the slip-pill-under-tongue and spit into toilet procedure. None of the Rosenhan people were believed to have any mental ill health issue by any of the other in-patients, rather they were thought of as psychologists, or investigative journalists. All diagnoses they received by the psychiatrists all over the US, were structured around the cartoonish 'thud', which

provided the lens through which their past was viewed and reconfigured as pathological, as schizophrenic. Eventually, all were discharged, for reasons as arbitrary as their admission. But this was the point Rosenhan had wanted to drive home to the psychiatric community, this was what had inspired his motivation, this was what he felt most strongly about, and this is also what many members of the psychiatric community never forgave him for, *all* of his people had been given a diagnosis, a label, a price tag that certified them as faulty stock. This was an experiment and the details were fake and any records consequently worthless, but the diagnosis itself remained indelible.

Thirty years later, psychologist Lauren Slater decided to repeat the experiment: she wanted to see whether it would produce the same results as earlier. Following a similar preparatory procedure of going low on body hygiene, Slater turned up at a number of hospitals seeking admission.

“How do I look?” I (Slater) say. “The same” my husband says. I drive there. I have chosen a hospital miles out of town with an emergency room set up specifically for psychiatric issues. I have also chosen a hospital with an excellent reputation, so factor that in. It is on a hill. It has a winding drive. In order to enter the psych ER, you must stand in front of a formidable bank of doors, in a bustling white hallway and press a buzzer, at which point a voice over an intercom calls out “Can I help you?”

I say, “Yes.”

The doors open. They appear to part without any evidence of human effort, to reveal a trio of policemen sitting in the shadows, their silver badges tossing light. On a TV mounted high in one corner, someone

shoots a horse – bang! – and the bullet explodes a star in the fine forehead, blood on black fur. “Name?” a nurse says, bringing me to a registration desk. “Lucy Shellman” I say³⁵. “*And how do you spell Shellman?*” she asks. I am a terrible speller and I hadn’t counted on this little hurdle; I do my best. “S-H-E-L-M-E-N”, I say. The nurse writes it down, studying the idiosyncratic spelling. “That’s an odd name,” she says. “It’s plural.” “Well”, I say, “it was an Ellis Island thing. It happened at Ellis Island.” She looks up at me and then scribbles something I cannot see on the paper. I’m worried she’s going to think I have a delusion that involves Ellis Island so I say, “I’ve never been to Ellis Island – it’s a family story.” “Race”, she says. “Jewish” I say. I wonder if I should have said protestant. The fact is, I am Jewish, but I’m also paranoid – not as a general rule, of course, but at this particular point – and I don’t want the Jewish thing used against me. Of what am I so scared? No one can commit me. Since Rosenhan’s study – in part because of Rosenhan’s study – commitment laws are far more stringent, and so long as I deny homicidal or suicidal urges, I’m a free woman. I’m in control.

I don’t feel in control though. At any moment someone might recognise my gig. As soon as I say, “Thud”, any well-read psychiatrist could say, “You’re a trickster. I know the experiment”. I pray the psychiatrists are not well-read." (Slater 2004:17-19)”

They were not. But not one of the altogether nine times that Slater presented a “Thud” at a psychiatric hospital, admitted her to the ward. But let me carry on with Slater’s first attempt at admission:

“I am brought to a small room that has a stretcher with black straps attached to it. “Sit,” the ER nurse tells me, and then in walks a man,

closing the door behind him – click, click. “I’m Mr Graver”, he says, “a clinical nurse specialist, and I’m going to take your pulse.” A hundred per minute “That’s a little fast,” says Mr Graver. “I’d say it’s on the very high side of normal. But, of course, who wouldn’t be nervous, given where you are and all. I mean, it’s a psych ER. That would make anyone nervous.” And he shoots me a kind, soft smile. “Say,” he says, “can I offer you a glass of spring water?” And before I can answer, he’s jumped up, disappeared only to re-emerge with a tall, flared glass, almost elegant, and a single lemon slice of the palest white-yellow. The lemon slice seems suddenly so beautiful to me, the way it flirts with colour but cannot quite assume it. He hands me the glass. This, also, I had not expected – such kindness, such service. Rosenhan writes about being dehumanised. So far, if anyone’s dehumanised here, it’s Mr Graver, who is fast becoming my own personal butler. I take a sip. “Thank you so much,” I say. “Anything else I can get you? Are you hungry?” “Oh, no no,” I say. “I’m fine, really.” “Well, no offence but you’re obviously not fine,” says Mr Graver, “or you wouldn’t be here. So what’s going on, Lucy?” he asks. “I’m hearing a voice.” I say. He writes that down on his intake sheet, nods knowingly. “And the voice is saying?” “Thud”.

While the assessment procedure, like the whole of Miles Terrace, was designed to be a safe environment for women seeking admission, it was not nearly as kindly as what Lauren Slater describes. Slater has, on the other hand, been criticised for merging fiction with reality. And what is interesting to note, is that her critics who demand that there be a clear cut line separating fiction from memoir do not only come from the scientific community. Nor are the people who are full of praise for her exclusively from the fields of literature and art. Looking back at my time at Miles Terrace from different vantage points, has also brought both

genres closer together, creating an overlap that I had not realised until I, myself, hit the computer.

I quote Slater to illustrate the big shift that had happened since the 1970s, when admission to and a stay at a psychiatric facility was predicated on the hierarchy between psychiatrist and patient in a much more dichotomous and polar way than is now the case. Certainly more oppositional than the way things were designed to operate at Miles Terrace. But even at Miles Terrace, ultimately, the power was still lodged in the staff who would take the assessment. And it was up to the women themselves who either offered themselves up to that power, or manipulated it in a way that would get them what they wanted, that would be admitted.

What is especially interesting, and also disturbing in Slater's research results on present day assessment procedures is the rapidity with which assessments were made - the total lack of attention to personal and social context with the emphasis being instead upon pharmaceutical possibilities: the quick solution to whatever. Slater's Mr Graver goes with the Slater's "Thud", and having detailed its hows, how oftens, whens, jumps at the first possible why that is offered to him in the form of a third grade neighbour who drowned in the swimming pool, latching on to it, doing everything he can to stretch it to fit into a diagnosis for Posttraumatic Stress Disorder. The psychiatrist who is called in at that point does not necessarily want to go along with the PTSD the assessment nurse had latched on to, and instead admits, sadly, that "there is a lot we don't know in psychiatry." Indeed there is. But Slater is sitting in front of him, presenting him with the sole symptom of a voice that is bothering her.

“I’m giving you an antipsychotic” he says, and as soon as he says this the sadness goes away. His voice assumes an authoritative tone; there is something he can do. “I’m going to give you Risperdal”, he says. That should quiet the auditory centres in our brain”.

“So you think I’m psychotic?” I ask. “I think you have a touch of psychosis,” he says, but I get the feeling he has to say this, now that he’s prescribing Risperdal. It becomes fairly clear to me that medication drives the decisions, and not the other way around. In Rosenhan’s day, it was pre-existing psychoanalytic schema that determined what was wrong; in our days, it’s the pre-existing pharmacological schema, the pill. Either way, Rosenhan’s point that diagnosis does not reside in the person seems to stand.

“But do I appear psychotic?” I ask.

He looks at me. He looks for a long, long time. “A little,” he finally says. “You’re kidding me,” I say, reaching up to adjust my hat. “You look,” he says, “a little psychotic and quite depressed. And depression can have psychotic features, so I’m going to prescribe you an antidepressant as well.”

“I look depressed?” I echo. This actually worries me, because depression hits closer to home. I’ve had it before and, who knows, maybe I’m getting it again and he sees it before I do. He writes out my prescriptions. The entire interview takes less than 10 minutes.”

Through thorough self-inventory and with help from medically knowledgeable friends and family, Slater determined that she was not depressed. Nonetheless, this is the diagnosis she was given every time she presented to a new ER, depression with psychotic features. As she

points out, a psychotic depression is never mild, the DSM, the Diagnostic and Statistical Manual of Mental Disorders, which is at the source of all her diagnoses, lists it in the severe category which comes along with gross and unmistakable motor and intellectual impairments.

Altogether, Slater was prescribed a total of 25 antipsychotics and 60 depressants. None of her 9 interviews lasted longer than 12 and a half minutes, although at most places she had spent an average of two and a half hours in the waiting room. Beyond a cursory religious-orientation question, no interest was expressed in her cultural background; no one cared whether the voice was of the same gender as her; no full mental status exam was given, including more detailed and easily administered tests to indicate the gross disorganisation of thinking that almost always accompanies psychosis. Everyone, however, Slater notes took her pulse.

BACK AT MILES TERRACE

Assessment at Miles Terrace was not based on the medical model. While medication was by no means banned at Miles Terrace, the underlying idea of the crisis project was the importance given to the women's environment during their time of crisis. The pathway into acute crisis care at Miles Terrace was straight forward: there was a clear roadmap for the women to follow. During assessment, the women seeking to be admitted into the crisis service had to locate themselves in their world, in their relationships, they had to situate themselves on many axes that worked together to create the context of their disease. Compared with Slater's non-admission into 9 US hospitals, there were of course further obvious differences. Slater confirmed that admission into a psychiatric ward was no longer that easy to gain. Within the thirty years since Rosenhan, the primary way of dealing with mental ill health, had shifted from institutionalisation towards medicalisation. And this, as noted above, was not the case at Miles Terrace.

.Many of the women who were admitted to Miles Terrace had on previous occasions been in a psychiatric ward. And it would be wrong to assume that there was an automatic preference by them for Miles Terrace. The food was better, it was kitted out in Ikea, but some conversations I overheard highlighted some definite plus points, from the point of view of the patient, with regard to psychiatric hospitals. But before those conversations could be had, the women first had to be assessed, so back to the assessment.

Assessment itself could prove to be traumatic for the patient. Thus we can see that what might be crystal clear in theory does not necessarily translate that way into practice. How did the women rate the assessment process at Miles Terrace? One factor that was rated highly was the friendliness of staff, the relaxed atmosphere at the assessment interview and the simplicity of being able to make self-referrals. There were however a number of drawbacks that were pointed out again and again. For one, the fact that initial referrals were only taken over the phone did pose the first stumbling block for many of the women. Many did not have a space where they could feel safe to phone from. Also, at the time when I was a project worker at Miles Terrace, mobiles were not as widely used as they are now. The problem of finding a safe space to make that call, was however a logistic one and as such could and would eventually be overcome. What many women found more challenging was the expectation to dive into a comprehensive discussion of their problems the first time they would phone in for a referral. Having gone through whatever they had to go through to refer themselves, which might have required waiting for an undisturbed moment in which to phone from home, or finding a phone box, having to explain their crisis in all its detail caused further stress for many of the women, and this at a time when they were very vulnerable, very upset and very, very low already. It was especially those women who found it difficult to talk to people at the best of times that found having to go into what was wrong almost straight away exceedingly difficult. While many women who noted this point acknowledged the logistic necessity for this, they nevertheless kept stressing the trauma of the experience. In addition to having to go right into their crisis on an anonymous phone, many women, given their difficulty in finding the safe space and time to phone, felt rushed at the time of phoning to provide all the details of their private circumstances.

This can be contextualised by the fact that the opportunity to talk things through at length was valued very highly by the women, regardless of whether they were in hospital or at Miles Terrace. Compared to hospital staff, the project workers at Miles Terrace were seen as more approachable and informal in their interactions, and overall rated as accessible and supportive. In general, the women at Miles Terrace felt that the project workers had more time to give than the health workers in a ward setting, a situation that they highly valued. In addition, the Miles Terrace staff received praise for making the women residents feel accepted and not stigmatised or judged because of their mental health issues. One woman said:

“When I was speaking to a member of staff, they understood. I wasn’t a bad dirty thing. They understood. You were able to let go a little bit of our feelings and the longer you were there, you were able to let go a little bit more of what you were thinking, inside all the time.”

After the first hurdle of the referral had been taken, many women commented on the fact that, once they had metaphorically stripped naked while phoning in for a referral, they were now hastening to pick themselves up, trying to fit into the precise situation of illness required to warrant admission to the crisis project: while they definitely wanted to seem ill enough to get into Miles Terrace, they were acutely aware that they would not be admitted if they seemed too ill to be manageable. One woman noted that:

“I thought they probably won’t think I’m bad enough. They won’t take me. The one thing that did put me off when I first went in for the interview, why I thought they wouldn’t take me, was because the girl

said to me You're dressed very well and you look very smart. And I thought Oh my God, she ain't going to take me. I thought she wants me to look scruffy and look like a down and out."

"It's almost like at Miles Terrace you're worst of being assessed to see if you can enter this exclusive club, and see if you measure up to their, you know, criteria. Whereas if you're in A&E you know if you need to be in hospital, you're going to be in hospital, you know, there is a difference because, you know, I think if you are unwell hospital will always take you, you know, whereas Miles Terrace won't."

The awareness of the fact that they could be turned away was very strong in the women seeking admission. When admission had been gained once, the women would develop explicit strategies to ensure they would fit exactly into the perceptual admission range. On more than one occasion I was witness to these strategies being passed on, with the women sitting in a little group in the living group, the more experienced ones advising the first timers on clothing choices, on how to do or undo their hair, how to strategise their way into the project.

In this way, the process of admission required the women to engage actively with the dynamics of an identity politics. Keith and Pile (1993) write in their introductory chapter to the *Place and Politics of Identity*:

"The problem of spatiality is that when a gaze from nowhere becomes a gaze from somewhere, it is possible to forget at times quite how problematic that somewhere actually might be. As a modesty suit constraining epistemological boasting, this is a fine act of public humility. But unless the sorts of spatiality that are being evoked are examined more closely, we have to ask whether it is more than

rhetorical gesture. A proliferation of sites of difference begets a Babel-like world where truth claims, ethical claims, and assertions of desire all offer no external criteria of refutation. There is an almost sensual challenge to 'the order of things', a danger that in articulating complexity we celebrate incoherence." (Keith & Piles 1993:31-32)

It was awareness of the gaze as being localised that had prompted the creation of Miles Terrace as an alternative service in the first place. Every effort had been made to create a safe space at the project, from admission to discharge. But as soon as the women presented in a way whose truth claims, whose ethical claims, offer no external criteria of refutation, the danger of celebrating incoherence becomes as acute as the complexity has become difficult to compute.

Jane Gallop (1992) was not the only one to argue that identity must be continually assumed and immediately called into question. This is very much the case, particularly with regard to members of any minority group, and the women of Miles Terrace were such a minority group. And the women seeking admission to Miles Terrace even more so. Miles Terrace was designed in a way that was assumed to minimise the intersection of any axes of power that would force certain identities into existence or into continuation, and in doing so trap the individuals where certain axes of power would collide. Keith and Pile see all spatialities as political, because they are the (covert) medium and (disguised) expression of asymmetrical relations of power (Keith & Pile 1993:38). And even though it tried real hard, Miles Terrace was no exception.

As mentioned, the women seeking admittance into Miles Terrace had to locate themselves in the world. This way, the authority of their position remained dependent on their spatial location. The staff were well aware

that such spatial location was never an absolute affair, especially in times of crisis. But for the identity location of the women to be tangible enough for the staff to work with, they just had to start somewhere. Clothes are changeable, but more so, at the time of presentation they have the advantage of being tangible. At this point I would like to point out that while there were women who feared they were dressed too well, there were also women who commented on the fact that they had not been able to go and get new clothes.

Identity alignments are forever shifting, they are never static at the best of times, and any crisis sends those alignments into ever faster twirling motion, losing touch with some of their fixed points. An acute mental health crisis, and as far as I'm concerned, an acute mental health crisis is the mother of all crises, can dislocate such seemingly stable axes, resulting in conditions such as gender dysmorphia, which leads people to believe themselves to be of another gender than what everyone else sees them as; or distorted ethnic identity in the case of Tessa, a black model, who came to Miles Terrace thinking she was white during a psychotic episode.

And yet, the construct of identity is useful. Here is Jane Gallop again, this time with the whole quote:

“I do not believe in some ‘new identity’ which would be adequate and authentic. But I do not seek some sort of liberation from identity. That would lead only to another form of paralysis – the oceanic passivity of undifferentiation. Identity must be continually assumed and immediately called into question.” (Gallop 1982: xii)

With regard to a mental health setting, in the face of such constant chaotic negotiation, what is often left out of the equation is the identity of the people taking the assessment. While looking for clues to work with in the person they are sitting opposite to, they themselves might be shifting around, their own identity arrangements informing their perception.

Looking back over my time at Miles Terrace, I see that my perception had certainly been influenced by my own shifting axes. One important axis was a relational one. Back in the seventies, Nancy Chodorow (1978) had drawn attention to the fact that women constitute themselves in a relational way to a much higher degree than men do. Men, on the other hand, were more likely to orient themselves using the guiding principles of law and justice. Miles Terrace was set up as an all female project with this factor in mind. But looking at myself, I see that there were times when I overdid it with the relationality. When the quality control of the care I was giving was skewed by my desire to create a relationship with the women at Miles Terrace in a way that was more informed by my need to underline my identity as warm, fuzzy, caring Salma rather than by the need of the women to be provided with fixtures that were more stable than the ones they themselves could provide, fixtures on which they could hang their own axes.

Chuang Tzu said that human beings cannot see their reflection in running water, but only in still water. And Miles Terrace was conceived as a refuge from the storm, as a canal on which the women could avert being crushed down Niagara Falls.

But such stillness can only be found in a designated place. This is captured by Liz Bondi (1993: 99) quoting Donna Haraway: "The point

is that if they are to retain their potency, the geographical metaphors of contemporary politics must be informed by conceptions of space that recognize place position, location and so on as created, as produced (Haraway (1990); also see Lefebvre 1991)". Then, the positionality of identities can be deployed imaginatively and creatively to construct a politics that, in Donna Haraway's words, can 'embrace partial, contradictory permanently unclosed constructions of personal and collective selves and still be faithful [and] effective (Haraway 1990, and reprinted in Nicholson (ed.) 1990: 199).

CRISIS AND IDENTIFICATORY AXES

A crisis occurs when something kicks you off one of the axes along which you negotiate your identity. This new perspective relocates the fixed points in the perception of the identity negotiator. These fixed points never are fixed anywhere but in one's perception, but when things are going dandy, the frame of reference is largely stable. Then something occurs, and I hasten to say that it in no way has to be an event external to oneself. But something happens that reshuffles the identity axes like Mikado sticks, and one axis which previously was the source of another one, has fallen off the frame. Some axes are more stable than others. Identificatory axes are endless and come in shifting categories, even though generally some are seen as more primary than others. The axes that are often seen as primary ones are those of gender, ethnicity and, and already it gets somewhat more shifty, sexual orientation. Other axes can be just as important, even more so, depending on the requirements of the moment, but it is those axes that are generally regarded as stable. The dualities that enable the perception of the Western world have long been unmasked as factitious, and gender is not

always as clear cut as Vogue and Playboy would have it, nor is ethnicity with the many mixed race individuals or people like me who grew up biculturally, and always have at least two fixed points to align with. And yet, in the face of much more volatile axes such as being the person who did not return the book to the library, or being the host who prepared a meal for someone, these axes are stable.

To return to the assessment process at Miles Terrace. Having to present themselves to a team for assessment, was a daunting experience for many of the women seeking admission. Many found the process very long, which is hardly surprising given they were in acute crisis. Others did not understand everything that was going on. Some women were quite clear they were in crisis, and they were prepared to do anything it would take to wrestle their way into the project: if their understanding was that they had to look shabbier than they normally would, they would adjust their appearance. Some women would take it one step further, and as one commented: “I think – I didn’t’ think it through at the time – but I think it was like saying I’ve got to be in here, but it’s supposed to be because I self-harm, so I’ll self harm so that I can accept in my head that I’ve got to be here.”

That women are prepared to harm themselves on top of being in crisis does indicate just how much they have slid off their identificatory axes. But more so, it points to the basis on which I am using this very picture, this very metaphor of the Mikado sticks collapsing, it points to the fact that Western society has constructed mental health along the lines that have the Mikado sticks support each other in the perfectly protective shape of some wigwam, of a tent that keeps the bad weather at bay. Mental health is a very strong construct that supports itself, separated by a clear-cut line from mental ill health, from insanity, from madness,

which needs to be kept at bay at all costs. This perceived need has shaped the mental health system. In Tom Heller's words:

"The current mental health system has been shaped by white, upper-class male-dominated medical establishment. This group of people has been bullied and cajoled into becoming terrified of their and other people's feelings, and desperate to be in control. If the mental health system was taken away from that influence, how would it change?". (Heller 1996: 367-369).

Miles Terrace is an attempt to change things around, to shift mental health care away from the justice and rule oriented identificatory model of the policy makers towards a relational and systemic model that responds to the needs not only of the women but also of the carers.

Heller goes on to say (1996:367-369):

There is a continual philosophical problem that health workers struggle with. In the world of mental health this is to do with notions of continuity or discontinuity. Are there some people who are 'well', who are in positions of authority and who can make judgments over those with a 'disease'? Or is 'mental health' a spectrum along which we are all arranged according to certain factors? Some people, when sufficiently stressed, may find themselves at the other end, and be labelled as suffering from a mental disorder. Either we are all in this human soup together, sculling around for answers to the meaning of our existence, or 'we' are here to help 'them'. Flawed and imperfect, 'they' need to be examined, diagnosed, categorised and treated. 'We', of course, need none of those things; we just need to get better at diagnosing and finding out more about brain biochemistry and the categorisation of diseases.

A middle position might recognise that it doesn't help if the people who are given the status and facilities to do health care work feel too guilty about the "medical model" and their own sins. There are skills to be learnt in this work and it is important to develop some understanding about the things, including physical types of treatment that may be effective (Heller 1996: 366)

At Miles Terrace, an attempt to incorporate the notion of continuity into the day to day running of the project had been made in so far as some of the workers had slid down on that continuum of positive mental health and mental ill health. Also, there are certainly skills to be learnt in this work, and it is important to develop an understanding about them. But even more important than an understanding of the physical types of treatment that Heller lists, is the fact that the staff needs to know who they themselves are in relation to the person they are giving care to (are you feeling guilty, or superior, for instance?).

A COMMENT ON MY OWN IDENTITY NEGOTIATIONS.

While I was working at Miles Terrace, I negotiated my identity in relation to the women I provided care to in a way that maybe did not provide them with enough fixtures to get better. Maybe I was one of the people who felt too guilty about the 'medical model'. And it was only when I myself was confronted with the fact that mental health was not something that I had, was not a given, that it indeed occurred along the lines of continuity, that I felt I was gaining an appreciation of what mental health was that allows me now to provide care on a much higher level.

It is only when a mental health worker can go beyond conceiving of mental health and ill health in terms of identity and make the shift to reflexivity that they can improve the care they provide. It is only through such steps close to the grassroots that a system that is predicated on a very static identity can possibly be transformed.

I would like to finish this section with a comment from the English Patient, a film I have seen countless times, and that to me, more than any other film, illustrates that an identity can never serve as substitute for an inner compass on a mapless journey.

“And the names of the tribes, the nomads of faith who walked in the monotone of the desert and saw brightness and faith and colour. The way a stone or found metal box or bone can become loved and turn eternal in a prayer. Such glory of this country she enters now and becomes part of. We die containing a richness of lovers and tribes, tastes we have swallowed, bodies we have plunged into and swum up as if rivers of wisdom, characters we have climbed into as if trees, fears we may have hidden in as if caves. I wish for all this to be marked on my body when I am dead. I believe in such cartography to be marked by nature, not just to label ourselves on a map like the names of rich men and women on buildings. We are communal histories, communal books. We are now owned or monogamous in our taste or experience. All I desired was to walk upon such an earth that had no maps.”
(Ondaatje 1993:261)

Ondaatje used cartography in the novel as a metaphor for people and history in the same way we at Miles terrace use case notes, medicine charts and diagnosis of territory, his long exploration of the past, the complicated threads of family experience, cultural syncretism, and

national ideologies that construct all our subjectivities and the myriad identities illness produces.

PART II: EXPERIENCES OF MILES TERRACE

CHAPTER V: NEGRESCENCE AND OTHER POWER

Everyone's A Little Bit Racist
You're a little bit racist.
Well, you're a little bit too.
I guess we're both a little bit racist.
Admitting it is not an easy thing to do...
But I guess it's true.
Between me and you,
I think everyone's a little bit racist
Sometimes.
Doesn't mean we go around committing
hate crimes.
Look around and you will find
No one's really color blind.
Maybe it's a fact we all should face
Everyone makes judgments based on race.
AVENUE Q

If we were to wake up some morning and find that everyone was the
same race, creed and color, we would find some other cause for
prejudice by noon.

George D. Aiken, US senator (1892-1984)

One of the first theorists to look into the development of Black racial identity in the Western World was the psychologist William Cross. In the seventies he developed a model that captured the different experiential phases African Americans go through in their development of a racial identity. Cross initially created this model of nigrescence³⁶ in the seventies (see Cross & Helms 1991), and through it identified five stages of identity development for African Americans, namely pre-encounter, encounter, immersion-encounter, internalization, and internalization-commitment. In the 1990's he further developed it (see Cross & Fhagen-Smith 1996). In the words of Evans, Forney and Guido-Dibrito, Cross's concept of psychological nigrescence describes the process that defines the resocializing experience in which the healthy

individual's identity is transformed from one of non-Afrocentrism to Afrocentrism to multiculturalism (Evans, Forney, & Guido-Dibrito 1998).

Without going any deeper into this, I would like to mention that this has been done in blue, yellow and red as well, amongst many others there is the work of Sue and Sue on Chinese-American children (Sue & Sue 1983), as well as the research of Kondana, Lee, Liang and McEwen (1002) who also look at Asian American identity development, while Johnson and Lashley (1989) conducted research among Native Americans. Shortly after Cross's Nigrescence, Vivienne Cass (1979) compared minority group identity formation with that of homosexuals. Cass suggested six stages to be involved through which the course of gay identity is formed³⁷.

While different theorists chop whatever identity formation they look at into slightly different developmental stages, the resulting theories are generally characterised by an ideal outcome in the final stage. A high degree of mental health issues, however minor they might be, can be traced back to an unresolved early developmental stage. To some degree this is the case for everyone, and it often is a matter of degree, magnified through other factors. With regard to Cross' last stage of black identity that is no longer Black for the sake of it but has transcended boundaries, it is quite possible for people to die before they even get a chance to reach this stage. This does not mean that people who do not reach this stage have any mental health issues. People who are well past adolescence do. We had one of them at Miles Terrace.

TESSA

Tessa was a 28 year old black model. Tessa was tall, beautiful, had a wide circle of friends and acquaintances in the world of fashion and beauty. She led a very middle-class life and had very middle class interests, and although Britain sports a considerable Black middle class, Tessa was completely white-identified. She was surrounded by white people, had a white boyfriend, and as we later found out, she had been adopted and raised by white parents. Tessa had been referred to the project because of psychotic episodes, in which she believed she was white. At the time of my fieldwork, Tessa was 28 years old, but her white episodes had started when she was 19, and by that time she would have had six episodes. Psychotic episodes are often described as disruptions from reality, and can last from a few hours up to months. Tessa's white episodes would last up to three months, and she would gradually slip into the delusion that she was white.

I myself grew up in Birmingham, in a visibly Black, predominantly Asian part of town, and never found myself in a position comparable to Tessa's adolescence in a white family, and a white middle class world. But, to understand Tessa, I find the experience of a Black friend of mine very helpful. Jai is of Sri Lankan descent, but grew up in Canada and the US before coming to the very white university of St Andrews. In the States, she went to a very posh high school where she really was the only black person around, and sometimes in the bathroom, she would see her black arms and hands under the tap, and it would take her a second to realise that those were her arms, that she was black, because every single face she'd see day in and day out was white. This realisation would only take a second to kick in, but still, there was a second of wonder, of disbelief. These suspended seconds wouldn't hold her back in anyway, as she charged through a succession of friend,

boyfriends, husbands, white, black, white, and as far as I can see she operates no quality control with regard to colour.

For Tessa, this was different. Just like Jai, Tessa would also see her long slender black arms and wonder who they belonged to. But unlike Jai, Tessa would fail to make the connection that they were hers.. She would, most of the time. But whenever she had another psychotic episode coming on, gradually, she would lose touch with her skin colour, until in her mind she was as white as could be. When she was at Miles Terrace, Tessa exhibited the exact pro-white/anti-black behaviour that Cross had detailed in the initial Encounter stage of his six-phase model of Nigrescence. As a model, Tessa's whole world revolved around the very white and Western aesthetic that fed into her wholesale denigration of Blackness, not only her personal Blackness, but Blackness as such.

This fits into the context of Cross' nigrescence, dominant white aesthetic, where Black individuals at the pre-encounter stage devalue their own racial identity and aesthetics. Contributing factors are miseducation, race image anxiety, and assimilation-integration. Miseducation is a result of the Eurocentric perspective, which, by emphasizing white accomplishments and downplaying black achievements provides Black people with little grounds for positive racial self-identification. Race image anxiety refers to a hyper sensitivity towards issues of race which causes some African Americans to be constantly on the look out for situations where blackness is portrayed in little favourable and demeaning ways. While the heightened awareness that comes with race-image anxiety often creates a self-self-fulfilling prophecy that turns Black people away from Black culture, assimilation-integration cannot be left behind.

These 'minority' developmental theories sit on the back of Erik Erikson's general model (1968:22), according to which everyone traverses eight developmental stages. Each of those stages offers a different polarity which to overcome is the game to be able to move on to the next level. The stages are as follows: 1) trust vs mistrust, 2) autonomy vs shame and doubt, 3) initiative vs guilt, 4) industry vs inferiority, 5) identity vs identity confusion, 6) intimacy vs isolation, 7) generativity vs stagnation and lastly integrity, with the alternative option of despair.

Erikson proposes that the definition of identity in the face of identity confusion typically occurs in adolescence. His concept of identity is of course much less multiplicitous than that of Donna Haraway's, but as a theoretical backbone and focus it does have its validity, and does in no way preclude countless further identity negotiations that are at the very core of human social life. However, with regard to Erikson's fifth stage, identity vs identity confusion, not many people would debate that a major developmental process that takes place during the years of adolescence, when individuals strive to discover who they are as a person through their personal characteristics, interests, through their relationships with family, friends and first lovers, as well as whether they feel a calling towards a certain vocation. In Santrock's words, this exploration of identity in the face of identity confusion takes place when adolescents are exploring who they are, what they are about, and where they are going in life³⁸.

It is important to note that in addition to the aforementioned issues that adolescents explore during this identity stage, adolescents from ethnic minority groups explore their cultural identity. One may argue that white

adolescents also explore their cultural identity. However, the racism, discrimination, and oppression that ethnic minority individuals encounter, as a result of living in a society dominated by the standards and norms of the white society, has an impact on their identity development. Ethnic minorities not only explore their cultural identity, but also explore their identity as a person from a culture who's "way of being" (i.e., physical appearance, style of dress, manner of speech, etc.) are different from that which society has proposed to be the superior or best "way of being". Thus, adolescents from ethnic minority backgrounds progress through the same identity stage, as proposed by Erikson, that white adolescents do, but they undoubtedly progress through an additional stage of development, that being their individual cultural identity within a dominant culture that often devalues or does not support their "way of being".

White adolescents are one thing, but white adult health workers in a multicultural context are another. In any context where different cultures collide, cultural competency is where it's at. We had one of those sheets kicking about in the office, a sheet that listed the product of strategies which white people use to deny, ignore and minimize the presence of racism in their own institutions, culture and personal behaviour. Such strategies include denial strategies, colour-blind strategies, patronizing strategies, omission strategies, decontextualization strategies, and avoidance strategies.

Interestingly, the theorist who went beyond such strategies, and constructed a whole white identity development is herself Black. Janet Helms, who heads the Institute for the Study and Promotion of Race and Culture at Boston College, had studied black racial identity, and went on to look at the wider context of the dominant white culture, developing a

theory of majority member cultural awareness. This developmental theory looks at how the majority group, by virtue of its control of the economic and cultural dimensions of our society, directly and adversely affects minority groups - and itself indirectly.

Helm's theory comprises five stages: contact stage, disintegration stage, reintegration stage, pseudo-independent stage and autonomy stage.

In the contact stage, members of the majority group are aware of the existence of minority groups, but do not perceive themselves as racial beings, much like Cross' pre-encounter stage, racial and cultural differences are seen as unimportant. In the following disintegration stage majority group members acknowledge that prejudice and discrimination exist. The realisation of racial and cultural differences may cause guilt in the majority group members; two ways emerge for the majority, a retreat to the contact stage, or over-identification with the minority. The next stage is one of reintegration, which sees majority group members turn the minority members into scapegoats for their own problems, disparaging the very minority problems that they found so sore in the previous stage, and perceive themselves as victims of reverse discrimination. The ego-centric reversal of the reintegration stage leads to majority group members accepting minority group members at a conceptual level, thereby developing an interest in understanding racial and cultural differences. At this stage, the majority group members seek out those minority group members who they perceive to be similar to themselves. The final phase is what Helms calls the autonomy stage. In this phase, the majority group members become not only knowledgeable about racial and cultural similarities but also accepting, respecting, and appreciating of both, members of the minority group as well as themselves (Helms 1992).

RELEVANCE OF MODELS OF DEVELOPMENT SUCH MODELS OF DEVELOPMENT TO STAFF RELATIONS AT MILES TERRACE.

So there we were, our staff team, some black, some white, with clearly delineated rules to follow. As we were all women, it was indeed skin colour which especially divided the staff team into different camps, depending on overall numbers of staff and women at the project. An additional factor was sexual orientation, or rather promiscuousness I should say. All staff were fascinated with the sexual experiences of especially Dinah, who'd happily share them the next day, and some of the black staff were shocked at times that Dinah had one night stands, but she'd just go 'whatever' or 'its your stuff and not mine'. Apart from Sarah, the pansexual polyamorist, all the white members of staff were in settled relationships, so there was nothing to comment about.

There were times when we had a lot of Black, primarily Nigerian, agency staff, but the thing with them was not their colour, but their religion, Charismatic Christians and Jehovah's witnesses would talk to the residents about how their distress was due to their rejecting or not finding God. At the back of the duty book, we had a list of agency workers who were banned from working at the project; most of them had confronted some of the women and called them sinners.

Dinah was the member of staff I connected with most. She was a feisty black woman with an Afro Caribbean background in her early 30s. She was very black identified and very much into black politics. She was not only outspoken about politics, but was very 'get go' in other ways too; she was very into sex, she was gay, and not wanting a long-term

relationship, she always got into short term relationships. Dinah's family rejected homosexuality as unnatural. She also smoked a lot of pot.

Dinah had had a psychotic breakdown in her late teens when she was at university and because of her own experience with the mental health services she was very out there and felt it was important to say exactly what she felt. While I often struggled with her outspokenness, I kind of admired Dinah for the fact that she wouldn't let go of issues that were important to her. The word that captured Dinah best was feisty, and her feistiness caused a lot of friction with other members of staff who were not as owning of their place as Dinah. During the time I was at Miles Terrace as a project worker (over the past 10 years), Dinah was promoted to the rank of senior member of staff. It had taken three years for her to get there. On average, three years was a very long time to reach senior status, some people turned up and became seniors in no time at all, but those people tended to be less controversial.

To me in particular, her outspokenness caused a lot of embarrassment, after she'd lost no time setting the tone on my first as research worker when she called me pussy. Once you've been in hospital, you're crazy. She always used the word crazy. It's a very silencing existence, your power is taken away from you, it's very important to never get into that situation again with anybody. We never really touched on why she had that episode and I didn't want to intrude.

But back to the different types of power strategies that we had lying around in the office for the white members of staff. They didn't really care. Not that they didn't care, they were just all sufficiently aware not to need such sheets.

And so the identity alignments would keep shifting according to the overall number of staff and women in the project and ethnicity would always be a fairly important one. Tessa and her psychotic episodes did bring out one difference in the approach that the white and black staff took to her. Having trailed through all the developmental theories, pretty much everyone on the staff team saw Tessa's episodes as a developmental 'psychopathology' – we weren't really into diagnosis at Miles Terrace, the thing with psychiatric diagnosis is that you are likely to get as many diagnoses as consultants, but also, the systemic approach did not look to explain the episodes, were not interested in codifying or reifying them. Instead they wanted her to get on the road as quickly as possible. Tessa's case would outlast the duration of the project.

So the difference that Tessa brought out in the staff was that the black staff were all for giving her a black worker, who she'd be very derogatory to, very despising of, and the black staff saw this as the opportunity to give her a reality check, whereas the white staff were whatever, they didn't see much significance in who was going to be assigned to Tessa, black or white.

MDEMBIE – MY SUPERVISOR

I was always told by the other staff how white-identified I was, which is not really all that surprising thinking about my small, medieval, white university, where I often was the only black person. At Miles Terrace, I had however asked for a black supervisor, and Mdembie was very cool. She spoke Xhosa³⁹ taking great pleasure of trying to teach me rude words, particularly when I was at fault. Mdembie was always pointing out that "colonial anthropology can't teach you culture - you are it or not. But you, my friend, are lost to the white's fancy ways". My

readings in postcolonial subaltern theory (e.g. see, for example, Asad 1975, and Bauman 1995 perhaps, came in handy here .

My supervisor Mdembie was very outspoken, and she would tell me to stop this negotiating bullshit, stop telling her I was facilitating things. “You’re a strong Asian woman, intelligent and successful, you’re a role model, if you don’t do things properly and take charge of a situation, what sort of message you’re sending. Next time they won’t employ an Asian woman again if you mess this up.”

I became very aware of black politics, a lot of talk of black politics, and people rights, suddenly I became conscious of all these Jamaican restaurants. Caribbean dance nights, very strong black presence in South East England. They always said to me I was very white identified, doing anthropology, a very colonialist subject, I was just feeding in the whole colonialist ... whenever I got into a conflict why I’m doing anthropology, I just want an easy life, I just want to do my fieldwork, and I should leave.

Whenever members of the staff team were on holiday or off sick, the shifts were covered by agency staff. Many of the agency staff were black. There was a fair proportion of black staff members on the normal staff team at Miles Terrace, but they were Black British, most of the agency workers were Black African, with very African points of reference that would uphold their cultural framework. There were many instances, where the cultural framework of the agency staff was incompatible with the systemic and inclusive way in which Miles Terrace had been designed as an alternative to a hospital admission. Especially the Nigerian nurses at Miles Terrace would at times be fearful

of the women patients, as in Nigerian culture, mental illness is contagious (see: http://anthro.palomar.edu/religion/rel_5.htm).

Mdembie was a Black South African woman, who had been in the UK for more than a decade, and she would say stuff like the reason that there is a lot of mental illness in England is because they have too much time at their hands; if people had to cut firewood and could not eat TV dinners, there wouldn't be any mental illness. They should go to South Africa where you can't afford to be sick and lie on your bed. She was harsh, but there was a truth to what she was saying.

In my culture, physical activity has always been thought to help mental processes, a thought not alien to Western culture. A more important point was the emphasis that many Asian cultures place on working to contribute physically to the family or the larger community.

Every winter Mdembie would take her three children, who were between the ages of 10 and 14, to her hometown in South Africa. There she would show them Black people driving a Mercedes, living in houses with big iron gates. This is what she wanted her children to aspire to. In England, Mdembie would say, Black people have the spirit knocked out of them, they're not aspirational. All they wanted from life in the UK was a giro cheque or a BMW, a fridge, a flat. In South Africa it was a mansion with a swimming pool⁴⁰.

I thought this was amazing. When I was younger, every summer, we would go to Pakistan, because otherwise we wouldn't learn our culture. In England we were quite invisible, existed in pockets, and my father was quite conscious of the marginality of this existence. He wanted us to know and understand our culture, and more importantly. And while he

wanted us to be proud of being Pakistani, he didn't really make a point of showing us mansion houses with swimming pools. I thought Mdembe was amazing.

MENTAL HEALTH IN A BRITISH PAKISTANI COMMUNITY

Most people working in the mental health field have an innate interest in the subject matter as they are sufferers themselves. Anthropology is a lot like that, and more so these days with its emphasis on reflexivity (for example see Marcus & Clifford 1986, and Marcus & Fischer 1986)

Being born into a Pakistani Muslim family in Birmingham, much like most Asian families, we had this overwhelming sort of voice in the back of our heads constantly saying that you're only in England and that you're not a part of sort of the local community; your community lies elsewhere, and elsewhere was always Pakistan, and every summer we were packaged up, and the entire family went for the summer holidays to Pakistan, and the more rural, the better. For some reason my father felt that the only way we would get a true sense of our culture was to live amongst other Pakistani people in a rural setting for the entire summer. During this time, we lived in a part of a family compound and we ended up taking on tasks, fitting in with the usual family dynamics. On one occasion I remember, when I was around 5 years old, all the children, particularly female children, were bundled up and sent away to the neighbouring village, and somehow, with a couple of other girls and a boy, we decided to hide on the roof of one of the compound roofs.

We used to sleep on sort of rope beds, and that day it was really hot and we just sat on the roof and just watched, as people started gathering. It was people from the local village, and mostly they were all men that were gathering on this compound.

One man who had arrived earlier in the day was given such lavish treatment, an Iman, a priest, all dressed in white, with a white turban. He came to the forefront at the head of the compound bearing a clay pot,

which he put on the floor. As dusk began to fall it was quite mystical. The Iman started reading verses from the Koran, and as he was reading we noticed the pot that had been placed on the floor, I think it was more like a cooking pot that had a clay plate over it. He lifted up the plate and put a piece of muslin over the top of it, and suddenly, as he started citing from the Koran, the pot moved, as if it started to vibrate, and a girl was brought to the fore by her mother and her father. This girl was someone who had brought shame on the village, who had been caught with her boyfriend in some sort of compromising position, I think the compromising position being kissing. And to stop her from getting a severe punishment, she said, she didn't know what had come over her, a sort of possession, and so the family thought she was mad and it was so out of character to behave that way. So they decided to have an exorcism, and this Iman, the priest, put his hand on her head and started chanting, and as he chanted, the pot was moving, sort of rotating, and she started to shake quite violently. It was quite frightening, it was dusk and getting darker, and it brought a more mystical quality over the procedure - for a 5 year old child it was very frightening. And after this violent sort of shuddering, the girl stopped, and the pot stopped, and quickly, the clay plate was put on top of the pot, and somebody carried it out of the compound. Everybody dispersed, the priest was paid and everybody left the courtyard and as if nothing had happened, everything went back to normality.

The next day I asked one of the older boys what went on, and the boy said the girl's behaviour was really bad, because she was possessed by a djinn, a spirit which lived out in the woods. There was this understanding that you never went out in the midday sun, you kept to the woods for the shade, because there were all these different kinds of spirits which were good spirits and bad spirits, and the bad spirits were

jumping on you, and then you'd become possessed and your behaviour, you'd do things that you would not normally do. Particularly girls were advised not to go out in the midday sun. So as the boy explained, the pot was taken out into the woods and buried under the trees and it held a spirit. So if you disturbed the spirit it would get released. This was the only way of healing this woman who was possessed, and clear enough, the next day she was functioning normal and was her old self and nobody said anything more about the fact that she got caught kissing this boy in one of the barns. Everything went back to normal. This sort of ritual, this communal kind of cleansing, this way of making sense of things has always sort of fascinated me. It inspired and informed my interest in mental health, and in many settings that I've gone to for work, I came across black men, Asian women, older people, basically people who didn't fit the norm of society. The people in these sort of peripheral spaces, because there was no ritual and no sense of recovery or of a journey that they could take for healing, they felt really stuck it seemed to me. This is what motivated me to look at this area of mental health, what mental illness is, and how it becomes a journey, either the journey of the patient who recovers – and equally a journey for the healer, who gains some sort of enlightenment or knowledge.

I had found it quite frightening, and at the same time very beautiful. These early childhood experiences had found their way into my sense-making mechanism; not so much that I was going around the outer reaches of Scotland and the inner reaches of South East England looking out for djinns, but more that I was profoundly aware that it was the whole village that was a part of the experience, that nothing ever was situated in any one individual, everything was community based. So when someone was depressed, it was the whole family that was asked what was wrong with them, not just the person struck by depression.

This way, I had come to see mental health as a profoundly communal process, and any psychiatric issues as very social, rather than individual, pharmaceutical, biological, or any other way.

This communal view of mental health was shared by many of the Black agency staff that were drafted in to fill the shifts at the crisis project. Especially the Nigerian staff however, saw mental health issues as something bad, as something that had been sent as some sort of punishment. Something so bad you could catch it by sharing a glass or touching the person, which is not really an ideal set-up in an alternative to acute hospital admission.

One of the rationales on which the project was based was the diversity of the mental health workers, and there was a healthy mix of colours, sexual orientation and personal experience of mental health problems. And yet I stood out like a sore thumb. And I don't mean because of the position I occupied between the senior staff and the other workers. It wasn't because I was black or gay or that I was at university. Rather it was that I came from a very sheltered Muslim background, I didn't drink, I didn't swear, and I went red at every available opportunity. It might not have shown through my brown skin, but it never escaped the blush radar of the staff and even some of the residents, who had soon turned it into a sport to embarrass me.

I had gone into the project with armed with my team building Tuckman theory⁴¹, expecting my therapeutic community to form, norm and storm in a straightforward way. I had it all mapped out, but my therapeutic team had none of it, they didn't conform. Where I expected to be included, the staff would continue to challenge me, when we went out to the pub, many of my co-workers would down their pints with the best of

them, while I, sheltered vegetarian non-drinking Muslim that I was, was working hard on the upper layer of a very light shandy. On one occasion I had half a lager and was so sick, I had to cry, because I felt so lonely and humiliated. Sooner or later you have to include me, I said. Do we?, said Dinah.

It was like I had gone into the field bearing beads and other gifts, and got nothing in return. Sure enough, it was a very challenging environment, and looking back, I was very under-equipped in dealing with those challenges. Or rather, I arrived at the project armed with theory, but very little experience, which the staff as well as residents did not fail to pick up on.

So once again, I found myself on the margins. At my very white university, I was usually the only black, or visibly black, person in my anthropology class, a discipline that had very colonialist origins anyway. When I started tutoring, and the students were using terminology like "Third World" and "developing countries" when referring to places like Pakistan, I started feeling quite self-conscious.

At Miles Terrace there was a fair proportion of black people, and it was precisely the black workers who challenged my whole notion of anthropology (with its stress upon 'culture', and 'types of culture'), which they referred to as tribalism, primitivism and exoticism. And they had a point, this was exactly what I had set out to do: I wanted to study Western culture through Asian eyes. And it never occurred to me that the theory I had come equipped with was rather 'white'. It was Dinah, who lost no time making me aware of the fact that I was simply not sufficiently aware of Black issues. I realised that there was more to

feeling black than having dark skin and having read Alex Haley's *Roots*⁴² and *the Invisible Man*⁴³

The other staff did not see me as black either, what they saw in me was shades of grey and whenever the team split around some conflict along colour lines, I was the last person to be picked by the black team, but I nevertheless was always pulled over by the Black team to make up numbers. I was very conscious of those colour lines and made sure I never found myself pulled over by the white team, because I knew, if that had happened once that would be it with me and the black members of staff.

Looking back also made me realise that I was watching out for a clean-cut manifestation of my cleanly delineated theory. The term liminal is derived from the Latin word *limen*, which means threshold, and this was indeed an image that fitted into how I saw things, I was looking for a clear-cut threshold, the last step towards a portal that would lead into a mental health sesame setting where I could move freely and be fully accepted by everyone. I wouldn't go as far to say that I expected someone to pick me up and carry me across the threshold, but I expected it to be a clearly delineated step I would take, right foot first, left one following, and there I was. It is only in retrospect that I see that for all their teasing and calling me pussy, and other names that would not sit very comfortably with me, whenever the shit hit the fan and things got really heavy, the other members of staff were very supportive. Looking back now, maybe it wasn't they who were not accepting me as an integral part of the team. Other than the sheet about institutionalized white privilege power, we had another one, that was also kicking about in the office.

DIFFERENT TYPES OF POWER

Coming into a psychiatric setting is very regimented. Regimens were very important: obeying, respecting, acknowledging and simply being aware of boundaries were very important. And there were many times when those boundaries had to be reinforced, starting in the mornings, when the project workers had to make sure the women were up in time for breakfast, which was prepared at a certain time, the same for lunch and dinner, and that they were in bed by a certain time, that they took their medicine, etc. The day to day running of Miles Terrace gave plentiful opportunity to wield one's power as a member of staff. Back in the 1960s, French and Raven (1960)⁴⁴ came up with six different types of power, and a sheet listing those six types was on show in the office: (the six different types of power are legitimate, reward, coercive, expert, and referent). Everyone on the staff team was familiar with French and Raven's six types of power, and they would often come up in conversation. Staff would even use these terms of power, while gesturing quotation marks in the air with their fingers.

I had a concept to aim for, I wanted to have legitimate power at the project. But what I really wanted was to be liked. Only I didn't realise that at the time.

One occasion to use power was to get the women to go to bed at a certain time. The women were meant to go to bed by a certain time so they had enough sleep by the time breakfast came along, so they could be part of the social life at the Miles Terrace. Many of the women, particularly in the plateau phase of their crisis, would have very sleep deprived patterns of working, and it took them a long time to break out of these patterns. Whenever it was my turn to send the women who were

still up in the living room to bed, I would tell them they needed to break their cycle of not sleeping. What I would also say was “You’re gonna get me into trouble if you don’t go to bed”.

And generally speaking, they did not want to get me into trouble. The women would go to bed, task done, but somewhere I knew that this was not the most powerful way of dealing with the situation. My unease with regard to power did not escape the other members of staff, and when they didn’t call me pussy, they called me the negotiator. “Okay Salma, go and do your negotiating.”

I realised that the way I dealt with these situations, I was not using power – in fact, the way I was dealing with them, it was almost like I saw the power lodged with the women. I was uncomfortable wielding the power that came with the position of staff. But the thing was that while the position of a staff member was one of power, this power would not automatically ooze out of every pore of the individual that filled the position. You had to fill the position in a way that there was no air between you and the role, it had to be a perfect fit for the power of the position to be transported into the way the women at the project perceived you.

I’m not sure whether I ever managed to get a tight fit during my time as a research project worker. I certainly remember times when there were quite a few air bubbles in between me and my mould.

ASSERTING POWER: ALCOHOL AND OTHER SUBSTANCE ABUSE

There were times when the staff really had to assert their power, and one such time was when any of the women drank alcohol.

A place at Miles Terrace was available to all women in acute crisis in the catchment area who had been referred and offered a place upon assessment. It was not available for women in crisis who were alcoholics. Miles Terrace Crisis Project was dry. A dual diagnosis of mental ill health along with alcohol abuse was deemed beyond the scope of the project, it was felt that addictions interfered with the approach of the project, with the way the staff were working with the women.

The way this dry rule translated into practice was that as soon as a woman drank, she was out of the project. Or rather, as soon as a member of staff caught on to the fact that she was drinking, she was given one night's reprieve and was discharged the following day. Only after six months had passed could she seek admission to the crisis project again, and at the referral she would be grilled about whether she had done any detox.

Alcohol had not been part of my sheltered Muslim background, and I didn't see these issues in the same ways as the other project workers. For me, the women who drank had that 'je ne sais quoi', there was a tinge of glamour about them. I would not have turned them away. They always seemed to find themselves in such intriguing scenarios, they were drunk

and had ended up at this and that party, meeting that and that person; there was a dimension to the stories they told that was unmatched by the accounts of the other women. The other women' stories told of physical and sexual abuse, of self-harm, etc...

But the bottom line was that I was much more naïve about anything to do with alcohol than the other project workers. When women who had been drinking before, wanted to go out for a few hours, staff would make a big fuss about alcohol and I remember many scenes of women pleading in the most colourful ways how they would stay away from it. But when they'd come back, their bottles of coke or orange juice would be laced with vodka. Only I was completely oblivious to this. It was not until the other members of staff made a point of tasting whatever drinks certain women brought back into the project that I realised they had been drinking all along. I was in fact quite impressed with their ingeniousness, with how creative they were to keep their addiction going. I thought we should acknowledge ingenious, quite creative. The other members of staff didn't think so.

JENNY JONES

Jenny Jones was a 35 year old white woman who had been brought up in Manchester. She was the first in her family to go to university, obtaining a double first in maths and computer science from Oxford. Jenny talked lots about succeeding in a man's world as a programmer and theorist in a research unit. She spoke a lot about having a very uneventful life. One day, at work, one of her male colleagues started making advances towards her, asking her on a date. Jenny had never related to anyone on that level before; she was never reflected upon relationships, and was very much a loner. She had come to South East England for her job, and was happy with her routine. From Monday to Friday she would be en route to work by 8am, buying a coffee before boarding the tube, sometimes with a newspaper. She was not very prone to reading novels as it took too much time, and on the weekends she would sleep in and go and sit in the park, read the Saturday papers and on the way home have fish and chips for her dinner. She was quite happy with that, in her mind working on some sort of maths problem. So as the advances of this guy started getting more intense, Jenny rejected them. Quite often she'd work late, till about 10pm, and on one occasion she was raped by this guy.

The classic thing you do in a scenario is to ask 'have you informed the police', but you have to fight it, because it could be taken as a criticism, you never know the capacity of the person to deal with the situation. It is a judgment to think a person is going to deal with things in the same way as yourself. Jenny tried to talk with someone at work but no one believed her. She became depressed and withdrawn, got sacked, began drifting, lost her flat and became homeless for two years. During those two years she developed a drink and drug problem, she'd been to the project on two visits previously, and her way to deal with the pain she

felt when she had to come off the drink and the drugs, was to begin to self-harm. This was her third admission. Somehow through the other women, she thought I was a historian, so she often talked about the history of maths, and always wanted me to be her worker. I quite enjoyed her company, but she never really wanted to talk about her problems. After her previous discharge from the project she'd been given a flat, but in 6 months she was back on the streets, where she said she felt safer. At least she knew what was coming.

On this occasion at the project, she had come into the project and seemed to be quite sleepy and swaying, and automatically, Kali, who was co-ordinating the shift at that time, said she'd been drinking or taking drugs. I had to take her into one of the interview rooms, asking her whether she had taken drugs. If she had done so, we'd have to cancel her stay at the project. But I talked to her about how things were. In the room she never sat opposite you; she found this too confrontational and preferred sitting side by side with you. If she liked you, she was forthcoming with information, but if she didn't, she was very monosyllabic. While we were talking, Kali, who was in charge of the shift, barged in, went up to Jenny and said 'Jenny, you've been taking drugs and you're going to be discharged'. Jenny became very distressed. I tried to intervene, telling Kali we were having a conversation, that we were discussing what had happened and what we were going to do. Kali was very curt, I'm in charge today, it's my responsibility today. I felt that it was my responsibility -the way I saw it, Jenny was in a crisis and if there ever was a time she needed support, it was now. Being on the street was no punishment for her, as she was used to it, but not being allowed into the project would mean being rejected. I felt that Jenny had gotten herself into a cycle of rejection, and as soon as things began to get better for her, she would sabotage the work/relationship to prove that she

wasn't worth it, with people always rejecting her in the end. And I was angry that Kali was about to prove her right. If only we could see her through this time. Then Jenny could maybe realise that there is no punishment. It was punishment that Jenny knew and created often. It was only outside of that cycle that she could, even had to, take on her issues and feelings of suffering, anger, distress and loneliness. I felt very strongly about this and Kali and I were getting into a heated argument about the situation. As we were shouting at each other, Jenny walked over to the basement window and stuck both hands right through the glass. A mighty crash, no screams, just silence and Kali and I looked around and saw her. I felt very guilty. We managed to get her arms out of the window and Kali helped Jenny on to a chair. I went to get the first aid kit. Jenny refused to make eye contact with Kali.

Since my days as an agency worker, Miles Terrace had instituted a very strict policy with regard to self-harm. If a woman self-harmed, the staff wouldn't help her with her injuries directly, but simply pass her the first aid kit so she could bandage herself. It was felt that by helping her, one fed into the whole cycle of manipulation, playing an active part in this ritualised behaviour. I couldn't bear this, because I felt that such a policy of objectified care provided care in the most punishing way.

All that Jenny did was extend her arms, and I thought, damn the consequences. The glass had cut quite deep, and blood was dripping through the bandages as I was wrapping them around Jenny's arms. I felt resentful towards Kali who I saw as the catalyst for Jenny doing this. Jenny had become more distressed as Kali got at her about how drinking was 'unsafe' and broke the policy and that she couldn't stay at the project that night. Also, the dynamic had shifted from the nice engaging, soft conversation with me to quite a confrontational tone, with Kali being the

challenging team leader. On top of that I felt resentful being ordered about, being told to go away and call an ambulance, when I had been in the middle of a conversation with Jenny before Kali barged in. I told Jenny to sit on the floor and stick her arms up for circulation, and she asked me 'would you hold my hand', extending her arms. Kali looked at me quite puzzled, I actually made eye contact with her. I had all this blood on me already, I thought to myself, it doesn't make a difference, there can be no harm in showing care. And I took hold of Jenny's hand and sat down next to her until the ambulance came and she was sent off to hospital. She was detained for several weeks.

On reflection, I realised that I was constantly pulled to one side or the other; one time I was an advocate for the patient against the staff, or I was a member of the staff team, showing comradeship towards my colleagues. I thought I'd gone there to show some sort of neutrality, but instead I had to question my own values and principles and felt I had to choose what I felt was right. Now, as a result, regardless of the positioning I chose, my behaviour was seen as a direct critique of the way the project worked, and that brought me into other conflicts. Staff started to withhold information, not information necessary to the running of the project, but personal sharing. So did the women in the project. On occasions, I would stumble over some of the women in the lounge and find them gossiping about the staff. Sometimes I was privy to their gossip, other times I was sent away. Each time that I wasn't allowed to stay, I felt very excluded, punished. I felt very lonely.

Each camp thought I didn't behave appropriately, supportive enough. They wouldn't let me into their lives, to share what they were feeling, thinking, they would just clam up. I guess some of my loneliest moments in my life have been at that project.

Kali said I needed to be more supportive of her. I said it was inappropriate for her to walk in, when I was just getting into why Jenny was behaving the way she behaved. But Kali was the shift's senior although she was a junior really, but in times of staff shortage, she would often head shifts. As would I for that matter, and I was did not have the grade of a senior either.

For Kali, there was no point in just observing Jenny and me through the glass pane in the door of the interview room. She was crystal clear that the rules prohibited Jenny's admission to the project, which is why she lost no time charging into the room before Jenny and I could get further in our conversation.

'There is no 'I' in team', Kali told me in response to my decision to step over the rules and administer care. In my defence I said this project was about being innovative, it's about taking the lead from the women, hearing what they said, deciding upon the care around that, otherwise it just became more claustrophobic, like a hospital ward with all those protocols, policies and guidelines.

But I did feel guilty. And I realised that having institutions without rules did not work. I had been trying to get Jenny to own her demons. It was clear that the trauma of her rape was unresolved and constantly re-enacted through the relationships and the interactions she had. If only we could get back to that point where the trauma itself had started.

It started dawning on me that maybe I was reaching beyond by own capabilities of organisational and limited life experience.

The women at the project might not have experienced unconditional love, only conditional love, and so recreated conditional relationships. If I'd had their lifestyles or experiences I don't think I would get out of bed in the morning. But they were managing to get out of bed and to exist. These were women who had been abused, raped, who had unresolved issues of loss and separation; they might have children, might live in one room, might have abusive boyfriends. For the workers it was temptingly easy to measure up the women's existence against an ideal, which they could never reach. Sorry, no alcohol, out you are. I thought this was very judgmental on the part of the workers, whose lives were not saintly either by any standard. And I still think that Miles Terrace, of all places, should not turn those women away.

A year later, I found out that Jenny had died living on the streets.

Recently, I was told a story that captured the nature of substance abuse so beautifully, so lucidly, without passing judgment, that I would like to repeat it here. The story was in fact told to me in a different context, but it fits all the same.

During the time that I was off sick, I visited a friend, Sonya. That moment in the doctor's surgery had been very powerful for me. She had forced me to see a side of myself I had not been aware of previously, had not wanted to know about. And even though now I had seen, or rather was beginning to see, how I had been floating through life in an aquatic bubble, I couldn't just open that door and leave that bubble. After all, I had not trained my muscles to swim.

Sonya had been a very successful management consultant. But she had reached a point, when she had become very disillusioned with the

spiritual poverty of what she was doing. It was then that she decided to retrain as a story teller. And now she was going around prisons and all sorts of places, telling people stories, passing on messages through narratives that would reach people in very powerful ways. Sonya's stories would always touch on something crucial, something that would deeply move her listeners.

I told Sonya that I was off sick, and how ashamed I was. Even though I'd had that moment in the doctor's surgery, even though I had started to see that the path I had been on was only ever going so far. Sometimes it's not that easy to change tracks. So I told her how ashamed I was. Why, she asked. And then she told me a story by Alice Walker. Sonya used many stories by Alice Walker in her work, she found her very spiritual, and very accessible. And the story she told me was exactly what I needed to hear, what there was for me to absorb, to understand, to take in. I've trailed the bookshops high and low as I knew paraphrasing was not going to do its serene beauty justice.

ALICE WALKER: TO KILL OR TO THAW THE ANACONDA

She dreamed she was emptying her freezer and there among the forgotten leftovers lay an alive but perfectly frozen anaconda. A huge orange and spotted snake, ashen, until she poured water on it and its ice sheeting began to melt; the colour of the sun. She felt she must kill it before it thawed. She ran to others for help. None could help her; they were busy with their own lives. Their own anacondas. She cried out to one person after another: Necesito ayunda! Puedo? I need help! Can I help? She thought she was saying, Can you help? But she wasn't. Only on waking, all outside help refused her, did she realize dealing with the anaconda was an inside job. Whether to kill it or let it thaw and live was entirely up to her.

And wasn't she always saying what Grandmother Yagé had taught her: We are all on the back of a giant anaconda. It is slithering and sliding, darting and diving, like anacondas do. That is the reality of the world.

She woke up remembering a story from her days in the Black Freedom Movement. When she and her companions sought to encourage voting in a population that had been terrorized all their lives for trying to do so. An old woman had said to them, as they walked their weary miles across Alabama and Georgia and other outposts of the soon to be dubbed 'New South', Le me tell you a story about a man and a snake. They put down their notepads and melting-in-their-hands pens, the heat was so intense, and hiked up their jeans, took a seat on a stump in her yard, and listened. She was so old she smelled like greens. And so real a number of them swooned. There was this man walking down the road, you see. And she pointed to the long dirt road down which they had trudged, looking for her house. And it was a very, very cold day. They looked into one another's profusely perspiring faces and couldn't begin to imagine it.

And what do you think he saw just ahead of him on the road? Well, she carried on, without waiting for them to guess, there right in his path was a snake. Kinda cute snake. You know, probably had hair like most people want and long eyelashes. Her audience smiled. It was frozen solid though, it was. But still, some part of it could talk to the man. You know how that is. They chuckled. And it said: Please, Mr. Man. I'm just a poor little ole snake nearly 'bout froze to death out here in this weather! Please take pity on me and warm me by putting me in your bosom. Now, the man wasn't usually no fool. But you know how it sometimes be. That one day, well. He thought about it. And he was after all a Christian kind of a man. He stood there thinking how amazing it was that such a cute snake could talk. And then he stood there a good five or ten minutes thinking about what Christ would do. If I was to pick you up, he said, leaning over the snake so that his own shadow became a part of it, and he being a sensitive soul, started to feel a connection, If I was to pick you up, how do I know you wouldn't bite me? Oh, no, Mr. Man, if you would be so kind as to warm me up and let me live, why, it would be a horrible thing for me to repay your kindness by biting you! I wouldn't dream of such a thing.

So after a while, the snake looking at him so pitiful, he picked the little ole thing up, and he put it in his bosom, in the pocket of his overalls. Just behind his package of Brown Mule chewing tobacco and right next to his chest, close to his heart, which was beating warming blood all through his sympathetic body. And they walked on. The man thinking real good things about himself and the snake beginning to feel like him or her self again. Pretty soon the snake was warmed clear through. The man could feel it slowly uncoiling, slithering behind his hanker pocket just a tiny bit. It make him smile, to tell you the truth. It tickled him to think that something as humble as himself could bring something frozen

almost dead practically back to life. He reached up to pat the snake. And the snake bit him.

He bit him on the jaw. And the man knew he was in the middle of Alabama or Mississippi or Georgia or north Florida or somewhere there wasn't likely to be no speedy help. He fell down in the middle of the road, just a cussin'. Why you do me like that? He asked the snake, who was now sliding nimbly across his pants leg. And the snake looked up at him and said, kind of shrugging his shoulders like those folks in France do: You knowed I was a snake when you picked me up. And the man started to die.

The old woman looked at the young people who had disturbed her peace to ask her to join their crusade. She had learned to live without picking up any snakes. She killed every one she saw, no hesitation and no questions asked. She did have a different ending for the story though, that she felt might do them good; for she could see they were understanding her to say what they were attempting was an exercise in futility.

She cleared her throat, which had as many wrinkles as the ocean has waves. Now listen, though, she said, most people stop that story right there. They act like the man was just a total fool, outsmarted one more time, like ole Adam. But when you think more about the story, about the man and the weather and the snake, you understand it differently.

How's that? Someone from the group asked dejectedly. They had walked all morning in the broiling sun just to be told they were picking up something whose bite would eventually kill them.

Well, said the old woman, think about the weather. It was still real cold. That snake, he was gonna freeze again. Once he froze again, he'd be helpless again. No kind of protection for a snake too froze to bite.

So? asked the same person.

So, said the old woman, this is an endless kind of a thing. Do we kill it or do we let it live? Do we ever believe its true nature and does that true nature ever change? And does ours?

She had given them some grapes that grew out behind her house. And some water from her spring. Bye, she'd waved to them, as contented as a girl.

(Alice Walker, from "To kill or to thaw the Anaconda. Now is the time to open your heart" 2004)

Sonya had in fact only told me the part about the snake. In her telling, she had done without the frame. Hearing that some things are just the way they are filled me with tremendous peace. With regard to alcohol or other substance abuse, it's so easy to see people as snakes. And when snakes are presented like that, you can't be angry with them.

I have to admit, that even despite the way I glamorise alcohol, there were times when I had really lost any faith I might have had in people. The times when women came back with vodka in their juice bottle for the nth time. After I'd had undergone a lengthy negotiation process to try to prevent it happening again.

And this brings to mind another story, anticipating the next chapter on medical narratives. It is a classic doctor's story, which explores power, applied forcefully, in the name of the greater good, but against the will of the patient. This is a side I never explored in myself. If I has, maybe I would have understood more at the time.

CARLOS WILLIAMS: (1984) "THE DOCTOR STORIES": ON THE USE OF FORCE.

They were new patients to me, all I had was the name, Olson. Please come down as soon as you can, my daughter is very sick.

When I arrived I was met by the mother, a big startled looking woman, very clean and apologetic who merely said, Is this the doctor? and let me in. In the back, she added. You must excuse us, doctor, we have her in the kitchen where it is warm. It is very damp here sometimes.

The child was fully dressed and sitting on her father's lap near the kitchen table. He tried to get up, but I motioned for him not to bother, took off my overcoat and started to look things over. I could see that they were all very nervous, eyeing me up and down distrustfully. As often, in such cases, they weren't telling me more than they had to, it was up to me to tell them; that's why they were spending three dollars on me.

The child was fairly eating me up with her cold, steady eyes, and no expression to her face whatever. She did not move and seemed, inwardly, quiet; an unusually attractive little thing, and as strong as a heifer in appearance. But her face was flushed, she was breathing rapidly, and I realized that she had a high fever. She had magnificent blonde hair, in profusion. One of those picture children often reproduced in advertising leaflets and the photogravure sections of the Sunday papers.

She's had a fever for three days, began the father and we don't know what it comes from. My wife has given her things, you know, like people do, but it don't do no good. And there's been a lot of sickness

around. So we tho't you'd better look her over and tell us what is the matter.

As doctors often do I took a trial shot at it as a point of departure. Has she had a sore throat?

Both parents answered me together, "No . . . No, she says her throat don't hurt her.

Does your throat hurt you? added the mother to the child. But the little girl's expression didn't change nor did she move her eyes from my face.

Have you looked?

I tried to, said the mother, but I couldn't see.

As it happens we had been having a number of cases of diphtheria in the school to which this child went during that month and we were all, quite apparently, thinking of that, though no one had as yet spoken of the thing.

Well, I said, suppose we take a look at the throat first. I smiled in my best professional manner and asking for the child's first name I said, come on, Mathilda, open your mouth and let's take a look at your throat.

Nothing doing.

Aw, come on, I coaxed, just open your mouth wide and let me take a look. Look, I said opening both hands wide, I haven't anything in my hands. Just open up and let me see.

Such a nice man, put in the mother. Look how kind he is to you. Come on, do what he tells you to. He won't hurt you.

At that I ground my teeth in disgust. If only they wouldn't use the word "hurt" I might be able to get somewhere. But I did not allow myself to be hurried or disturbed but speaking quietly and slowly I approached the child again.

As I moved my chair a little nearer suddenly with one catlike movement both her hands clawed instinctively for my eyes and she almost reached them too. In fact she knocked my glasses flying and they fell, though unbroken, several feet away from me on the kitchen floor.

Both the mother and father almost turned themselves inside out in embarrassment and apology. You bad girl, said the mother, taking her and shaking her by one arm. Look what you've done. The nice man . . .

For heaven's sake, I broke in. Don't call me a nice man to her. I'm here to look at her throat on the chance that she might have diphtheria and possibly die of it. But that's nothing to her. Look here, I said to the child, we're going to look at your throat. You're old enough to understand what I'm saying. Will you open it now by yourself or shall we have to open it for you)

Not a move. Even her expression hadn't changed. Her breaths however were coming faster and faster. Then the battle began. I had to do it. I had to have a throat culture for her own protection. But first I told the parents that it was entirely up to them. I explained the danger but said that I

would not insist on a throat examination so long as they would take the responsibility.

If you don't do what the doctor says you'll have to go to the hospital, the mother admonished her severely.

Oh yeah? I had to smile to myself. After all, I had already fallen in love with the savage brat, the parents were contemptible to me. In the ensuing struggle they grew more and more abject, crushed, exhausted while she surely rose to magnificent heights of insane fury of effort bred of her terror of me.

The father tried his best, and he was a big man but the fact that she was his daughter, his shame at her behaviour and his dread of hurting her made him release her just at the critical times when I had almost achieved success, till I wanted to kill him. But his dread also that she might have diphtheria made him tell me to go on, go on though he himself was almost fainting, while the mother moved back and forth behind us raising and lowering her hands in an agony of apprehension.

Put her in front of you on your lap, I ordered, and hold both her wrists.

But as soon as he did the child let out a scream. Don't, you're hurting me. Let go of my hands. Let them go I tell you. Then she shrieked terrifyingly, hysterically. Stop it! Stop it! You're killing me!

Do you think she can stand it, doctor! said the mother.

You get out, said the husband to his wife. Do you want her to die of diphtheria?

Come on now, hold her, I said.

Then I grasped the child's head with my left hand and tried to get the wooden tongue depressor between her teeth. She fought, with clenched teeth, desperately! But now I also had grown furious--at a child. I tried to hold myself down but I couldn't. I know how to expose a throat for inspection. And I did my best. When finally I got the wooden spatula behind the last teeth and just the point of it into the mouth cavity, she opened up for an instant but before I could see anything she came down again and gripping the wooden blade between her molars she reduced it to splinters before I could get it out again.

Aren't you ashamed, the mother yelled at her. Aren't you ashamed to act like that in front of the doctor?

Get me a smooth-handled spoon of some sort, I told the mother. We're going through with this. The child's mouth was already bleeding. Her tongue was cut and she was screaming in wild hysterical shrieks. Perhaps I should have desisted and come back in an hour or more. No doubt it would have been better. But I have seen at least two children lying dead in bed of neglect in such cases, and feeling that I must get a diagnosis now or never I went at it again. But the worst of it was that I too had got beyond reason. I could have torn the child apart in my own fury and enjoyed it. It was a pleasure to attack her. My face was burning with it.

The damned little brat must be protected against her own idiocy, one says to one's self at such times. Others must be protected against her. It is a social necessity. And all these things are true. But a blind fury, a

feeling of adult shame, bred of a longing for muscular release are the operatives. One goes on to the end.

In a final unreasoning assault I overpowered the child's neck and jaws. I forced the heavy silver spoon back of her teeth and down her throat till she gagged. And there it was--both tonsils covered with membrane. She had fought valiantly to keep me from knowing her secret. She had been hiding that sore throat for three days at least and lying to her parents in order to escape just such an outcome as this.

Now truly she was furious. She had been on the defensive before but now she attacked. Tried to get off her father's lap and fly at me while tears of defeat blinded her eyes.

(Carlos Williams 1984, "the doctor stories". Also see website: <http://mbhs.bergtraum.k12.ny.us/cybereng/shorts/force.html>)

First published in 1938, Williams' *The Use of Force* is a classic that has been used for teaching medical students in the US. Whatever one thinks about Williams' use of force, it evokes with great immediacy a number of important issues about doctoring, which becomes relevant to the following two chapters, VI and VII:: there is the predicament of having quickly to assess a medical/social situation in an unfamiliar, even hostile environment; there are the doctor's impressive powers of observation, and concern to do the right thing medically; there is the anxiety of the sick child's parents; and most importantly, there is the doctor's power, and more specifically the dark side of human nature which can take such power into various directions, well out of the professional encounter. And whichever direction people would tend to take that power in a similar situation, it is the opposite direction this story allows them to explore. Maybe Kali did have a point.

CHAPTER VI: THE RITUAL OF HARMING THE SELF.

CLARISSA

Clarissa was a 25-year old English woman, born and bred in South East England, and a notorious ‘cutter’, i.e. self-harmer. The day before she came to the project, the staff would encircle the cooler fan with their swivel chairs, as if they were creating a corral, like in those black and white cowboy movies when the cowboy trains fell under siege and they would get all the horse-drawn wagons and put them in a closed circle and sit behind waiting for the enemy. Every time I chanced upon such a formation, it made me feel quite anxious, like they didn’t tell me the full story. Maybe they weren’t even aware of their own angst. Or maybe comfortably sitting in a circle was the easiest way to confer with each other.

Clarissa had a history of severe self-harm, and she was known to the services in the local area, who had referred her to Miles Terrace. When Clarissa arrived, I was asked to work solely with her. This basically involved checking on her regularly, seeing that she wasn’t in any distress or harming mode. One day when I wasn’t working with her, I noticed I hadn’t seen her around. Unlike some of the staff I spent a lot of time talking to most residents in the lounge, which gave me a fair idea of their patterns, their comings and goings. And I realised she hadn’t been around for a while, so I went up and knocked on her door. Conscious of her privacy, I was desperately thinking of something I could develop into a conversation to distract her or rather deflect from my own anxiety. I knocked on the door, calling ‘Clarissa, Clarissa’, but there was no response. I waited a few seconds, wondering what excuse I could charge into the room with, tried the door handle, but it was locked. I could feel my heart pounding in my ears, beads of perspiration forming on my

forehead, and with my clammy hand I searched for my master key in my pockets. I made sure I completed the whole process in the noisiest fashion, which got the other residents out of their rooms, but still no response from the door. After I had encouraged the other residents back into their rooms I turned the key, and my anxiety made me fall on the door handle and the door flew open, stretching out the wiry chord on which my key was attached to my belt. Because the door was on the spring it rebounded into my face which was so painful I was going to cry. And even all this noise did not create a response. I went into the room calling out Clarissa's name and the bathroom door flung open and she was standing there, just a bath towel around her. I said 'why are you having a shower in the middle of the day', and she just smiled 'no reason'. I asked 'have you done something, has something happened', and she said 'look at this', dropping her towel, getting out four fingers and inserting them into her stomach. She had cut right across her stomach. She brought her hand back covered in some fleshy tissue and blood.

She held the towel in a way so it was not actually touching her body, and I became transfixed by the amazing grin on her face, she was in a state of ecstasy. But I can remember how lucid I was myself, 'I'll be back in a minute, don't move', I managed to free those keys out of the door and started walking the two flights of stairs, thinking how to best convey the urgency and the shock of the situation to the staff without panicking myself or creating quite a furore around this person. So I got to the office door, where a few members of staff were sitting at their desk writing up their notes, I went into the office and said 'excuse me, do we have a first aid kit', and without turning around the woman sitting with her back to me just pointed somewhere, and another woman asked 'have you cut your finger or something'. 'Clarissa, she's just cut

her stomach and I think we need some latex gloves as well, and an ambulance', at which point everybody turned around and looked at me. 'What did you just say?' 'Clarissa's in her room, in a towel, she has quite severely cut into her stomach and I think we need an ambulance. Could one of you call an ambulance, and would one of you like to come with me.' So I went back up with the team leader of that shift, and Clarissa was still standing in exactly the same position with her towel open, and I thanked her for not moving 'this is Geraldine, she is in charge of the shift today, so I've asked her to come and see what first aid you need". Geraldine went up to her and confirmed that we needed an ambulance, asking me to call it, at which point I went downstairs and fell into a chair and could not get back up. I could hear the sirens approaching.

Geraldine had applied some pressure bandage to the cut, and the paramedics helped Clarissa to get dressed and rushed her to A&E. After she'd left the building, the rest of the staff gathered around me, and congratulated me on my resolve of the situation, how a proper member of staff couldn't have dealt with it as well as I had. They asked me if I was okay, did I want to go home. And I thought to myself, this situation could be the making of me, as part of initiation to be a part of the team - if I could witness something so awful and get myself through it; they all had their war wounds and war stories, and there was mine, and if I could just see this day through, maybe they would accept me more, even though my legs were wobbling underneath me and the blood had been drained from my face and hands- a classic symptom of shock.

People were telling me she had used her scissors, and I kept seeing the bits of flesh she had gouged out of herself. I was constantly reliving the scenario with ever more detail, what they were wearing, the pieces of

flesh on the floor, the way she had been holding the towel so it did not actually touch her body, everything from the hairbrush on the table to the colour of the toilet paper. I think that is how trauma starts. You try to re-see things again and gain, evoking them to be real⁴⁵.

I tried to see it in so many different combinations if my reaction was appropriate, meaningful. I tried to adopt different perspectives. For months after Clarissa had cut her stomach open, I was interrogating everyone how they felt at a specific point, during a specific action, trying to fathom the phenomenon that is appropriate response. We are always trained to respond in an appropriate way; we are told not to let our emotions get into the way, that we are there for the other person. But your emotions do get into the way. Distress fragments the self. So much so that one is getting beside oneself.

MY REASONS

'Twas the night before Christmas and all through the house
not a creature was stirring; not even a mouse....
Parents in bed, they're snoring away,
Brother in pub and sister in room.
Silently laying with nowhere to play
I should be excited and not full of gloom
Blade in my hand – I escape it all now,
Just one little cut and it all goes away.
Hearing my heartbeat I draw a deep breath
As my blood trickles down the black melts to grey.
So calm and so peaceful, I'm feeling relaxed
Perhaps I'm a freak who's insane?
But either way, for now I don't care-
Strawberry gashes release all my pain.
I know this is wrong, and it's only short-term
But I feel so much better already.
Just a few hours ago I was shaking like mad
And now I can hold my hand steady.
This euphoria's good – I'm escaping this world
I wonder how long it will last.
With each cut I make and with each drop of blood
I escape all the pain of the past.
Now I get scared – don't think I can stop
My metal is just so compelling.
I feel safe when I hold it – nothing can get me
My eyes fill as I watch my skin swelling.
I must make more cuts, let out more blood
Let all the bad in me, flow away.
Content with my work, and even more tired
I stop, as my head starts to sway.
The "process" is finished; I clean up, get dressed.
My arms sting and no-one else sees.
What I do on the outside's what I feel on the inside
Though I doubt anyone else would believe.
I stare at my wrist – still not healed from before
Should I just end all of it now?
No, I won't, I can't, it's wrong and I know it
I just can't see another way out.
It's not fair to feel like this – not on me, not on Greg
Nor on anyone else I've let in.
But I really can't help it – it just sort of happens
And I conceal it all with my grin.

Would it be better for everyone if I were not here?
I'd be missed but I'm sure they'd move on.
(This is just random thinking, I couldn't just die
but why me? What have I done so wrong?)
As deeply as I love him, that's how I hate me;
So passionately, madly, so sure.
He's such a good person, deserves better than me
Someone innocent, perfect, and pure.
Why am I like this? Messed up in the head
Why's it all come flooding back?
It must be my fault (so I'll hate myself more)
How long left before I'm gonna crack?
This big hole appears – dark, cold, and empty
It just comes from nowhere at all.
I'm surrounded by people yet I still feel so lonely
I'd shout-but who'd hear me call?
It completely engulfs me – suffocates, strangles
Sometimes so bad I just want to die.
If I could do something else, then I would and not cut;
Maybe I really should cry.
Still, crying's not easy – it used to be though
Now it just makes me all scared.
(it lets down my guards and me makes me more vulnerable;
especially if I'm not prepared).
But cutting is different – it causes me pain.
Pain which I feel I deserve.
For letting it happen, for being controlled
By an evil 15 year old perve.
And if I feel numb, if I can't feel a thing
If I've taken a total nose-dive,
Then I think of a lyric that's SO real to me...
"...yeah you bleed just to know you're alive".
So it seems at the moment its my way of coping
And until all my anger is gone.
'til I leave all my pain; all my guilt; all my past
My Crimson Tears will go on.

elle 24/12/03

<http://www.madnotbad.co.uk/poetry/poetryhome.htm>

I do not claim to fully understand the phenomenon of self-harm, but I can hardly leave it uncommented upon in the face of its heavy occurrence at Miles Terrace.

In the midst of all those cutters, I had to find the means for explaining them to myself. However, whichever way I attempted to make the deep cuts more intelligible to myself never lasted long; nor did it drain the shock and also disgust over such self-harm. I do not know whether the scars were motivated by a deep sense of guilt over some event in the past, that needed to be quenched through punishment, or whether they were a way of making the experience of the world actually felt, by creating a tangible sensation of the life that had been numbed and blunted through scars in the past.

An overall epidemiological assessment of self-harm poses logistical problems. For instance, different UK hospitals have different coding systems for self-laceration. Moreover the case-mix of other forms of self-harm, such as self poisoning, the most popular form of self-harm, appeared roughly similar (see Kapur, House, Creed, Feldman, Friedman & Guthrie 1999 171). Research suggests that up to 60% of individuals who harm themselves do so in the context of a psychiatric disorder (see Ennis, Barnes, Kennedy, & Trachtenberg 1989:41-47).. Thus, as Kapur, House, Creed, Feldman, Friedman and Guthrie suggest, patients who present to hospital with self-harm should be assessed by someone with appropriate psychiatric training. In research on the comparison of doctors and nurses in assessment of deliberate self-poisoning patients, it has been found that it is not only psychiatrists who can make adequate assessments, but, as has been demonstrated almost 30 years ago, adequately trained psychiatric nurses, social workers, junior doctors, clinical psychologists, occupational therapists and A&E staff are also

capable of making adequate assessments (see Catalan, Marsack, & Hawton 1980; Newson-Smith & Hirsch 1979; and Gardner, Hanka, O'Brien 1977). As so often with psychiatric care, it is a multidisciplinary approach that goes furthest. An interdisciplinary team offers the advantage of the development of special expertise. Whatever the procedures Kapur, House, Creed, Feldman, Friedman and Guthrie (1999:171) point out, to work exclusively with such a patient group is demanding, and thus considerable staff support is necessary to prevent burn-out. In addition to multidisciplinary, especially trained carers, another important factor in the successful care of deliberate self-harmers is the provision of follow-ups. The need for this was only too evident in the revolving door patients we saw at Miles Terrace.

The self-harm we come across in psychiatric care in the Western World can be put within a global and cultural context, as does Armando Favazza, the founder of cultural psychiatry (Favazza 1996), Accounts of a contemporary Moroccan group of mystical Islamic healers who work themselves into a ritual frenzy and slash open their heads, and serve bread and sugar cubes dipped in their blood for the sick to eat, and Karl Menninger's (1935) contention that some acts of self-mutilation serve to avert suicide, prompted Favazza to pursue the question that if ritual self-mutilation serves a therapeutic purpose for some cultural groups, then can it serve a similar purpose for a mentally ill person (Favazza 1996: xi)

If self-harm represents an attempt at self-healing, some individuals cry out for help louder than others, displaying a combination of self-harm and eating disorders. Such a co-occurrence was definitely visible at Miles Terrace. Most cutters as well as people with eating disorders are women. Both self-harm and eating disorders has been found to have a

much wider occurrence than expected, a that has generated a wide body of literature (see Favazza, Derosear & Conterio 1989:352-361). Brenda and William Parry-Jones (1993:394-402) located the earliest literary reference in a bizarre story about Erysichthon in Ovid's *Metamorphoses*. It seems that after scorning the Gods and violating the sacred groves of Ceres, Erysichthon was punished by an insatiable craving for food, which prompted him to cannibalise his own limbs⁴⁶. The Parry-Jones also provide the case of Dr Samuel Johnson, who appears to have been a lifelong bulimic and ruminator given to melancholy, tormenting scruples, obsessive-compulsive rituals and hypochondriasis. His companion and biographer James Boswell describes Johnson in the following way: "such was the heat and insatiability of his blood that not only did he pare his nails to the quick; but scraped the joints of his fingers with a pen-knife, till they seemed quite red and raw" (see Parry-Jones, B & Parry-Jones, W.L. (1993:394-402). However, although the above two cases refer to men, what is striking in the literature, is that the connection of skin-cutting and eating disorders is more present in women than in men. And even though Miles Terrace did not offer any comparative observation with regard to gender differences, this connection of self-harm and eating disorders was visible.

Cross (1993:41-68; cited in Favazza 1996:40) related the connection between self-harm and eating disorders in women to the fact that women (according to him) perceive their own bodies as mysterious and uncontrollable. The control that is made possible through food intake and self-harm represent, he suggests, attempts of the woman to own her own body, to perceive it as self rather than as a mysterious other. Such 'self-control' over the body allows the woman to know something that would otherwise be for her uncharted and unpredictable. Thus, for Cross, the self-harm and eating disorders of a woman become her way

of coming to terms with the element of ambiguity, paradox and discontinuity in her experience of her body!

While Cross notes that self-harm occurs right across the board of different levels of functional backgrounds, he states that a further wedge is driven into the mind/body split in those women who grew up in an environment of severe physical pain, sexual abuse, or parenting that strongly lacked empathy. In Cross's perspective, self-harming behaviour can be explained as a developmental deficit, a situation where a "psychological chasm between body and self" has been erected. For Cross, it is not so much the level of abuse, but the fact that the connection between the parent and the child's needs has been severed. Thus in his view, since different individuals have different thresholds with regard to pain, the important point is how pain, what ever the level felt, is incorporated into the developmental journey that paves the path to self-harm. According to Cross, self-harming behaviour allows bridging that chasm between body and self in a kind of internal projection which transforms psychological problems into concrete, physical ones. This way, the body serves as whipping boy as well as solace. In his words, "the metaphorical destruction between body and self collapses: thinness is self-sufficiency, bleeding emotional catharsis, bingeing I the assuaging of loneliness and purging is the moral purification of the self" (Cross 1993:: 41-68)' According to Cross, this process is doomed to fail because the body comes to resent its task master; "it escapes control and inflicts its own persecution, as body and self constantly shift roles of victim and victimiser, master and slave" (*ibid.*) which hints at powers that are forever at play as long as there are more than two people around.

Favazza, in considering the topic of cannibalism, puts these developmental insights into the larger context of society. If anything, the fact that Western societies see cannibalism as the ultimate ghastly antisocial act of aggression, makes it more interesting from an anthropological perspective. In the 1930s, Malcove (1933:557-561) arrived at a theory according to which childhood fear of mutilation resulted from the practical experience of learning to eat, as children identify with food. Initially, the act of eating is rewarding, hunger is satisfied, albeit temporarily. Later in life, self-mutilation offers other primary gain in the temporary respite from unpleasant experiences such as anxiety, tension, depersonalization, and racing thoughts. Similar to Cross's theory, food and self-mutilation present a source of solace. Much psychoanalytic thought has gone into the various ways children exert control over their environment, their parents, through exercising control over their bowel movements. If one goes with an identification of child with food and child with bowels, maybe more apparent to some than to others, such behaviour can be seen, as prototype of self-mutilation, as a retaliation against an abusive adult. For this reason, Malcove (1933: 557-561) sees eating as a cannibalistic procedure.

Setting out to research self-harm, Favazza was disturbed by the bad press given to self-mutilators in the mental health literature. Portraying self-harmers as exasperating patients who demanded enormous amounts of professional attention, a large part of this body of literature does in fact focus on the therapist's struggles to maintain a sense of equilibrium in dealing with the idea of the cannibalistic violence of these patients rather than the experience of the self-harmers themselves (Favazza 1996.: xiv). According to Favazza, cutting is most directly related to relief of psychological distress. It is also symbolically associated with healing and salvation. Skin cutting is much more prominent in women

than men. It is also the most common type of pathological self-mutilation by adolescents. He explains mutilative acts of mentally disturbed adolescents as attempts to escape feelings of loneliness and abandonment and to attain the heightened self-awareness that often leads to change and maturity. "They are desperate, primitive attempts to achieve social acceptance and integration into the adult world. They are pacts, unconscious and sealed with blood, indicating the adolescent's desire to be reconciled with society" (Favazza 1996:281-282).

I certainly do not claim to understand self-harming fully. If anything, facing incidents of self-harming behaviour while on the staff team at Miles Terrace gave me an opportunity to experience myself, not so much my reaction to the harm done, that came much later, but rather my own ability to function in the face of shock, and my helplessness in the face of my preferred course of action being obstructed by the rules and structure of the crisis service.

The social environment can play an important role in the onset, course and spread of any form of mental ill health, and Miles Terrace was designed with the importance of the environment in mind, even though in practice, the ideals of the systemic approach were maybe less than ideal. With regard to self-harming behaviour, literature exists as to the identity that comes with it. Podvoll (1969: 313-221) observed a distinctive identity that cutters or slashers develop on hospital wards, an identity that does not only situate the self-harmer in the ward setting, but also creates and feeds into the pillars that support it: self-harming behaviour is seen as a pathological symptom and must be controlled, which casts the carer in the role of reinforcer of rules. On the flipside of the coin, such behaviour can be seen as 'something seemingly more honest, pure, or disciplined' than other behaviours', as something which

demands respect, envy and collusion. In this way, the reaction of the staff to the self-harming behaviour can be a considerable influence as to whether the cutter continues or ceases.

The policy at Miles Terrace was not to encourage such behaviour. Rather than giving first aid, the staff were meant to pass the first aid box and have the woman do it themselves. Like much of the pathological behaviour at Miles Terrace, much of the self-cutting was part and parcel of the maladaptive behaviour of recurring cycles of crisis. The reality was that many of the women that came to Miles Terrace came again and again, their crisis never resolving in ways that would allow them to step out of the cycle. And confronting the woman with the reality of the self-harm by having her bandage herself up, was part of a strategy to break that cycle.

SLIGHT WELTS⁴⁷

slight welts,
red, mounded ridges
rising
to that slender
ribbon split of skin.
ruby-red bleeding,
but not quite.

dancing down the base
of thumb and wrist,
delicately cascading,
but stopping short

as though
some invisible dam
had cut them off,

from reaching
that perfection
of repetition and rhythm;
decorating my thin
and densely scarred arm.

Lady Gish

Like any psychiatric construct, attempts to understand self-harming behaviour as a DSM (Diagnostic and Statistical Manual for Mental Disorders) sanctified pathology have been criticized, but by definition of being a conceptual classification, a nosology can only ever get so close to actually treating diseases, to understanding them⁴⁸, and to appreciating the fact that part of any disease or illness exists or is created in the eye of the beholder that perceives it as such, thereby granting it status and street cred. This ill health creating gaze does not necessarily have to come from the outside; with regard to the identity that is given by an illness and filled by a patient, an aspect of this gaze is internalized, in the form of the anticipated behaviour of the surrounds, the family, the care-givers. Temple and Harris make an interesting point: although there are epidemics of self-harm, usually in hospital settings, self-harm is generally defined as evidence of mental illness and as such, as an individual problem. This has consequences for treatment. Re-defining self-harm as a social act as well as an individual one has implications for how people who self-harm are seen and treated (Temple & Harris 2000). Going back to the gaze, in addition to changing how self-harmers are seen, it would also effect a shift in how self-harmers perceive themselves.

The identity a self-harmer constructs in an institutional setting is underpinned by a multiplicity of factors that feed into it. Certain circumstances might give more explanatory clout to some factors over others: psychodynamic and developmental approaches, which in the great scheme of medical science, are not rated very highly, may best explain cutting and burning, and many types of stereotypic acts of self-harm seem to make most sense through the lens of behaviourism, which, based as it is on the quantitative measurement of observable facts, is rated highly (see Favazza 1996:282).

SOCIAL FACTORS LEADING TO SELF-HARM:

Social factors can clearly feature strongly, as in explaining the self harm in prisoners, or in those in similarly institutionalised circumstances. One important example relates to a locked adolescent psychiatric unit discussed by Crabtree and Grossman (1974:350-359) in the mid-seventies⁴⁹. The locked unit had a high incidence of self-mutilation, patients ran away from the hospital as far and as often as they could, and other disruptive factors featured. Conditions were so bad that for Crabtree and Grossman the locked doors overshadowed any positive effects, such as the provision of containment, safety and security in dealing with acutely psychotic, suicidal and impulsive behaviour. Locked doors instead evoked “the breeding of institutional mistrust, the development of staff mistrust and rigidity, and the promotion of regressive behaviours” (Crabtree & Grossman 1974: 350). Things were so bad that the decision was made to open the doors, not without comprehensive preparation of both parties, staff as well as impulsive patients. The results were astounding. The first month saw a decrease in self-mutilation by 94%, along with a 73% decrease in elopements in addition to a 69% decrease in disruptive incidents. At the end of the year, the self-mutilative episodes had not only decreased by 67% overall, but were also more spaced out with a considerably lower occurrence of ‘epidemics’ of self-mutilation. According to Crabtree and Grossman, the open doors represented an increased sense of security and safety for a majority of patients and staff alike.

Another example that highlights the importance of understanding social factors is Ross and McKay’s ‘carving study’ at a Canadian correctional facility for girls in the late 1970s (Ross & McKay 1979). There were 136 girls at the correctional facility, and of them . 86 had carved their

bodies. Having gone through all traditional approaches including solitary confinement, medications, lectures, threats, counselling and increased recreational activities, the administration of the correctional facility was at a loss and brought in Ross and McKay. Ross and McKay's initial increase of intensive psychotherapy was not on for a winner either, and instead produced a tenfold increase of carving. Various other behaviour modification programmes also failed to yield any decrease in carving, at least initially. Ross and McKay instituted a reward-based economy programme, in which the girls earned poker chips for good behaviour which enabled them to purchase goods and privileges. Such rewarding of good behaviour was paired with the withholding, on the part of the staff, of a negative or corrective response to carving. When this basic economy-model failed to produce a reduction in carving, an additional factor was introduced: girls in the token economy were provided with specific training in reinforcement therapy principles and encouraged to utilize these principles in attempting to modify the behaviour of their peers (Ross & McDay 1979: 315)⁵⁰. The introduction of this feature into the economy programme did reduce the total number of carving incidents slightly, but the behaviour persisted in half of the girls. The situation completely changed when a view of carving was presented as "the epitome of personal freedom by which they could reassure themselves that they had some mastery over their fate" (*ibid.*). This understanding was the basis of a strategy of co-opting. Co-opting presupposed the girls' embracing the above understanding of their carving as a free use of their personal freedom as their personal business – couched within the context that by demonstrating the mastery they had over their own fate. Thus, by actually carving, the girls came to understand that they played into the hands of the staff at the correctional facility, whose control they opposed. According to this logic, carving benefited the staff as it created

more excitement. Ross and McKay managed to convince the girls that while it was entirely up to them how they chose to use their freedom whichever way they wanted, claiming their autonomy by refusing to carve was even better than to carve. This way, the girls moved up in the perceived hierarchy from research objects to research assistants; the girls with the most influence were made paraprofessional therapists and, eventually, programme directors for a cadre of girls. Immediately after girls were proclaimed 'therapists', their adjustment to the institution improved markedly. The use of this approach on one troubled and troublesome girl is instructive. Her pathology was relabelled by referring to "her manipulateness as social skill, her unreliability as flexibility, her domineering as leadership, her histrionics as creativity, her callousness as pragmatism, her suspiciousness as insight (*ibid.*)" Once a 'therapist', the girl manipulated her friends into working for her and picked several assistants, whom she trained in simple behavioural techniques. Those techniques were not only for use with girls whose behaviour caused withdrawal of privileges for the group, but also with staff whose behaviour was not to their satisfaction. Not a single incident of carving occurred among the girls who acted as therapists for the duration of the five months that the co-opting programme was up and running. Notwithstanding the considerable reduction of carving incidents, the co-opting programme did come to a stop. Ross and McKay explained this with a disgruntlement on the part of the institutional staff, who were not only forced to abandon traditional roles, but who also had their power reduced which went along with diminished status. McKay and Ross saw the staff as miffed at their conclusion that clinicians were not needed. As soon as the old programme of individual and group psychotherapy and behaviour modification were reinstated, supplemented with a side order of some new programmes, a resurgence

of carving followed. "We should have co-opted our colleagues," commented McKay and Ross.

It is worth drawing attention to the fact that this experiment was conducted in the seventies, the late seventies, but the seventies nonetheless, which were characterized by a climate of experimentation that finally gave in to the power-crazy 1980s. How happily McKay and Ross would have surrendered their own power, from which stemmed their satisfaction at the reduction in carving incidences, is left to our imagination.

Both studies, the McKay and Ross's Canadian correctional facility and Crabtree and Grossman's locked adolescent psychiatric have one factor in common: the primary line of attack with regard to reducing the self-harming behaviour is an administrative one. Favazza calls this administrative therapy. There are some areas of overlap between such administrative angles and the systemic approach taken at Miles Terrace, although Miles Terrace aims to incorporate systems that pre-exist the women's stay at the crisis project. This is where the parallel runs out as Miles Terrace was conceived as a temporary reprieve from the outside world, as a liminal place in which the outside order could be restored, or rather, in which the individual could deal with their upheaval in a way that would allow them to re-enter the world outside the crisis house. McKay and Ross's girls in the Canadian correctional facility and Crabtree and Grossman's adolescents in the locked ward were in there for longer than Miles Terrace's maximum target time of 28 days. As with most other forms of mental ill health, the most troublesome of all self-harmers are the career patients who have spent most of their lives in various mental institutions and whose problems often started in

childhood. Some people have become wised up and have perfected strategies that allow them to resist all attempts to be deinstitutionalised.

To me, highlighting ways of dealing with, of treating self-harm is more important than erecting theories with regard to their aetiology, while ultimately, one will lead to the other. Other than what Favazza calls administrative therapy, he lists a number of other approaches. Biological approaches in the form of SSRIs, selective serotonin reuptake inhibitors, have been successful not only as the antidepressants, as they are marketed, but also in the treatment of panic disorder, obsessive compulsive disorder, eating disorders as well as self-mutilation (Favazza 1996:290). While medication can be enormously effective, at times there can be an inbuilt expiry date, when its effects diminish or cease altogether, at which point the self-harming behaviour can resurface, although not necessarily as strong as it was initially⁵¹.

Other lines of attack are psychological and alternatives of social treatments. The following treatment principles for repetitive self-mutilators were defined by Tantam and Whittaker (1992: 451-464): First and foremost is the relationship between carer and patient, with the carer being calm, reframing self-mutilation as an expression of feeling, avoiding threats or promises, sticking to limits, leaving the responsibility with the patient while sticking with the patient. This certainly characterized the policy at Miles Terrace. It can however be tricky, and presupposes great maturity on the part of the carer. Trying to save the self-harmer from themselves or from their families can easily backfire. If a special need is met, the carer will recognize this, but involuntary commitment or home visits can lead to a feeling of rejection on the part of the patient as their real need has been unrecognized or cheated because the caregiver has been unable to trust them to sort out the

situation for themselves. Furthermore, Tantam and Whitaker list the importance of breaking the habit, which involves coping with withdrawal symptoms and increasing the determination to change. And lastly, the maintaining of change, which is achieved through rewards for new behaviour, minimizing medicalisation, resolving emotional conflicts, tackling coercion and training in intimacy. Hawton (1990)⁵² identifies further principles with regard to management, and in line with Tantam and Whitaker's last point, in-patient time should be brief.

In addition to drug based, cognitive, psychological and social approaches to treatment, Favazza also mentions psychodynamic therapy, which is probably the most common long-term treatment for moderate and mild self-harm. Especially expressive forms of psychodynamic therapy that depends on the verbal articulation of the behaviour in transference. Furthermore, cognitive therapy aims to change maladaptive thoughts that underlie self-harming behaviour (1985: 119-120)⁵³. Behavioural therapy has also been used a lot with regard to self-harm, albeit primarily with mentally retarded patients, and self-harm is viewed as a learned behaviour that is maintained by positive and social reinforcement.

As my experience of the women at Miles Terrace was largely informed through my dual role as researcher and care provider, looking into the therapies currently available was the most valuable approach to self-harm. Favazza's administrative therapy is the last in a long line of therapeutic approaches, but nevertheless one that can have a profound effect. As a result, it is nevertheless limited to the institution in which it occurs. But, as I already mentioned, there are cases, where certain institutional surroundings cause self-harm to surface.

There is something in self-harm that makes it hard to deal with. Suicide, while shocking, can be assuaged by contextualizing it with fate and even the relief that the victim is dead. Self-mutilation, as Favazza points out (Favazza 1996:289), is horrific and seemingly senseless, but more so, the victim is very much alive and able to haunt us in the flesh. The power of self-mutilation to mystify and horrify even seasoned therapists seems to derive from more than what are generally considered to be the sources of countertransference. The physician's horror goes so far that some A&E doctors make no attempt to distinguish the two (see Solomon & Farrand 1996: vol.19, 111-119). People who do distinguish often refer to such behaviour as 'deliberate' self-harm. Using the qualifier of intentionality, effectively creates a label that implies premeditation and wilfulness, which many self-harmers object to (Pembroke 1996).

The issue of intentionality is called into question when looking at first incidents of self-harm. Researchers were surprised to find self-harming behaviour in children. This raises the following question: at which point can children know the consequences of their own behaviour. For example, should a baby ever be in the data of a self-harm study? Different researchers have decided on different answers. Scott and Powell and Hawton and Goldacre (1982: vol.141, 166-170), for instance, choose 12 as the minimum age of inclusion for their studies. However, personal accounts by people who self-harm suggest that they began when they were under 12 (Solomon & Farrand 1996: vol. 19, 111-119). As Temple and Harris⁵⁴ point out, there is no one age at which a definition, a diagnosis of self-harm is more right than at another. "Even if we leave them out", Temple and Harris (2000:) state, "the problem still remains of establishing at what age someone can be said to know the consequences of their actions."

This question of definition is of little interest to Favazza. He would probably say that such definitions are a way of escaping from the real issue, that hiding within such questions offers a means of protecting oneself from the horror of self-harm. Favazza believes that in addition to the standard reasons, self-mutilation challenges our equanimity because “its bloody tendrils reach out to the sacred”, the sacred that has been sanitized and rendered palatable in the Christian rite of transubstantiation, the sacred that releases a powerful energy which was noted by Frazer, Tyler and Smith in the early days of anthropology when there were no fashion constraints to talking about energies.

“In sum, even though deviant self-mutilators are not liminal beings, even though their acts have no real transcendence, even though their use of religious symbolism is based on private rather than public delusions, they open a window on to the turbulent, bloody space of the Sacred. It is a space that truly great shamans can visit briefly, although the voyage is dangerous and fearful. So can adepts of Tantric Buddhism who have achieved the great liberation through hearing in the bardo mediations. For most of us, however, it is a space in the cosmos and in ourselves that remains hidden. When self-mutilators draw us to this space, we resist and feel “helpless, horrified, guilty, furious, betrayed, disgusted, and sad (Favazza 1996:289-290; also see Rinpoche 1975 on the Tibetan Book of the Dead).”

Few people want to be drawn into this space. Most resist, and instead go into over-drive to offer help and care. If help is rejected, how easy is it to be hurt, to take this rejection personally. Sheer helplessness on the part of the carer is one of the most difficult situations to be in, provided the carer is not in an emotionally blunted space that does not leave any capacity for real care, care that is anything more than perfunctory.

Severe self-harm demands a high degree of composure on the part of the carer. Babiker and Arnold found that patients who are suspected of having harmed themselves are sometimes seen as less deserving of sympathy and treatment than patients who are classified as having injured themselves accidentally (Babiker & Arnold 1997).

Favazza states this in a more comprehensive way:

“Self-mutilators have a difficult life. There is significant physical morbidity when an irreplaceable body part such as an eye, hand, or penis is destroyed. Chronic self-mutilators often require medical attention for their cuts and burns. Hair pullers and others who interfere with wound healing may endure repeated infections. Many will make bona fide suicide attempts in desperation over their inability to control their behaviour. Social morbidity also may be great. In addition to disfiguring scars, most chronic self-mutilators usually feel empty inside, misunderstood by all, a burden to others, and scared when close to anyone. Put simply, no one loves self-mutilators. Their very presence seems to threaten the sense of mental and physical integrity of those around them. Even surgical personnel who are used to amputating limbs and treating mangled accident victims may display uncharacteristic poor judgment when confronted with these patients; for example, only a half-hearted (or no) attempt may be made to reattach a severed genital. Not a few chronic cutters have recounted that, because of the brutish treatment they have sometimes received in emergency rooms, they will falsely admit to a suicide attempt in order to facilitate a warmer reception. (Favazza 1996:246)”

According to clinical practice wisdom, there are few therapists who can deal intensely with more than two cutters and burners at any one time. During my time at Miles Terrace, my own composure was challenged. I

was torn between the compulsion to give care, to help, and the frustration that they would just go and cut again, that my help was futile. After my compassion had been stretched to the limit, without producing any results that were apparent to me, and exposure to all sorts of self-harm, fairly 'harm'less to laceration of genitals made my equanimity wear thin, to use the word that Favazza favours, even though I'm not sure equanimity captured my approach to self-harm. What enabled me to uphold any measure of equanimity was the vision of what lay beyond my time at Miles Terrace.

What struck me was the different contexts that produced parallels between the self-harming body of the individual with the body of society that can only go on after a ritual passage which implied some sort of chaos, and when writing this chapter, I never expected to retrieve Carlyn Marvin and David Ingle's totem of American patriotism from the back of my memory. But maybe it is not so surprising, given my undergraduate diet of Genep, Turner and Douglas, all of whom talked about transition in some way, and more specifically about rites of passage. Mary Douglas (1992) emphasizes the danger that is associated with all social transition, as temporarily, people in transit have no place in society and their status is undefined. Such transitional danger does indeed resonate with the field of self-harm, as self-harmers indeed are perceived as dangerous, not only as the threat to themselves that they pose, but on a more gut kind of level, the danger they pose to what we have to face in our reaction to them. It is remarkable, that something that poses such a fundamental challenge to human empathy, something so defying of easy comprehension attracts the structuralist model van Genep⁵⁵ devised a century ago. Or maybe it is precisely the fact that van Genep's categories of the sacred and the profane are on the one hand easy to grasp, precisely because they represent a conceptual model

describing the sacred, which cannot be fully known, while the sacred, as elaborated by Douglas, is dangerous, and yet its shimmer is luring.

Van Gennep had theorized about the restitution of whole societies at the turn of the 20th century, but thanks to the Anglo-centric publishing industry of the English speaking world, Turner developed the concept of the liminal just at a time when the notion of the 'individual' was all the rage, and hastened to apply it to status changes of an individual within a community. A concept that yields certain parallels, is Bakhtin's notion of the carnivalesque. Writing some two decades after van Gennep, the Russian theorist talks about the scatological writing of the French Renaissance writer Rabelais. Looking at *Rabelais and His World*, Bakhtin uncovers the peculiar language and practices of the carnival environment, which is very different from any contemporary version that pales in comparison to the unbridled lusting, crazed bingeing, primordial gaiety that did involve physical mutilation that occurred in the carnival environment of days past. Rabelais' Renaissance carnival culture involves the "temporary suspension of all hierarchic distinctions and barriers among men ... and of the prohibitions of usual life (Bakhtin 1984:15)". While Renaissance Carnival is perceived the real thing, involved primordial gaiety, the term "carnavalesque" refers to the carnivalizing of normal life. This can take one of three forms: ritual spectacles, comic verbal compositions, and various genres of billingsgate or abusive language.

Carnivalisation "makes it possible to extend the narrow sense of life(Bakhtin 1984:177) ", or, in Foucault's words (1975), it helps to extend our participation in the present system. Underlying the desire of the carnivalesque to uncover, undermine, to destroy even, the hegemony of any ideology that seeks to have the final word about the world, and

also to renew, to shed light upon life, the meanings it harbours, to elucidate potentials; projecting, as it does an alternate conceptualisation of reality. In this sense, dialogism is a fundamental aspect of the carnival - a plurality of 'fully valid consciousnesses' (Bakhtin 1984: 9) 'Two voices is the minimum for life, the minimum for existence, Bakhtin says (1984:252), if dialogism ends, 'everything ends.' While there is a dialogic dimension to self-harm, I am not sure whether it is the element that stands out most. Likewise, even though the concept of the carnivalesque takes its roots in a deeply physical experience, it is one of bauldness, that sits uneasy with the sacred or sacrificial element of some forms of liminality. For me, despite its aspects of bodily roots and dialogic communication, the carnivalesque fits more awkwardly with self-harm than other liminalities.

In whichever way the liminal is conceived, it has been a very powerful concept for theorizing self harm, one that grants us explanatory power by letting us impose a structural order on a phenomenon that can be challenging to understand conceptually and emphatically exhausting. But more so than any explanatory powers that liminality might grant us as part of a developmental model that posits the regeneration of individuals and societies, it is the connection it throws up with something that otherwise exhausts our perceptual and emphatic boundaries. When Turner talks about anti-structure to describe both liminality and what he calls *communitas*, he does not mean it as a structural reversal, but rather as the liberation of human capacities of cognition, affect, volition, creativity, etc., from the normative constraints incumbent upon occupying a sequence of social statuses (Turner1977).

The liminal is dangerous, and as our human experience is an embodied one by default, any threat to this immediate level of existence and

experience resonates in a very raw way. Experience can be fuzzy and inchoate at normal times; for people with mental ill health it may be even more so than for others. But an embodied experience poses very clear cut limitations in the environment in which it occurs.

FAKIR MUSAFAR

I cannot finish a discussion of self-harm without a mention of Fakir Musafar, a professional piercer, and the founder of the modern primitive movement of body-modification. Musafar met Favazza in 1990, when they both appeared on a television talk show in San Francisco, Musafar's stomping ground. The programme was on self-mutilation, primarily that of young women who locked themselves in a private space and slashed themselves with razor blades. In addition to Favazza and Musafar, another guest was Raelyn Gallina, who is renowned for and openly does cutting on others in a socialized ritual. A less illustrious guest was a young woman cutter from Los Angeles who had a long history of isolated cutting and psychiatric treatment. As Musafar says "I felt sorry for Dr Favazza. Favazza did not get much of a chance to present his side of the story on the program. Raelyn and I (Fakir) had filled the audience with highly modified people, all of whom were pierced, tattooed, or cut with intricate patterns – and were very vocal and positive about their experiences.

Musafar tells us (1996) that after the programme, the young woman cutter from Los Angeles connected with other women in the audience whose urge to express feelings by body acts had been more social and sanctioned than hers. In listening to their conversation, Musafar had the feeling that if this woman had been in the San Francisco area and had connected sooner with a supportive peer group like this one, her shame and negative experiences as an isolated cutter might have taken a different turn. Who knows (Musafar 1996:329-330)?"

In the early 1990, as the Modern Primitives movement had come into full bloom, Musafar worked as a professional piercer. Monthly tattoo and piercing parties held in backrooms of restaurants in Los Angeles in

the 1970s had never produced more than ten to fourteen people. Musafar recalls one meeting in 1975, when they tried to list everyone they knew of in the subcultures of Western society who had pierced nipples. There were only seven people – all males except for one woman who had been pierced in 1965 (Musafar 1996: 326). These days, even the hunky baseball boy in safe southern set US teenage soap *One Tree Hill*⁵⁶ sports a nipple piercing.

Favazza has done extensive research on body-piercing, marking and modification rites in so-called primitive tribal societies, about a dozen reasons kept cropping up. It is hardly surprising that the first reason was rites of passage. It followed creation of lifelong peer bonding; a sign of respect or honor for elders and ancestors; a symbol of status, belonging, bravery or courage; an initiation into greater mysteries or unseen world; a protection from evil spirits/energies; opening for beneficial spirits/energies; a rebalancing of body and /or spirit energies; a healing of diseased body, self and others; a healing of wounded psyche, of self and others; a healing of tribal disorder and creation of tribal bonding; a tribal/community connection to greater forces, especially in times of chaos or disaster.

When Musafar asked his clients about their motivation he was surprised that most of them responded. Their reasons were largely the same as the ones he had already identified, headed by rites of passage or memorial. But there were some that were never or seldom heard in the tribal cultures. It was particularly rape victims who cited a sad commentary on the abusiveness and disregard for other's sacred space in our society, as they underwent the ritual of getting pierced to claim their body back as their own after it had been taken by another without their consent (Musafar 1996: 32).

With the aftertaste of the repugnance that self-harm can inspire in the carers still lingering, I will end on Musafar's words on the other side of the fine and mythical line, on the other side of what can be explained by structural and functional theories with regard to transformation.

“Why have people through all ages and most cultures sought expression of life through the body, through its sensations and modification? I've felt the 'urge' myself and have come to terms with it. I've investigated this phenomenon for almost fifty years, and I've found it to be a significant part of human development. The more I look, the more convinced I am that the phenomenon wells up from some deep inner source – perhaps a behavioural archetype that may be encoded in our genes. This past year, I had the opportunity to explore the phenomenon's universality. As a young man, I was emotionally moved by the body worship of the Savite Tamil Hindus in such cultural rites as the Thaipusam Festival. As a teenager, I had seen photographs of these Hindu in old National Geographic magazines – on the streets in Southern India with hundreds of limes or other objects suspended from their bodies by hooks pierced through the skin, in huge arched frameworks supported by long iron spears embedded in the chest and back, with long spikes pierced through their tongues and cheeks. The glazed look in the eyes, their seeming indifference to pain, said something.

I vowed to witness this event some day, to soak in and understand firsthand what was happening inside these people whom I had only observed externally in pictures. So after waiting nearly fifty years, I finally had my chance to attend the Thaipusam in Penang, Malaysia. I

was not disappointed. Over 200.000 people had gathered in Penang, 500.000 in Kuala Lumpur, and another 250.000 in Singapore. These were not tourists but devotees with their priests, family, and friends assembled for openly sanctioned public worship through the body. In Penang, the procession streets were purified by smashing over two million coconuts; the milk was believed to clear the way for the passing of the image of Lord Muruga (also known to the Tamils as Murugan, Subramanya, Velan, Kumara, and many other names, each indicating an aspect of an unseen deity.)

The atmosphere on the morning of the body-piercing and procession ritual was intoxicating. As I watched group after group of Tamil Hindus get pierced to cries of 'vel, vel' and let themselves enter deep trance states, I began to feel the utter reality of the deities whom they were invoking. Murugan was there. Lord Siva was there. Goddess Kali was there. All welling up from somewhere deep inside the devotees. I had felt this before in my own rituals and in the ones I had conducted for others in California But never of this magnitude. What I felt in Penang was not sickness, but rather a state of grace."⁵⁷ (Musafar 1996: 333-334)

CHAPTER VII: NARRATIVE

All else is means; dialogue is the end.
A single voice ends nothing and resolves nothing.
Two voices is the minimum for life.

Mikhail Bakhtin

Even at its scientific best, medicine is always a social act⁵⁸.

F. Davidoff

“What else could underline so neatly that it is literature which⁵⁹
communicates the complex truths?”

FROM EVIDENCE BASED TO NARRATIVE BASED MEDICINE

Someone once made a comment to the famous landscape photographer Ansel Adams, that there were no people in his photos. In any photo, there are always two people, Adams replied: the photographer and the viewer. Likewise, an illness rarely occurs in isolation, there is always someone with a symptom and another one who perceives it. This is the case for all types of illness, not only for mental health issues. As psychiatry is firmly located in the medical model, I feel that my discussion of mental health benefits from looking at some of the questions that preoccupy medicine in general and feed into the ways health or ill health is perceived.

Any perception of illness can only be one of many, it can be a societal perception, that of a family, a carer's perception. Let us start with the medical encounter, where one party is trying to make sense of the other person's symptom in order to be able to give effective care. At the basis of such care, according to the medical perspective, lies the diagnosis,

and there are different ways to arrive at a diagnosis. However, according to the dominant medical model, which is governed by scientific discourse, the way forward is based on evidence based medicine.

Sacket (1996) explains and promotes this such a medical model in the following manner:

“Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centred clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer.” (Sackett in: Sackett, Rosenberg, Gray, Haynes & Richardson 1996: 71-72)

Greenhalgh (1998), one of the strong critics of such a position, points out that evidence based medicine is often incorrectly seen as resting on the assumption that clinical observation is totally objective and should, like all scientific measurements, be reproducible. He goes on to note (*ibid.*) that evidence based clinical decision making involves the somewhat counterintuitive practice of reifying the individual patient by assessing the clinical problem at hand in the light of epidemiology and Bayesian statistics, the aggregated results of hundreds or thousands of 'comparable' cases in a distant population sample, expressed in the language of probability and risk.

In Western medicine, a medical encounter takes place in a highly structured transactional space, in which the behaviour of both parties is determined by socialised expectations. The American philosopher Leder (1990: 9-24) saw a diagnostic encounter as a "text", a text that he distinguished from other human narratives or modes of communication in so far as it was a story about a "person as ill". Such a text leads to four separate secondary texts: an experiential text, a narrative text, a physical or perceptual text and an instrumental text.

The experiential text refers to the meaning the patient assigns to the various symptoms, deliberations and lay consultations in the run up to the clinical encounter. The narrative text is the doctor's interpretation of 'the problem' from the story the patient tells about his or her illness. The physical or perceptual text is gleaned by the doctor from a physical examination of the patient. And the instrumental text is what the blood tests and x rays 'say'. X-rays or MRI scans involve complicated technology that determines evidence which would otherwise evade human perception. In this sense, according to Heath "machines are employed to "co-author a fuller story" (Heath 1995: 17-21).⁶⁰ Such

supplementation can however never substitute the real thing of the clinician's attention. For Leder, insisting on an "objective" analysis of diagnostic tests is pointless, it is a flight from interpretation, and one that is doomed to fail Leder 1990: 9-24).

And, as Greenhalgh points out, the frustration physicians experience when trying to apply evidence based research findings to real life case scenarios is well documented and occurs most commonly when the interpretive framework is abandoned and physicians attempt to get by on evidence alone (Greenhalgh 1998; also see Grimley Evans 1998 460-464; and Asch 1995:846-850)⁶¹. In their critique of evidence-based medicine, Williams & Garner (2002: 8-12) conclude that it "must be underpinned by the need to understand and respond empathically to the illness in accord with the patient's experiential perspective", and they go on to underline the importance of engaging with the humanities as part of professional development. Similarly, rather than abandoning the interpretive dimension of the medical encounter, Greenhalgh argues (1998) that appreciating the narrative nature of illness experience and the intuitive and subjective aspects of clinical method does not require the physician to reject the principles of evidence based medicine. Nor does such an approach demand an inversion of the hierarchy of evidence so that personal anecdote carries more weight in decision making than the randomised controlled trial. In fact, genuine evidence based medicine presupposes an interpretive (and textual) paradigm in which the patient experiences illness in a unique and contextual way. It is only within such an interpretive paradigm that a clinician can meaningfully draw on all aspects of evidence to reach, including their own case based experience, the patient's individual and cultural perspectives as well as results of rigorous clinical research trials and observational studies, to reach an integrated clinical judgment.

The need for such integrated judgment prompted Arthur Kleinman to develop his patient mini-ethnographies (1988:230-251) in the 1980s, which emphasized the fact that when doctors take a medical history they inevitably act as ethnographers, historians and biographers, required to understand aspects of personhood, personality, social and psychological functioning, and biological and physical phenomena (see Hunter 1996:303-320) and Greenhalgh & Hurwitz 1999:48-50). This multi-factorial, multi-levelled view has however only partly filtered through into medical practice, as Jones points out, even the most pompous professors have been known to warn their students, "*Listen to the patient: he or she is telling you the diagnosis* ." Jones 1999:253-256) " Kleinman, however, was well aware of the fact, that it was not the diagnosis his patients were telling him. He also knew that no patient ever talks about isolated symptoms. Any symptoms that are presented by patients inevitably occur within an Interactional framework. The more about this framework the doctor understands, the easier for him to get to the heart of the matter. Kleinman called it the patient's explanatory model of his or her illness. He devised eight questions designed to elicit such an explanatory model:

- What do you call the problem?
- What do you think has caused the problem?
- Why do you think it started when it did?
- What do you think the sickness does? How does it work?
- How severe is the sickness? Will it have a short or long course?
- What kind of treatment do you think the patient should receive?
What are the most important results you hope he/she receives from this treatment?

- What are the chief problems the sickness has caused?
- What do you fear most about the sickness?

But not all doctors were as sophisticated as Kleinman, who also understood the importance of the relationship of illness to cultural factors. A biographical note on Kleinman allows a little glimpse on to the epistemic groundwork that underpins his notions about good medical diagnoses: Kleinman, an American married to a China scholar, has conducted considerable of cross cultural research, particularly on depression both in China and the US, and was an important figure in the current edition (DSM IV) of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, the psychiatric bible of the profession. This last edition is the first to make an explicit attempt to include cultural factors^{62 63}

The use by the physician of 'cultural considerations' and 'interpretation' in the diagnosis of illness is big step away from the dominant medical model as described by Greenhalgh, and certainly a long way from the conclusions arrived at within earlier editions of the Diagnostic and Statistical Manual of Mental Disorders. As Norman Sartorius notes about categories of mental illness, such a classification is a way of seeing the world at a particular point in time (Sartorius, *The International Classification of Diseases-10*, Preface vii, Chapter V)⁶⁴, and regardless of whether or not culture has been included in such a nosology that physicians might use for their diagnoses, the issue of interpretation remains. While interpretation has been a central concern of philosophers and linguists, interpretation is a concept with which doctors and other scientists are often unfamiliar, and hence uncomfortable (see Greenhalgh & Hurwitz 1999:48-50).

With regard to clinical medicine, Kathryn Montgomery Hunter, a professor of literature who has a strong involvement in medical education, has made the argument that clinical medicine "shares its methods of knowing with history, law, economics, anthropology, and other human sciences less certain and more concerned with meaning than the physical sciences. But unlike those disciplines, it does not explicitly recognise its interpretive character or the rules it uses to negotiate meaning (Hunter 1996: 225-241)." Puzzled by the medical profession's preoccupation with the gold standard of science in clinical practice, Hunter believes to the contrary that medicine is better characterised as a "moral knowing, a narrative, interpretive, practical reasoning" (Hunter 1991).

The core clinical skills of listening, questioning, delineating, marshalling, explaining, and interpreting may provide the most powerful way of mediating between the very different worlds of patients and health professionals. Whether these tasks are performed well or badly is likely to have as much influence on the outcome of the illness from the patient's point of view as the more scientific and technical aspects of diagnosis or treatment (Greenhalgh & Hurwitz 1999:48-50). And it is the narrative dimension of the medical encounter, where above meaning is created. As Leder noted already, a patient never offers isolated symptoms, he or she always offers their own interpretation. There is always a tension between the complex narrative that a patient brings into the consulting room and a doctor's understanding of what is really going on as formulated in a diagnosis or an idea about pathology. Which account of reality is "truer", the patient's or the doctor's? Can both be true? If so, how? This dynamic is part of every patient-physician

encounter, but it is particularly relevant in mental health care for a number of reasons. The most important reason for the importance of the narrative dimension in the clinician patient encounter is the fact that psychiatry is the only area of specialist medicine in which talking and listening are explicitly understood to be therapeutic (see Brown, Nolan, Crawford & Lewis 1996:1569-1578).

It is then understandable then that psychiatry, more than any other medical field, has been identified as peculiarly culture bound by ethnography and sociology (Kleinman 1980, and Lupton 1994). Moreover, psychiatry lies in an uncomfortable no man's land between conventional medical science and the search for meaning which may extend into political and religious domains (see Stevens on evolutionary psychiatry, 1996). Also, mental health professionals often describe their observations using apparently confusing and contradictory language. As Masson (1992), former keeper of the Freud's archives has argued, when put under close scrutiny, the explanatory models used by medics often seem to cancel each other out, which leads him to think that they may be a way of asserting the therapist's power more than anything else. It is his argument that compared to the professional version, the patient's own story often seems saner.

One important impulse that nudged clinicians from different schools to move away from the search for a normative explanation of a problem came from systems therapy. Instead of such 'normative explanations' Papadopoulos and Byng-Hall (1997), writing on the psychiatric condition of multiple voices and the use of narratives and family therapy in its treatment, pointed therapists towards the search for an appropriate new story for each patient. Another set of systemic thinkers, Anderson and Goolishian (1992), have made strong arguments for the need to

abandon those paradigmatic models that test the patient's experience against some predetermined view of normality. In their view, it is the acknowledgement of the client as an expert that facilitates any possible account of reality, provided that it makes sense in the client's eyes. Along similar lines, Burck (1997), amongst others, proposes a concept of selfhood as something that is produced rather than discovered.

The encounter then between clinician and client no longer serves as a tool to identify hidden truths, but instead is seen as a means of creating previously unformulated truths. Such a new approach is however not entirely unproblematic, and Hoffman (1992) and Frosh (1995:175-190) were not the only therapists to ask questions about the place of professional expertise in such a postmodernist encounter. Patients who come to see psychiatrists looking for certainties, not for deconstructions, are psychiatrists not alienating their; how do professionals retain their professional knowledge, their theories and beliefs, while at the same time allowing the patient's story its full opportunity to evolve, even if it does so in directions the professional might neither expect nor wish?

Many practitioners found an answer in the medical narrative. Launer (1999:117-119) identifies three aspects of the narrative in the client-clinician encounter: firstly, the narrative he takes in the form of a traditional medical history; secondly, the narrative that occurs in counselling as something that needs to be listened to, to allow patients to give coherence to their own history also see Shapiro 1993: 47-53); and thirdly, narrative as a therapeutic stance which involves questioning the patient in a way that explores new meanings which may make a difference to the patient (Launer 1995: 379-389). The last point is of particular interest, and to illustrate it, Launer cites the example of Helen in the 1995 case study.

Helen is a woman in her mid-70s, who sees him every month for her high blood pressure. The blood pressure is however dealt with quickly because Launer and his patient have other important things to talk about: Helen was widowed about 10 years ago and immediately offered to share her home with an elder sister. Tragically, the elder sister began to develop Alzheimer's disease. In the years that followed, Helen was torn between her sense of responsibility and an awareness that her sister's needs could break her own health. She battled to keep the situation afloat, and sometimes we fought together for resources against an inadequate welfare system. Eventually, two years ago, Helen's sister went into a nursing home; recently, she died. She had become mute, doubly incontinent, and unable to recognise anyone, although Helen always visited her daily. So after the blood pressure is measured, they talk about Helen's grief and also her relief, she still has some unresolved guilt about putting her sister in a home; also, she has a terrible sense of waste concerning the seemingly meaningless end of her sister's life as well as the fact that she spent her own widowhood toiling away which now leaves her facing her own old age exhausted and quite depressed.

Is Helen suffering from depression? How does the predetermined, quasi-scientific template of psychiatric diagnosis hold up against the clinician's personal reading of Helen's story? General practitioners, like all clinicians, are under pressure to make a diagnosis. Under pressure from training, from managers, from the medical literature, and from institutions like the royal colleges which exhort us to "defeat depression." Indeed, the depression sound bite of NAMI, the US National Alliance for Mental Illness, goes **TREAT IT – DEFEAT IT.**

But a diagnosis, certainly from a hermeneutics point of view, is actually nothing more than a linguistic construct. Although it is often designed for the needs of one profession, it may well serve others' needs inadequately or not at all (see Armstrong 1996: 119-122). Used thoughtfully, a diagnosis can be a convention that helps the doctor to help the patient. Used without thought, it can become a tool for fending off a doctor's anxiety. It may also distract attention from parts of the patient's story that might create cognitive dissonance for the doctor.

Launer sees one solution to this challenge in looking at his work not just as listening to Helen, nor just as formulating diagnoses, but to see it as asking questions which explore a better story: the story of Helen not as a person in decline who has failed and thus become a psychiatric case but of a conscientious sister who did her best when faced with a terrible dilemma. This type of exploration does not preclude offering Helen the diagnosis of reactive depression or even suggesting treatment with antidepressant drugs, but not without trying to find out if such suggestions fit Helen's view of her story even when she expressly concedes authority to the doctor (Launer 1986: 255-268).

Attempts to reframe mental health issues as stories are hardly ever straight-forward, especially not for clinicians who have been trained in the medical model of objective facts. For those clinicians, a story telling approach may collide rather violently with the concepts of positivist, objective viewpoints. Narratives are not necessarily about categorisation, in fact, they may be about a lack of boundaries. Clinicians who stand at the intersection between the world of stories and the world of categorisation, between the role of interpreter and the ICD-10, the 10th revision of the World Health Organisation's international classification of diseases, may well feel that they are in an impossible position.

Social constructionism does of course offer a way out of this dilemma, and the social sciences and arts have been rife with literature about it for nearly half a century now. It took however a while for the concept of social constructionism to make the leap across disciplinary boundaries. Often cited for introducing social constructionism into the medical world are Burr (1995) and the therapists McNamee and Gergen (1992). Pure social constructionism that sees all types of knowledge, including professional knowledge, as stories that are negotiated as agreed versions of reality, often as a means of exerting power, the sort that has been a tremendous inspiration to anthropological and literary thought, was too radical to be take hold in medical thought. But according to modified versions of social constructionism, some stories may approximate to a testable scientific reality, although they can never quite reach it. Used in this way, social constructionism does not reject medical activity in the name of (some idealised) interpretive purity but rather creates an acceptance of the partnership between patient and doctor in exploring, creating, and testing the efficacy of new stories.

When seen in this light, the medical consultation becomes an opportunity for dialogue between different stories: the patient's biographical one and the doctor's professional one. The doctor's contributions may come in different forms, including interpretations about the family origins of a problem or a conventional biomedical story (e.g. an account of the genetics and biochemistry of schizophrenia). Indeed, if mind and body are seen as interactive, then all medical interventions, including even psychopharmacology, can be seen as an agreed intervention into patients' "storying" of themselves. The doctor's contribution to the story is valuable not as a truth which has prior and superior validity to the patient's truth, but only if the patient finds the

doctor's contributions to the plot useful (which would be Launer's view: 1999:117-119).

To give doctors more cause for worry about the chasm that lies between the dominant medical and social constructionist perspectives on diagnosis and treatment, research by Louis-Courvoisier and Mauron (1002: 9-13) that compares the quality of doctor/patient relationships of the 18th with those of the 21st century suggests that not much has changed.. In both cases, the patient feels misunderstood. For instance, the patient's pain (an experiential, personal story) cannot be translated into the anonymous language of medical theory. Very briefly, it is the argument of Louis-Courvoisier and Mauron that the patient and the doctor not only vary in their respective social constructions of the illness, but they also have different perceptual frames of the suffering and pain of the patient: the personal pain of the patient is non-sharable (also see Le Breton 2001). This fundamental chasm is therefore a permanent feature of the patient-physician relationship. As such it predates the advent of scientific medicine, and is also reinforced by the latter (Louis-Courvoisier & Mauron 2002:9-13).

The phenomenologist, German Plessner (1970), has made a similar argument as that of Louis-Courvoisier and Mauron about physical suffering in the West. The way Plessner saw it, the experience of illness in the West led people to recognise that they 'are' their body, as well as 'having', i.e. experiencing, a body. While being the sick body, the ill person realises that they also 'have' a sick body - a sick body that is distinct from their self. It is distinct insofar as it can be observed as if it were someone else. As a result, the sick both are their illness and at the same time are distanced, even alienated, from the illness (also see Kleinman (1988:27) who notes the export of this western experience of

the body-self dichotomy throughout this century to the rest of the world as a psychological component of modernisation). As Hick notes (1999: 129-140), this classification of diseases based on mind-body split "must be seen as a mutilation of what is perceivable in the individual patient - 'a loss of reality'".

So in addition to different perceptual models between doctor and patient, Louis-Courvoisier and Mauron determined an 'understanding' that a 'real' understanding of another person's illness and pain is not possible, as that illness is unshareable. These are some of the thoughts that float around with regard to why it is so damn difficult to come up with a correct diagnosis or rather an understanding that satisfies both patient and physician. But regardless of how uncomfortable many clinicians are with social constructionism, they are all aware of the trickiness of making a diagnosis.

The narrative dimension of the physician-patient encounter is obviously important. It is also multifaceted, and can be approached at all sorts of levels. Unfortunately most conventional studies of the doctor-patient consultation have tended to focus on structure rather than content and therefore tend to be relatively superficial. Studies of the consultation process, most of which have been conducted in primary care, have focused on the structure of the encounter from greeting to closure (see Byrne & Long 1976, and Pendleton, Schofield, Tate & Havelock 1984), and played particular attention to concepts of doctor centeredness or patient centeredness. Such concepts have been examined following the medical tradition: they have been described (see Levenstein 1984:276-282) and measured (see Stewart, Brown, Weston, McWhinney, McWilliam & Freeman 1995), and discussed in terms of their influence on professional practice (see Laine & Davidoff 1996: 152-156).

What is particularly interesting for my purposes is that they have also prompted an ongoing exploration into communication styles with regard to patient satisfaction as well as clinical outcome. In recent years we now have a number of discourse-centred studies that pay attention to the stories of the patients, and which have produced valuable findings in language use in different contexts (see Edwards & Potter 1992). Wodak, for instance identified previously hidden patterns and perspectives in outpatient clinics (Wodak 1996); Drew and Heritage (1992) looked at health visitors, while Silverman analysed transcripts of interviews conducted by HIV counsellors (Silverman 1997). Discourse analysis has roots in linguistics, sociology, and psychology, and can be pitched at very different epistemic levels. Regardless of the context, discourse analysis follows the text, which, in most cases, is a piece of talk.

I wish to dwell upon the studies of Elwyn and Gwyn (1999) who examined the processes of naturally occurring talk within the context of clinical practice. In this case the patient was suffering depression, partly as a result of the death of her son. Among the questions these researchers asked of this example were: how is one version of events selected over any other? How is a familiar reality described in such a way as to lend it an unquestionable authority. Elwyn and Gwyn understand that for all the science that underpins clinical practice, practitioners and patients make sense of the world by way of stories⁶⁵. Even the most evidence crazed doctors have to translate their perception of "biostatistical truths" into accounts that make sense to others. It was Elwyn and Gwyn's conclusion that through the detailed study of discourse in context, clinicians might learn to listen more constructively to their patients' stories. So in order to define some principles for clinicians to follow, Elwyn and Gwyn's textual analysis of patient-

doctor interactions in clinical practice used detailed transcripts. In their paper, 'Stories we hear and stories we tell' (1991: 186-188), they expose the variety of Interactional perspectives that may occur within the clinical encounter using techniques of microanalysis that take account of text, tone, pauses, interruptions, and non-verbal communication..

Such information is critical to the understanding of patient-doctor interaction, and other studies have emphasised such factors. For instance, Copeland, Robinson & Copeland (1994) have noted that during patient-doctor talk a cough might function as a discourse marker signalling the speaker's wish not to terminate the interaction. Coulthard & Ashby (1976) have found that the phrase "Anything else?" is characteristic of doctors' preclosing moves in interactions with patients, which however leaves it to the patient to go with it and allow closure, or shift to a new topic. Brown & Levenson (1978) note that using the past tense ("I wanted") for a request in the present allows the speaker to remove herself from the here and now, which constitutes a common feature of "negative politeness", a form of speaking that tends to be used by people reluctant to be too pushy or demanding. The pace of the conversation" is also important to note. As Elwyn and Gwyn say, "the ritual of correct timing is necessary to maintain the necessary gravity accorded to the ceremony of consultation and prescription" (Elwyn & Gwyn 1999).

In addition to the pace, time can be used in a number of different ways: while the doctor uses linear time in phrasing his questions: "How long have you been taking those?", the patient, on the other hand, might respond in event time: "Well my son was killed", as in the case studied by Elwyn and Gwyn (1999). For the patient, linear time was only relevant in relation to event time, i.e. her son's death, which is the event

that initially led to her being prescribed antidepressants. Mishler (1984), on the dialectics of medical interviews, made the relevant distinction of the "voice of medicine" and the "voice of the lifeworld." By insisting on a real time scale over a personal one (the one more meaningful to the patient), the practitioner subordinates the voice of the patient's "life world" to the voice of medicine. On the other hand, as Elwyn and Gwyn discovered in the case of the depressed mother, when the doctor allowed for the voice of the life world to take some precedence, the patient was provided with the opportunity to fill in the kinds of linear detail which she thought might be relevant: "well my son was killed" – lengthy pause - "five years ago"). For the patient, "life meaning" comes before "time meaning". Bearing this in mind, biographical detail helps establish the narrative basis of the patient's condition, in this case, depression. It also legitimises anything that might arise as a result of it, such as the patient's continued use of antidepressant drugs. The patient's autobiographical account gives insight into what Hillman (1983) called "sustaining fiction", i.e. the explanatory causes that underlie the patient's story. What is important to note is that ever new elements are added, other ones renewed, reconstructed or abandoned. The patient's autobiographical account is a processual matter.

In Elwyn and Gwyn's patient-doctor interaction example, the patient's biographical detail didn't stop at the death of her son. To illustrate how Elwyn and Gwyn proceeded with their textual analysis, I quote the following paragraph:

"We find that the patient's son did not simply "die." He was "killed", that is died as the victim of a particular agent or set of circumstances. Implicit in the pauses is an opportunity for the doctor to ask how her son was killed, an opportunity that he chooses not to take. The pauses act as a rhetorical device allowing the gravity of her loss to sink in and gives an accounting for the prescribed drugs. But that is not all. Seeing that the doctor does not request further information about the circumstances of her son's death (a request which Elwyn and Gwyn see as highly threatening to both doctor and patient), the patient then enumerates two other losses in her family: the death of a baby granddaughter from meningitis and the death of a son in law from a heart complaint. The fact that the causes of death and the ages of the dead are enumerated in both these other cases only draws attention to the lack of explanation regarding the killing of her son".

"By emphasising the extent of her losses within a short space of time, the patient avoids the possibility of being categorised as somebody requesting antidepressant drugs without good cause. Hanging over every patient is the potential accusation of malingering⁶⁶ resulting in an obligation to prove that a malady is not contrived and to express a wish to get well. Moreover, in this transcript, the patient insists that it was her doctor who "wanted her" to take the tablets (reinforcing her own passivity in this decision despite their effectiveness). Then (as if further evidence of her good intentions were needed) she states her wish to reduce the dose, thus maintaining her contractual responsibilities to

recovery. This wish to lower the dose is shown as her choice, a choice unaided (indeed hindered) by her practitioner ("but doctor Y said she still wanted me to take those antidepressants"), which strengthens the representation of herself as a responsible member of society; she states later in the consultation: "I wouldn't like the thought of being on them forever (Elwyn & Gwyn 1999: 186-188)

For the doctor in Elwyn and Gwyn's example, this narrative appeared out of the blue. He records:

"I hadn't expected this: three deaths and a request to withdraw from antidepressants during a routine repeat prescription. Would that be all right? To participate in a shared decision about the end of grief, about a symbolic farewell to a son, killed five years ago. I attempted to give her autonomy over her decision, hoping not to abandon her. But it wasn't enough. How could I tell her that I didn't know. That if I had lost a son I can't imagine surviving at all, never mind coming off tablets (Elwyn & Gwyn 1999: 186-188)

It is reassuring that he was aware of the devastating effects that physicians' abandonment can have on patients (Quill & Cassel 1995: 368-374), and consequently this doctor was adjusting his response to an anticipated arrival of what he said. Elwyn and Gwyn maintain that the consultation gains a whole new dimension through the ways in which the patient continuously engages in their own sustaining fictions that are central to the individual's presentation of self and sense of personal identity. Elwyn and Gwyn acknowledge that this sustained fiction is not unique to the patient, that we all do it⁶⁷. I am however not sure, just how aware they were of the extent to which their textual analysis was

saturated with their own interpretation; like emotikons⁶⁸ on e-mail, transcripts without the tone of voice are not the whole story.

Through their transcripts of doctor-patient interaction, Elwyn and Gwyn reveal intricate communication strategies. An awareness of those can reveal much to the physician about how patients construct their roles within consultations, and open up a new way of listening to the signals which so often pass unnoticed. Elwyn and Gwyn (1999:186-188) go on to rejoice over the possibilities opened up by such an analysis, namely to get that step nearer to reconstructing "the imaginative universe in which human acts are signs". This might well include some signals acquiring meaning in the doctor's mind that they never had when they left the patient's mouth. And this will always be a feature of human interaction. And going beyond the mere medical model of blood pressure and linear time is certainly a step in the right direction.

There is another dimension to the type of discourse analysis that Elwyn and Gwyn conducted: regardless of whether one refers to such efforts as sense-making, meaning production, explanatory model, sustained fiction or narrative, more and more medical studies have shown that the patients' perceptions of what happens within consultations are more valid than measures based on coding structures can be (see Tuckett, Boulton, Olson, & Williams 1985; Margalith & Shapiro 1997: 419-427); Stewart, Brown, Weston, McWhinne, McWilliam, & Freeman (1995).

These examples indicate that the limits of medical measurement and the importance of the way patients perceive medical consultations are important, but even more important is the acknowledgement of the bias or sustained fiction on the part of the health care provider, which turns the interaction into "finding common ground" from both angles. But

even more important than the mere acknowledgement of meaning, beyond the blood pressure, involves the patient in the decision making process, an important factor that is known to reduce costs for the health service, which underlines how critical a role the patient-doctor interaction plays in the use of health resources (Redelmeier, Molin & Tibshirani (1995): 1131-1134). Going beyond a superficial assessment of the consultation allows physicians to examine the perceived messages that patients take away into the longitudinal discourse of their own lives (Charles, Gafni, Whelan (1997: 681-692).. By becoming interested in talk, clinicians might be able to listen more constructively to their patients' stories, as Kleinman does, and might be able to allow what Silverman (1987) calls a more "democratic arrangement of voices"⁶⁹. And lest we forget, Elwyn and Gwyn sigh, "for countless patients it is the telling of their stories that helps to make them well".

This observation has been made by countless physicians, and it has particular relevance for mental health issues. Not for nothing is psychotherapy often referred to as the talking cure. There are two dimensions in which telling their stories makes the patient feel well: on one level it is the fact that someone listens, which allows the patient to create themselves within the social, rather than a medical encounter. In this regard, whether the listener is the practitioner or not is often of subordinate importance. This urge to tell their story to someone, the basic human need to be understood, to be known, is what brought many women to Miles Terrace. The fact that at Miles Terrace the staff was more easily available to talk their stories through with the women, or rather to listen to the women talk their stories through, was one aspect that was much appreciated about the set up of the crisis project. Those women with experience of both, hospitalisation as well as experience of the residential care in the setting of the crisis project, rated Miles Terrace

much higher in this respect, as it provided a favourable, more or less non-judgmental listening in which they could make sense of what had happened to them, what was happening with them. And this brings us to the other dimension of a patient's need to tell a story which complements the need to be heard, with the need to make sense, the quest for meaning, which lies at the basis of social constructionism.

RECONSTRUCTING ILLNESS AND LITERARY GENRES.

The ground work for such use of narratives in the healing process had of course been laid by Arthur Kleinman in the late 1980s. It was his publication (1988) of the *Illness Narratives* that had greatly enriched the patient-physician encounter by looking at the patient in the changing context of illness and care. It was Kleinman who had introduced the narrative element into diagnosis and care by drawing up mini-ethnographies of his chronic pain patients (1988) But Kleinman's illness narratives focused on the spoken narrative and the wider context of the physician patient encounter.

Instead of the immediate medical encounter, Anne Hunsaker Hawkins looked at illness from further a field; instead of analysing the way information was coded in a diagnostic context and a care setting, Hawkins attempted to reconstruct illness by looking at written illness narratives, at autobiographical and biographical accounts of illness that she calls pathographies⁷⁰. Her book *Reconstructing Illness: Studies in Pathography*, was first published in 1993. With a background in medieval literature, the constraints of the medical model in conceptualising illness did not apply to Anne Hunsaker Hawkins and her specialist knowledge of John Donne had her see illness writing as deeply pervaded by mythic thinking. Looking at examples of pathographies

primarily from the 20th century, she locates stories of illness within a larger framework of medical discourse and cultural practice.

Mythic constructs, she argues, organize the way patients understand their illness, and influence how they interact with the institution of medicine. According to Hawkins, myths are at the basis of how patients write their narratives. These myths are formulative in that they attempt to create order out of the disorientation of illness. Hawkins identifies archetypal myths that transcend cultures and occur all throughout history, examples are myths of journey, of battle, myths of death and rebirth. Since the first edition, she has added more myths, e.g. ideological myth, which stand in contrast to the archetypal ones in that they are fixed to a particular point in time and place. An example for such an ideological myth is the myth of healthy mindedness, a way of thinking that Hawkins had called merely "*mythos*" in the earlier edition. Hawkins proposes two additional ideological myths, the Gaia myth which links illness with environmental problems as well as the myth of narrativity. In specific cases, Hawkins identifies how the myths function, differentiating between those that are enabling or disabling, and whether they are medically syntonik or dystonik, coherent with the self or not. Myths that have an enabling function are adaptive, useful, help recovery or adjustment, ameliorate suffering. They are often medically syntonik-compatible with the belief system of Western medicine. A notable exception is the myth of healthy-mindedness, which, when it is enabled, often controverts traditional medical practices.

Hawkins' focus on written pathographies was taken up further by Arthur Frank and Thomas Couser; it was the theories of those three scholars, all couching their explanatory models of the narratives of ill people into a larger developmental context, that effectively launched the study of

pathography as a new literary genre, a genre that would have a tremendous impact on the way illness is perceived.

In 1995, two years after Hawkins' publication of the centrality of myths in pathography, Canadian sociologist Arthur Frank published *The Wounded Storyteller*. Frank (1991) based his concept of an ill person's narrative on his own experience of cancer and heart disease. , six years before the wounded storyteller and one year before Anne Hunsaker Hawkins introduced the concept of myths. In a meaning-making move that transcends the picture he had painted of a picture of illness that begins where medicines leave off, a picture of a remission society, whose members all live in some state of illness or disability, Frank reclaims the power he had lodged in the physical body and instead recasts it in the ill person's narrative of their illness.

Arthur Frank (1991) writes as a wounded healer himself and rejects the term pathography on the basis that no ill person would use it. His use of the concept of the wounded healer draws attention to the fact that, in contrast to the way the western medical model would usually have it, illness is not always exclusively on the side of the ill person, and nor is all health on the side of the healer. It is the healer's own wounds that are the source of his healing power. Likewise, telling the story of one's own illness allows ill people to access their own healing powers. In fact, Frank's wounded healer does not only access his own healing power through his story, but rather he reclaims it from the modernist conception of illness; this conception had been colonized in so far as the body of the ill person, and with it its life narrative, had been taken away from the ill person and handed over to the biomedical expertise of medicine. When wounded, people may be cared for, but as storytellers, they can care for others. The ill and all those who suffer, are not

confined to being ill, they can also be healers. Their injuries become the source of all the potency of their stories. The healing takes place on both levels that I mentioned earlier: by claiming the life narrative back from medicine, authority over one's own fate is reclaimed and through sharing the illness stories, the ill create empathic bonds between themselves and their listeners. As the stories are retold over and over again, these bonds expand and are reinforced. Those who listen need then tell theirs, and the circle of shared experience widens. Frank identifies four dimensions by which one's relationship to the body may be understood: control versus contingency, self-versus other-relatedness, dissociation versus association with the body, and desire versus lack of desire.

In Frank's model of the Wounded Storyteller, serious illness destroys the destination and map that had previously guided the ill person's life. At the moment when the illness kicks in, all order is turned upside down and all previous meaning is drained away, and thus ill people have to learn to think differently. They learn by hearing themselves tell their stories, absorbing others' reactions and experiencing their stories being shared. According to Frank, this story is told through the wounded body.

Frank defines three ways the upheaval of the illness can take. A restitution narrative, refers to a gee whiz type of a remarkable recovery, that reintegrates the person back into society pretty much the way it was before. Illness is seen as transitory, the narrative itself is a modernist one that response to an interruption, while being above the interruption. The body returns to its former image of itself, the illness has been managed. Illness in a restitution narrative is transitory, but offers no dimension of spiritual growth; rather it's like a broken car that's fixed.

In Frank's second narrative, illness is not transitory and the chaos introduced through illness is not resolved. Life is never going to get any better, the ill person has thrown away all narrative meaning making power, it is in fact an anti narrative.

Frank's third type of narrative comes closest to the spiritual moment of van Gennep's liminality, and involves transformation. A quest narrative meets suffering head on. In contrast to the chaos model, illness is accepted and ways to use it are sought. Illness is the occasion of a journey that becomes a quest. Quest narratives talk about what it's like to be in pain; they involve a person's hopes and fears, his or her sense (or lack of sense) of the meaning of suffering and the possibility of death. Rather than telling others what they should do in order to return to their former state, quest narratives bear witness to the experience and shared wisdom. By writing to his younger self before illness, Frank enters into a quest narrative:

"For all you lose, you have an opportunity to gain: closer relationships, more poignant appreciations, clarified values. You are entitled to mourn what you can no longer be, but do not let this mourning obscure your sense of what you can become. You are embarking on a dangerous opportunity. Do not curse your fate; count your possibilities." (Frank 1991:23)

The medium through which Frank's narratives are told is the body, and I would like to remind the reader that mental health is never divorced from the body. Despite the way the mind/body split still informs Western society, social and psychological factors in all illnesses are recognised, and from this point of view, the World Health Organisation

argued in 1963 that every illness is psychosomatic, there are no psychosomatic illnesses per se.

In sum, Anne Hunsaker Hawkins introduced the concept of myths for making meaning of illness, while Arthur Frank lodged the narrative power in the teller of the story, and in the narrative itself. Two years after Frank's *Wounded Storyteller* had hit the scene, Thomas Couser (1997) added the element of authorship to the so-called pathographies, a term that, I have to agree with Frank, is rather grating. With a background in autobiography and other forms of life writing, Couser was primarily interested in the issue of narrative authority. Other than Frank, who locates the issue of narrative authority primarily as reclaiming power over the body, which had been colonised by the medical model, In his book *Reclaiming Bodies* (1997), Couser further explores such discourses of dominance; he is interested in the ways autopathography can be counterdiscursive to the prevailing biomedical narrative of western medicine, and in particular, how autopathography, as the literary expression of the self-determined life, is counterdiscursive to the cultural stigmatization and marginalization that often accompany illness or disability. Couser (*ibid.*) explores these issues of marginalisation by focusing on four illnesses and disabilities that have been particularly associated with stigma, namely breast cancer, AIDS, paralysis and deafness. Both issues, marginalisation and stigma, are also very high on the mental health agenda (see Sayce 1000); in many ways, the questions are the same. For an example writing of the lived experience from the perspective of 'the deaf voice': Is deafness represented through a biomedical model, as a pathology; through a social model, as an impairment made into a disability by an indifferent or hostile hearing culture; or through a cultural model, as a legitimate way of living and being" (Couser 1997: 230). By analyzing how

“embodied difference” is culturally constructed, Couser also deconstructs "discriminatory or marginalizing cultural hierarchies" (Couser 1997: 179). To what extent, Couser asks, do authors integrate illness narrative into a larger life narrative? Can only the autobiographer narrate illness, how about the biographer? How exactly are the stories constructed, do they achieve a "comic plot" and narrative closure. He looks into the ways subjectivity is instrumental in forming narrative authority, representation, and resistance to a dominant medical or cultural narrative.

Underlying Couser’s argument is the strong belief that the boundaries of normal/disabled are blurred and can be contested, that society treats disability as foreign when in fact, sooner or later, it is part of every life. Couser’s final point is the other side that comes with stigmatisation, namely how by privileging self sufficiency, the profound ways in which we are all interdependent are ignored. I cannot emphasise this point enough, as it was at the very heart of the systemic model, on which Miles Terrace was founded⁷¹.

As a note on the concept of pathography, Peter W Graham coined the term metapathography after he had looked at three writers with a health problem, Norman Cousins, Reynolds Price, and Raymond Carver, and saw a correlation between the ill person’s gift as a writer and the strength of their own pathographic healing power, along the lines of the better you write, the better you heal (Graham 1997: 70-87), or, stated differently, illness develops differently in writers than in less gifted people.

At this point, I would like to provide a narrative given us by Carol Thomas which she entitles "Living in the Borderlands of Disability", and

through which explores aspects of the issue of marginalisation and stigma. Her narrative (1999) refers to a physical disability, but the issue at heart remains in many ways the same, whether it be deafness, AIDS or schizophrenia.

CAROL THOMAS: LIVING IN THE BORDERLANDS OF DISABILITY

I was born without a left hand, an impairment which I began to conceal at some point in my childhood (probably around 9 or 10 years of age). This childhood concealment strategy has left a long legacy: I still struggle with the 'reveal or not to reveal' dilemma, and more often than not will hide my 'hand' and 'pass' as normal. But concealment carried, and continues to carry, considerable psychological and emotional costs and has real social consequences. This hiding strategy was partly bound up with school life, but looking back I think a key influence was my association with the 'Roehampton Limb Fitting Hospital'. Once a year from a very young age I was taken by my parents to this hospital. My parents felt it was their duty to do this for my sake: to seek the advice of 'experts'. On these annual visits, my 'hand' was examined by a doctor who I remember as being very kind, and questions were asked about how I was 'managing'. As a result of these visits I was kitted out with a number of 'aides' like a strap which went around my left 'wrist' in which a fork could be inserted so that I could eat with 'two hands' like everyone else! The main 'prize' of these visits, however, was a series of artificial, or 'cosmetic' hands. These were ghastly, heavy and uncomfortable objects which I invariably relegated to the drawer soon after receipt. By the middle of my teenage years I had a gruesome collection of hands in the drawer. It was only some years later that I finally threw them away I remember standing in front of a full-length

mirror gazing at myself with the latest cosmetic hand on – how strange and unnatural it looked. Fortunately my parents never pressed me to wear these hands – leaving it up to me to make the decision. You could count the number of times I wore these on the fingers of one hand! However they did their work indirectly because the underlying message was clear. The experts were saying that my ‘hand’ was something to be hidden, disguised. I had to appear as ‘normal’ as possible. I found the easiest solution was to hide my ‘hand’ in a pocket, and I became very skilled at this concealment. Thereafter I always had to have clothes with a strategically placed pocket. So it was, and so it is.

Doctors and others in ‘caring’ positions were conduits of the “conceal that which is ‘bad’ or shameful, make things appear to be ‘normal’” narrative which was embedded in their professional and personal identity narratives. My own ontological narrative, like those of the others discussed, has been retold through and in the new public narratives associated with the disabled people’s movement. However, one of the difficulties in sustaining it, or rather in ‘acting it out’, is that the long history of ‘hiding’ my impairment has meant that it is ‘second nature’ to me now. There is thus a disjuncture between my sense of ‘who I am’ (a disabled woman) and the sense of ‘who she is’ held by most other people who know me.

This means much of the time I feel that I am in the ‘borderlands’ between the disabled and non-disabled worlds, and I suspect that this is a very common experience for people like me who have impairments which, for one reason or another, are not obvious.” (Carol Thomas 1999: 11-12)

CHAPTER VIII:RELATIONAL ETHIC THROUGH NARRATIVE COMPETENCE

FROM PRINCIPLE BASED TO RELATIONAL ETHIC

Arthur Frank would call Carol Thomas a wounded storyteller, Couser would refer to the account as an autopathography, but regardless of what name they go by, stories like this one can communicate certain issues in ways more powerful and that reach further than textbooks. The recognition that certain issues that are central to the field of medicine and medical care, are better communicated in non-scientific ways led to the development of medical humanities. The US were leading the way, and the first medical humanities programmes were established in American medical schools in the 1970s and '80s. Literature in medical humanities programmes was seen as making a particular contribution to teaching medical ethics (Jones 1990).

Some theoreticians have distinguished between an “additive” and an “integrated” application of narrative to medicine (Evans & Greaves 1999:1216). The former sees the arts as adding on to an existing biomedical knowledge base, whereas the latter attempts to refocus the whole of medicine to an understanding of what it is to be fully human. Richard Smith has observed, ‘The additive view is that medicine can be "softened" by exposing its practitioners to the humanities; the integrated view is more ambitious, aiming to shape the nature, goals and knowledge base itself (Smith 1999: 319)’.

LITERATURE AND MEDICAL NARRATIVES.

On an additive level, literary stories were understood to be useful in "fleshing out" issues or dilemmas in medical ethics, encouraging them to be seen as embedded in particularised human contexts, complicated by

powerful emotions and complex interpersonal dynamics. Writings by physician-writers have become staples of such teaching, and the short stories of the physicians Williams (*The Doctor Stories* 1984) and Selzer (*Letters to a Young Doctor*, 1982) have become especially well known and frequently taught. Initially, discussions of stories such as Selzer's "Brute" and William's "The Use Of Force", served to explore standard ethical principles such as autonomy or respect for persons, beneficence and non-maleficence, and social justice" (Bell 1984:143-151). In both "The use of force" and "Brute," a doctor physically assaults a patient in order to diagnose or provide treatment. Such stories as these obviously allow an exploration of the ethical issue about whether such powerful medical paternalism can be justified by claiming that what the doctor did was for the patient's own good.

The use of such stories as literary cases to complement the teaching of principle based ethics, is the most basic way in which narrative has become important to medical ethics. In addition to principlism, an ethics exclusively based on principles which has been the dominant form of medical ethics in the Western world, literary narratives were used to illustrate two further dimensions in the early days of ethical humanities: narratives were used as moral guides for living the good life, not just in the practice of medicine but in all aspects of life. Furthermore, autobiographical accounts of either patients or their friends and family were useful as witness accounts, as their experiential truth and passion compelled re-examination of accepted medical practices and ethical precepts (Jones 1999: 253-256).

In the past decade, medical narratives have been used more and more to replace the emphasis upon the principlism of medical ethics with a

paradigmatically different practice (Hudson Jones 1999: 253-256). Harold Bloom, a distinguished literary critic, asserts that reading does not make us better, more-caring people, but rather, reading is essentially a selfish activity (Bloom 2000). While reading can expand an individual's intellectual horizons, it does not automatically engender altruism or increased sensitivity to others. In the same vein, the physician Raymond Tallis (1995), in his book *Newton's Sleep*, goes to great lengths to argue that an acquaintance with the arts does not make individuals more caring; in fact, it might make them less so. He quotes Tolstoy's tale of an aristocratic woman weeping in the theatre at the imaginary tragedy enacted on the stage, while outside a real tragedy is taking place as her faithful coachman freezes to death. Here art serves to deceive the woman that she is sensitive, when she is actually inconsiderate. As Proust wrote, "reading is on the threshold of the spiritual life; it can introduce us to it: it does not constitute it (as quoted in De Botom 1997: *How Proust Can change Your Life*)"

It is, however, precisely this inducement that feeds the claims that books about illness and suffering help doctors better understand the inner experience of their patients and, as a consequence, develop greater empathy. It is considered that a medical culture that takes a positive approach to the humanities will greatly encourage such explorations (See Beveridge 2003: 385-387). Several canons have in fact been proposed (see Greenhalgh & Hurwitz 1999:385-387 on reasons for the medical use of narratives).

However, if the aim of using literary narratives in medical training is to develop interpretive skills, this can be achieved no matter what books are read; they do not have to be about medicine, psychiatry or mental illness. This leads to another function of medical narrative in medicine,

and that is of its form, the emphasis upon which has led to the development of the field of narrative medicine. The techniques involved in understanding and analysing a novel can be applied to the understanding of patient discourse. This allows the practitioner to become more sensitive to the nuances and subtexts of a patient's communication. Such an approach leads to a development of complex interpretive skills. Several literary devices have clinical resonances. For example, the concept of the 'unreliable narrator' is especially applicable to the understanding of a patient's history. This refers to the situation where the character telling the story might give, either by design or unwittingly, a misleading or distorted account of events. For example, in *The Diary of a Nobody* by George and Weedon Grossmith, the narrator, Charles Pooter, attempts to present himself as a man of dignity, but his account of himself and his encounters with others reveals that he is instead a figure of fun. A similar phenomenon can occur clinically when a patient's story suggests to the psychiatrist a different picture than the patient intended (Beveridge 2003:385-387).

Familiarity with and knowledge of the principles of narrative fosters awareness of how those principles are at work in narratives - or rather how we apply them ourselves in our readings and consequently how they shape our understanding. The questions that are asked about a literary text - who is the narrator? is the narrator reliable? from which angle of vision does the narrator tell the story? what has been left out of the narrative? whose voice is not being heard and why? what kind of language and images does the narrator use? and what effect does that kind of language have in creating patterns of meaning that emerge from the text? - can also be used in the examination of ethical texts and practices (see Chambers 1994:60-78).⁷²

As already mentioned (see Chapter VII), Hunter's work on the narrative structure of medical knowledge has helped clarify some of the mental processes involved in medical education and practice; and Brody has described a narrative ethics in which the doctor must work as co-author with the patient to construct a joint narrative of illness and medical care (Brody 1994: 79-92). This co-authoring involves more than simply recognising the patient's autonomy as author. Brody calls it a relational ethic (*ibid.*), and it is such a relational ethic that Kleinman (1988) has written about from the doctor's perspective, and Frank (*The Wounded Storyteller...* 1995) from that of the patient. Both, the doctor and the patient, agree that such a narrative practice is relational and requires the doctor to be an empathic witness of the patient's suffering. Ideally, narrative ethics recognises the primacy of the patient's story while still encouraging multiple voices to be heard and multiple stories to be brought forth by those who are involved in the resolution of a case (see Jones 1999: 153-256).

FROM NARRATIVE ETHIC TO NARRATIVE COMPETENCE

As I already mentioned in Chapter VII, North American medicine was much quicker than the UK to incorporate what the humanities had to offer for medical curricula, with the result that every self-respecting North American university runs a faculty, a department, or at least a journal with a focus on the medical humanities. The medical profession in the UK was somewhat slower to engage with the humanities. It was not until 1993 that the General Medical Council of Tomorrow's Doctors recommended the inclusion of medical humanities in the required curriculum for undergraduate medical education in the UK. The British Medical Journal, which represents the most important medical

discussion forum on the basis of its excellent website and because every doctor in the country gets it for free, only launched its journal, *Medical Humanities*, in 2000. It was the same year that a national conference on "The Healing Arts: The Role of the Humanities in Medical Education" was held. There was also the creation of an Arts and Medicine faculty at Durham University and a faculty of Medical Humanities in Wales.

NARRATIVE MEDICINE

The term narrative medicine was invented by Rita Charon, a subject on which she has written widely since the late eighties (see Charon 1989, 1992, 1993a, 1993b, 1994a, 1995b, 2001a, 2001b, 2004) . She is a general internist, and also the director of the programme in narrative medicine at Columbia University, NY. In a website of LitSite Alaska, she recently explains the reasons for her developing Columbia University's programme of narrative medicine (see [Http://litsite.alaska.edu/uaa/healing/medicine.html](http://litsite.alaska.edu/uaa/healing/medicine.html)). She notes that after a several years of general internist practice, she realized that what patients paid her to do was "to listen very expertly and attentively to extraordinarily complicated narratives". These narratives, she says, were told not only in words, but also through gestures, silences, tracings, images, and physical findings. It was her job to provide coherence to such (often contradictory) narratives. She was at the very least obliged to give them provisional sense, enough sense to be acted on. She came to understand herself as the interpreter of a myriad accounts of events - those telling of pain, suffering, worry, anguish, or the sense of something just not being right. She tells us that she came to the realisation that patients have these very demanding "telling" tasks to do, while doctors are responsible for the very demanding "listening" tasks. Wanting improve her listening skills, Charon began postgraduate

studies in the English Department at Columbia University, where in time she completed her Doctorate. It is her position that the narrative skills she learned in her English studies made her a much better doctor: she became capable of following the narrative thread of her patients' stories, recognizing their governing images and metaphors. She became able to adopt the patients' or family members' points of view, and to identify the sub-texts present in all stories. She became able to interpret one story in the light of others told by the same teller. She also found that the better she was as "reader" of what her patients told her, the more deeply moved she became by their predicament. She tells us that she then made herself more available to patients in her daily practice of medicine. She concludes that the conceptual frameworks of literary studies, especially narratology, "give us theoretical means to understand *why* acts of doctoring are not unlike acts of reading, interpreting, and writing and *how* such things...[as the latter] ...make us better doctors" (<http://litsite.alaska.edu/uaa/healing/medicine.html>). She notes that "by examining medical practices in the light of robust narrative theories, we begin to be able to make new sense of the genres of medicine", and ethics (e.g. the role of empathy) attached to them. (*ibid.*)

However, narrative medicine is not only about a much improved understanding of the patient's story, but also about the therapeutic listening of practitioners across the range of oral history, trauma studies, autobiography and psychoanalysis. In addition to the patient's story, Charon paid attention to the doctor's own story (2001:84). She noticed how many medical school memoirs were being published, examples being Dr X (INTERN 1965), Shem's House of God (Shem:1995), Mullan's White Coat, Clenched Fist: The Political Education of an American Physician (Mullan 1976), Konner's Becoming a Doctor: A Journey of Initiation in Medical School (Konner 1987), Perri Klass' A

Not Entirely Benign Procedure: Four Years as a Medical Student (Klass 1987), (unusual in that she got pregnant), and her subsequent Baby Doctor (Klass 1992), Takakuwa, Rubashkin and Herzig's anthology (2003), What I Learned in Medical School - Personal Stories of Young Doctors, and even Ramsdell's (1994), My First Year as a Doctor: Real World Stories from America's MD's. Many of those memoirs were told in sadness, rage and contrition, which Charon attributed to an urge, or rather need to tell them: "The width of the alienating discontinuity opened by medical training suits physicians particularly well for writing autobiographies and even suggests that they, more than other professionals, need to write them" (Charon 2001b: 84).

When doctors write down their own narrative of themselves in relation to the patient's story, focusing upon an aspect of their care, they often render whole that which they observe and undergo, revealing transcendental truths about ordinary life, truths that are exposed in the course of illness. So Charon began coaching her medical students and colleagues in writing reflectively about their practices in what she labelled as 'Parallel Charts' to more accurately understand what their patients experience and also what they themselves endure in the course of caring for the sick. She tells us about encouraging her students to document "their own anguish in caring for patients as well as their victory when things go well, their rage and mourning and dread, their fear of mistakes, their inability to know what to do, their sense of loss as patients sicken, no matter what they do" (Sharon 2005: <http://litsite.alaska.edu>).

While narrative was once considered a civilizing veneer for the gentleman physician, narrative understood as reading literature, studying humanities, writing in literary ways about practice, narrative competence

is now being recognized as central to medical training for empathy and reflection. Narrative competence improves many capacities that medicine sometimes lacks, such as attunement to patients' individuality, sensitivity to emotional or cultural dimensions of care, ethical commitment to patients despite fragmentation and sub specialization, acknowledgment and then prevention of error (Charon 2004: 862-864).

Between 1989 and 1995, *Annals of Internal Medicine* conducted workshops entitled "Meaningful Experiences in Medicine" at annual meetings of the American College of Physicians and the Society of General Internal Medicine. Most of the stories involved one of three major themes: a fundamental change in the doctor's perspective, a connection with patients, and a difference made in someone's life (see Horowitz, Suchman, Branch, & Frankel 2003: 772).. They could have recounted tales of diagnostic or therapeutic triumphs, but they uniformly told stories about crossing from the world of biomedicine into their patients' world, and more so, they described how relationships deepened through the process of recognizing the common ground of each person's humanity. More than vehicles for medicine or surgery these doctors discovered and were deeply gratified by the intrinsic healing capacity of simply being present. The writing process stimulated clarification of personal values and priorities, created a context for peer support and fostered recognition of opportunities to make constructive changes in their professional lives – all in line with Charon's vision of narrative medicine (see Horowitz, Suchman, Branch, & Frankel 2003: 774).

Likewise, in line with Charon's observation of the surge of medical school memoirs, Brady, Corbie-Smith and Branch (2002: 220-223) tracked their primary care residents through three years of their training. The first year had everyone search for professional identity and core

values, while the narratives produced during the second year were characterised by despair, disillusionment and detachment, with most residents lost in the depths of agonizing experiences. It was as if second year was a liminal period again, leading to a transformation in third year, which reenergized the house staff, leading them to theme their narratives around hope and reconciliation.

Gillie Bolton, who has made a case for reflexive practice through the use of narrative in the UK (see Bolton 2001),⁷³ points out that any such reflexive exercise involves a risk of ‘uncovering things they don’t want to know about themselves (Bolton 2001: 51)’. Especially with sensitive and competent facilitators, both, Bolton and Brady, Corbie-Smith and Branch have had the experience that, generally, people participating in such exercises will intuitively go only to the point at which they are psychologically comfortable.

Doctor’s narratives are now mainstream, and many medical journals have inaugurated narrative features such as *Annals of Internal Medicine’s* “*On Being a Doctor*”, *The Journal of the American Medical Association’s* “*A Piece of My Mind*”, and *Health Affairs’s* *Narrative Matters*.

There is so much more to say about medical narratives, let me introduce to you Michael Foxton:

For two years, Michael Foxton wrote the *Bedside Stories* column in the *Guardian* (see Foxton 2003) - about the hell, the horror and the humour of being a junior doctor. In 2003, when he qualified as a psychiatrist, he decided it was time to put away the pen and take the day job seriously. He says the following:

“...There are some doctors who put me to shame. When I talk to my girlfriend I am mortally embarrassed by how truly caring she is. There are doctors like this in the world. But then I remember that when she first started as a house officer she was just as much of a misery guts as I was. Medicine toughens you up. Maybe that is why they make you work those hours, to separate you off from the pain. Once you stop being incompetent and you forget what it was like to go to bed, you can turn into a nice guy again.

I stopped writing my column in this paper because I started to love my job, and there is nothing more tedious than reading about a requited love affair. I was starting to be an all-right psychiatrist in a nice job. You can't write about that in 800-word anecdotes, and I didn't want to carry on just talking about the horrible stuff. That is the trite answer. ...For six months, we drank until we vomited, and then gave each other drips, anti-emetics, painkillers and ulcer drugs to get through the next day without collapsing. I never saw any of these people again more than twice in the next two years.

These were the things that kept me sane, and made me happy. Now, the things that make me happy are my girlfriend who will soon be my wife, and the babies I plan to have, and the chance that I might one day get better at being a shrink. I don't want to make my work into funny stories, and I don't need to any more.

I'm a psychiatrist. Not a journalist. And I hope I will be an all-right one.” (Foxton 2003: *The Guardian*. 17 November)

By the sounds of it, Foxton, while he might not be a wounded storyteller, did eventually graduate to stage three of Brady, Corbie-Smith and Branch's (2002: 220-223) primary care residents, by which time

their professional identity and core values had been defined, they had gone through a second year of destitution and despair, only to emerge reenergized by themes of hope and reconciliation.

ASHA : MY NARRATIVE FROM MILES TERRACE.

Asha was a 23-year-old woman of dual heritage, her father was white and her mother Afro-Caribbean. Asha's father wasn't very present when she grew up, and as she put it herself, she'd find herself faced with a stream of temporary uncle Bobs, her shorthand for a series of substitute fathers, the succession of her mother's flames. "It was one of these flames which burnt down my childhood. These bastards Mom brought home were either ignoring me or trying to suck up to me in a way to impress my mother. Maybe they were trying to demonstrate that they were father material, in an attempt to extend the shelf life of their relationship with my mother".

"I just hated all this false attention, these men showed me, and as I grew older, their attention became sexual - which was always unwanted. On one such occasion I was at home alone with Max, the flame of the day, and he molested me. He said that this would be the making of me, but instead it was the unmaking. Since I was seven I have been in and out of some institution or other for head stuff, you know. I have this uncontrollable rage, which is getting me into trouble, a tendency to lose it over the simplest thing, you know what I mean, just lose it bad. It's usually when I feel that people aren't respecting me, they're just ignoring me, you know me Salma."

Over the years that I was working at Miles Terrace, I got to know Asha very well - She was what is referred to as a 'revolving door patient', a resident who came back regularly. Each summer I was working at the project, our paths crossed, she was either leaving when I arrived or arriving when I was leaving to return to St Andrews. So we often had a

conversation, usually about who had let her down or who had messed with her head - which usually meant a relationship break-up.

The thing I found really curious was that no matter how unwell or distressed Asha felt, she always found the energy or desire to turn up each night at her job in the city as a pole dancer. I remember the first time she told me about her job, when she laughed at my shock. "How do you think you can work with me when you have such a sheltered upbringing?" asked Asha. "What do you mean... I just thought that if you're in the project, you can't really be up to going to work" I replied. "What you're really shocked about, is the fact that I am an exotic dancer... I should not be doing this, particularly with my history of sexual abuse and all the other abuse that must be in that file of mine in the office".

"Okay I seem such a stereotype caught in a cycle of sexual exploitation, yeah... being abused as a kid, then becoming a dancer. The club I dance at is for women only... no way would I dance for any slimey bloke fiddling with himself under his dirty raincoat whilst watching me wriggling on a stage where you couldn't swing a cat. No way man... I'm not that stupid".

I just laughed nervously and said "How is dancing for women any different from dancing for blokes?"

"It's very different - you are in control, the women watching are less about penetrative sex, but more about love and sensuality, dancing makes me feel alive, good about myself. There's many ways to skin a cat."

During my fieldwork year at the project, Asha was one of the main people I had worked with on and off. I remember a particularly chaotic discharge of Asha. She had been admitted for excessive drug-taking and not sleeping, which made her feel chaotic and out of control, which spiralled into anti-social behaviour, with her knocking on people's doors, shouting through their letter boxes, etc. in her local neighbourhood. Asha's social worker felt that her mother should take in Asha's ten year old daughter Clara, so that Asha could come to Miles Terrace for a break, so things would not deteriorate any further. Her time at the project was quite uneventful and passed without incident. The staff helped Asha with the three large carrier bags which contained a collection of colourful jumble, heaps of clothes that Asha had just thrown together. All residents were aware at the point that entry into the project had a maximum stay of twenty eight days. So by the end of the third week and the beginning of the fourth, residents are preparing to leave by packing their bags in advance. Asha always left the throwing of clothing and make up into a bag to the moment she knew the taxi had been called.

I helped her throw her things into bags whilst the taxi was en route... in fact, I found it quite amusing. We would laugh about Asha's belongings and she would recall which lover had given her which 'sexy top or pair of pants'.

She liked to embarrass me, and rarely missed out an occasion to see whether she could shock me with some comment. Embarrassing me had become a sport for her. On each admission I thought she would tire of it, but she never did.

Another interesting phenomenon which would occur was that on the day of discharge the staff in the project would pull out all stops to help the woman physically leave the project. Every effort was made to be helpful and supportive of this transition from the project to the pavement outside.

Asha was waved out of the project and into the street. The staff usually stood at the front door or peered through the office window. They needed to make sure and see with their own eyes that the woman had left the project. This particular time she left on a Saturday, the day of a big match at the local football stadium, and her taxi had been caught in the traffic. Asha was very conscious of the staff watching, and keen to get away from their gaze; she started to walk towards the taxi, walking in the middle of the road, finding her way through the stationary cars, dragging her bags behind her. Suddenly, she must have caught sight of someone in a car. Asha suddenly dropped the bags, lunged forwards and grabbed a man out of a white van, screaming, punching and kicking him. I am ashamed to say that I moved away from the office window and busied myself with the trivial task of collecting all the empty coffee mugs in the office.

The project manager flew out of the door, down the street, in the direction of the screaming. I replaced two handfuls of mugs on one of the desks and rushed back to the window, but viewing positions had been filled. So I resigned myself to standing on tiptoes, looking over the shoulders of a shorter member of the staff team. I could make out the project manager, pulling Asha back to the project by the wrist, clutching on to her bags with the other hand.

On arriving back at the project, Asha was in a flood of tears and Jane (the Project Manager) was really red in the face. She brought Asha into the quiet room which was opposite the staff room and sat her down on the couch. This was a rare occasion for Jane to assert her authority by commanding one of the staff to bring Asha a cup of tea, and two members of staff headed towards the kitchen. I continued to look out of the window and saw the young man picking himself off the road and while he got back into his van the other cars uncharitably tooted at him to get a move on. That signalled the end of the show, and as he approached he slowed down at the door of the project, which I found quite threatening, it was as if he was telling us that he knew the woman had come back into the project. I had noticed that he had a young woman as a passenger and I was surprised that during the whole incident the woman did not leave the protection of the van to help him.

I went back to my mugs and took them into the little kitchen in the corridor and washed them. Very slowly. Very methodically. By the time I reached the final mug, I heard the front door slam. I went back into the office to find that Jane had sufficiently calmed Asha down, found out about her reasons for her violent reaction and put her into the waiting taxi headed for her home. Times like this, post-event, were some of the most seductive moments, because you heard the most lavish stories and interesting facts about the women's lives. Jane recounted that Asha, on seeing her ex-partner, the father of her child, who she hadn't seen for 10 years, sitting in the van with another woman, got into a rage and dragged him out of the van and felt able to readdress all the violence and abuse she had suffered at his hands. When telling this to Jane she said the only regret she had that there was no staircase available from which she could have pushed him down, like he had pushed her when she was pregnant. I was quite curious to know how Jane had managed to sufficiently

reassure her and get her into that waiting taxi, because once the staff had decided that it was time for somebody to go home, neither hell or high water could prevent it. So I was quite suspicious of how she had managed to do this. Jane had told her to look at it as a positive experience insofar as you had the strength to stand up to him. It's unlikely that he will ever behave that way to you again. So you're in a good space to continue with your life, your taxi's waiting. And do feel free to come back to the support groups.

ASHA - THE NARRATIVE OF THE DUTY BOOK

Texts become crystallized when we treat them as authoritative representations of stable objective realities. Texts might be said to 'encourage' such treatment because they are made up of written words, numbers and visual images that objectify the events, objects or issues that they purport to represent. The words, numbers and images 'freeze' the ongoing events of life, making it impossible for us to return to them from time to time in order to verify our remembrances of, and others; claims about them Miller 1997: 72):

With regard to health care texts, at the most basic level, there are records of work undertaken and to be undertaken, records as an aide-mémoire, and as such, case notes have obvious uses for health professionals. Also, they are often evaluated, to check whether they are sufficiently detailed or up to date. Or, they are examined for evidence to have followed the procedure, or failed to have done so, or to have recorded having done so. They are scrutinised for evidence, or at least indications of professional evidence, and in this respect, records are a medium for organizational and public accountability.

Hak analysed psychiatric records (Hak 1992: 138-139). Well aware of the issues of psychiatric labelling, he treated his records neither as descriptions of the patient's condition nor as a distortion produced by the pernicious and controlling activity of psychiatrists, but as 'a phenomenon intrinsic to social practice itself' (*ibid*:139.). This way, Hak treats the records as part of psychiatric practice as a social activity which orders phenomena in particular expected ways and his records allow insights as to how occupational groups order 'reality', and thus it is an important component of a reflexive approach to our work (See Taylor & White 2000).

Taylor and White argue (2000) that by undertaking periodic analysis of their working documents, practitioners can become more aware of the kinds of ideas they take for granted or use unconsciously in their work, as well as of the institutional frameworks in which they are located (Taylor & White: 143). Their main concern is not with the 'reality' or the accuracy of the records, but instead with what the records can reveal about what Taylor and White call 'background expectancies', those aspects that are taken for granted in health practice. After all, one cannot be reflexive about what is taken for granted (Taylor & White 2000:144). There are people out there, in whose eyes such examination of records is self-indulgent, completely missing the goal of the very proper activity of monitoring outcomes and ensuring the best possible 'evidence-based' service delivery.

According to Garret (1999), the idea that health workers should simply get on with the concrete, pragmatic task of form-filling in the name of improved services and measurable outcomes and ignore the assumptions embedded in these forms, "reflects a wariness and impatience with critical inquiry" (Garret 1999: 28; also in Taylor & White 2000: 144)).

Unwittingly, writers of case records use strategies to ascribe blameworthiness and creditworthiness. This can be seen with regard to the duty book entries referring to Asha. I reproduce them here without much further comment, an alternative narrative that reflects on the workers more so than on Asha.

ASHA – ACCORDING TO THE DUTY BOOK

Monday 6th March 2000 Night Shift
moving in tomorrow

Tuesday 7th March 2000 morning
arrived for admission

Tuesday 7th March 2000
night staff to read agreement plan. Negotiate checks in the night.

Tuesday 7th March 2000 Nightshift
expressed that she didn't want to be checked during the night.

Wednesday 8th March 2000 Night
Distressed + unsettled in early evening. Compulsions to clean her bathroom. Spoke of feeling 'High' due to medication.

Thursday 9th March 2000
Verbally abusive & shouting in the house meeting this am. Addition to A.P. done, needs to be discussed with her + Incident with cleaner

Thursday 9th March 2000
Out to meet a friend, due back 11:30pm

Thursday 9th March 2000 (Night)
Returned around midnight

Friday 10th March 2000 (am Shift)
out until 6:30pm

Friday 10th March 2000 PM Shift
out of the Project, due to return at 8:30ish

Friday 10th March 2000 (Night)
left the building just after handover and returned at 12:20am

Saturday 11th March 2000 PM
had various visitors

Saturday 11th March 2000 Night
left the unit and went to the shops with her two visitors. She returned at 10:45pm and appeared distressed She advised staff that she witnessed an incident in McDonalds, She and her friends said that a man had gone in with a knife or machete behind the counter and demanded money, the

women came back and calmed down, a cab was called and the visitors left. Asha was very distressed and crying she spoke to staff and calmed down she then took her meds and went to bed. Also needs a wake-up call at 8:45

Sunday 12th March 2000 (am Shift)

left the project at 10:30am to meet friends due to return at 6pm

Sunday 12th March 2000 Night

Returned to the Project at 23:00, Mood appeared stabled.

Monday 13th March 2000 Night Shift

I spoke to Asha regarding Tarot Card reading and expressed my concerns of the effect giving any of the lady's bad news, she became very upset and expressed that I am the only one who has a problem, the other workers never said anything also about the incense that was burning downstairs and then the alarm going off due to the smoke in her bedroom. The women that took part said they were fine, but the others said the smell of the incense made them feel sick and they were frightened.

Tuesday 14th March 2000 (pm Shift)

Out of project, due back 2:30am

Night Shift 14-15 March, 2000

returned at 2am

Wednesday 15 March 2000 – pm Shift

out due back at 10pm

Thursday 15 March 2000 – Night Shift

did not return to the Project as planned at 10pm. Contacted the Project at 12:05 am and 12:20am stating she would return in 10 min. Returned at 1:10am. Contact from Asha's mum at 10:40pm stating Asha would be late back to the Project.

Thursday 16 March 2000 – pm

returned around 18:30 with her daughter. Appeared 'stoned' possibly - raised with her and she denied it. Later talked about wanting to leave project. Advised to stay tonight + discuss tomorrow. Agreed to this.

Thursday 16th March 2000 Night

reported that her green filofax has gone missing last seen in her bag yesterday afternoon, to be brought up in H.M.

17th March 2000 AM

House meeting – missing items (sunglasses, money, filofax) were discussed, but few attendees.

will go on leave tonight & return tomorrow. Mood wired since last night. (gone by 3pm)

17th March 2000 pm

remains on leave due back in project to collect 20policlone.

Friday 17th March 2000 (Night)

due back sometime Saturday

Saturday 18th March 2000 AM

has not returned from overnight leave

Saturday 18th March 00 pm Shift

Returned from leave.

Sunday 19th March 00 am

asked to turn her music down as it was very loud. Asha was then heard to be kicking her door. She denied this but agreed to not do it.

Sunday 19th March 00 pm

Handover Issues: prompt with St. John Wort

Monday 20th March 2000

going out at 8pm aprox. is due back at 3am

Monday 20th March 2000 (PM)

Plans to be out until 03:00. Will phone or return to project if unsafe or distressed. Left at 20:45.

Handover Issue: prompt with St. John's Wort

Monday 20th March Night

Handover Issue: prompt with St. John's Wort

Tuesday 21st March. AM.

Handover Issue: prompt with St John's Wort

Tuesday March 21 PM

Enquired about a man coming to repair her shower. Since yesterday nobody has turned up.

Tuesday 21st March 2000 Night

returned to the project at 2:35am. Staff unable to contact Dr Miller Maxine's appointment, could not locate her number. AM staff to keep trying

Handover Issue:
prompt with St Johns Wort

Wednesday March 22nd 00pm

Handover issue:
prompt with St. John's Wort.

Wednesday 22nd March Night

Handover Issue: prompt with St Johns Wort

Thursday 23rd March 2000 (AM)

expressing anger + distress re mother + mother's boyfriend. Working with staff.

Thursday 23rd March 00pm Shift

on leave due back midday tomorrow, will ring night staff between 11:30pm – 12 midnight.

Thursday 23rd 2000 Night Shift

was contacted to see, how she was doing. Stays with a friend at home.

Friday 24th March 2000

has not returned from overnight leave as yet. Telephoned by staff and stated she was fine.

Handover Issue: prompt with St. John Wort

Friday 24th March 2000 00pm

Asha's mother called to say that Asha had been abusive to her and she couldn't deal with it. Staff have spoken to Asha re 3 way meeting Sun 4:30. Asha has agreed not to phone her mum, and wait until Sunday 'verbal agreement'.

Handover Issue: prompt with St Johns' Wort

Friday 24th March Night

Returned to the project 9:55

Saturday 25th March 2000 Early Shift

strong urges to harm herself but managed to resist this.

25th Saturday 2000

Saturday 25th March 00 pm Shift

Massage:

Handover Issue: prompt with St. Johns Wort.

26-03-00 Morning Shift Sunday

Handover Issue: prompt with St. Johns Wort

Sunday 26 March 2000 PM

Expressing thoughts of harming self+suicidalisation. Distressed following meeting with mum. Out of project – Due back by 22:00 having made agreement with mother.

Monday 27th March 2000 AM

Attended therapy. Met with staff as due to leave today. Stay extended to be renewed on wed 29th March, with aim of completing referrals + woubaet?? with CMHT

Tuesday March 28th Night Shift

Handover Issue: Prompt with St John's Wort

Wednesday March 29th PM Shift

Said she cut herself superficially 2 a few days ago and told staff couple of days ago?

Asha has agreed to approach staff if having urges to harm herself.

Wednesday March 29th Night

Handover Issue: Prompt with St. John's Work.

Thursday 28th March Nights

Handover Issue: Prompt with St. John's Wort

Friday 31st March 2000 am shift

out for lunch, due back 4:30

Friday 31st March PM

Night staff to meet with Asha please.

Saturday April 1st 00

Handover Issue: prompt with medication – St Johns Wort.

Saturday April 1st pm

Handover issue: prompt with medication – St Johns Wort.

Sunday 2nd April 00

Handover Issue: prompt with medication, St Johns Wort

Monday 3rd April 00 AM

Due to leave by 4pm today but bed to be kept until tomorrow now. Is still leaving today.

Added: Ex-partner went past outside Miles Terrace as she was leaving, incident occurred.

Monday 3rd April pm

on leave tonight – bed will be closed tomorrow, staff tried to contact her over the phone, no reply.

Monday 3rd April Night

O/L. She called to confirm that she was fine

Tuesday 4th April 00 AM

contacted by staff, 12-1pm, had overdosed last night, no treatment sought, will come in 2-3pm to see assoc worker.

Tuesday 4 April 2000 PM

came to project. Met with staff. The Royal Vic Poison Unit contacted. Asha agreed to attend A+E for blood test + medical clearance. Contacted project several times – unhappy with wait – advised she must be medically cleared before she can return to the project and be given any meds Asha stating she does not plan to return to the project.

further entry

Asha discussed at H/over re need to access medical assessment via Royal Vic / A&E / GP plan & inform workers this pm once Asha seen

Tuesday 4th April 2000 Night

read previous page – we have had no contact.

Wednesday 5th April 2000 Morning

Phone contact, does not want to return May want day-care however advised needs to be checked out by GP first. Did not see anyone in A&E yesterday. Discharged. GP informed. Manage left for Dr. Advant to call us for update. Community assessment planned for Friday.

5th April 2000 Late Shift

contacted the project, agitated + crying requesting some meds had just seen her GP? who'd refused to give her meds. Agreed with GP to give her 2 Zopiclone+2 Mellerill for tonight this is in the medication cabinet.

5th April 2000 Night Shift

Came to the project 9pm for her medications.

Thursday 6th April 2000 PM

Attended for day-care and left the project around 18:45 pm for home.
Given 2 × Zopiclone

7th April 2000 FRI PM
Just given meds for tonight + will collect others tomorrow – Clive made
?? Melleril

Saturday 8th April 2000
Rang saying she would be here sometime around 1:30, came in 2:30pm

Saturday 8th April PM
Asha attended D/C. Was very agitated. Talked with staff seemed calmer.
Night staff to contact Asha.

Saturday 8th April 00 night
telephone contact with her she is ok.

Sunday 9th April 2000 (am shift)
contacted at home at 12noon, will come in later. no concerns.

Tuesday 11th April 2000 AM
attended for day-care

Thursday 13th April 2000
attended for day-care. She's returning later to be discharged.

13th April pm Shift
Handover Issue: now discharged from day care – can have phone
contact for next few days.

REFLECTING TEAM AS IT COULD HAVE BEEN

The concept of a reflecting team was pioneered by Tom Anderson (1987: 415-428). The Norwegian therapist knew a stuck system when he saw one. He knew that once you were stuck in on the treadmill of one's mind, asking oneself the same questions over and over again was not going to do the trick. It's the very same situation as being trapped in the spider's web of one's own imagined meaning. What was needed to overcome such stuckness is by generating alternative knowledge's that would redefine the premises of the context that kept a person or a family from moving on in their lives. Such a fresh perspective can not come from a stuck person. And this is where the reflecting team comes in. In Anderson's approach, the reflecting team operates in the following way: a team behind a one-way screen watches and listens to an interviewer's conversation with the family members. The interviewer, with the permission of the family, then asks the team members about their perceptions of what went on in the interview. The family and the interviewer watch and listen to the team discussion. The interviewer then asks the family to comment on what they have heard. This may happen once or several times during an interview.

The way Anderson envisaged reflecting teams to operate, they do not come to a consensus. Nor do they speak in the voice of the professional.

According to Lynn Hoffman, a systems therapist who uses reflecting groups, this can be quite an unusual experience for the therapist. Shedding that professional persona, refraining from making suggestions or being supervisors, or teaching, or being useful in any of the ways they had been taught, to Hoffmann felt like they had to keep in mind the saying: "Don't be mad at me, I'm not trying to help you" (Hoffman 1999:85).

There is no emphasis on solution in a reflecting team. And quite possibly, it is for this very reason that there is no need for a structured, causal narrative to emerge, that an answer of some kind will so often fall out of the air, even though there is no attempt to answer any question or to reach any goal (Hoffman 1999: 103).

As Paré suggests (1999: 293-306):

“Reflecting teams do not strive to capture or crystallize clients’ purported true identities. Rather, they generate multiple descriptions - and especially descriptions that highlight qualities which help the clients resist the influence of the problems in their lives.”

Reflecting Teams are not a kind of like therapeutic brainstorming, they are nothing like an old grand round of professionals discussing the patient on a ward visit. Instead, whoever came in for help is themselves asked to be a critical audience. The family or person with whatever problem would first listen in on the conversation between the professionals, before they were then asked about what they heard. Regardless of what, how much or whether they said anything at all, this put them in the novel position of being consultants to their consultants.

One very important factor in a reflecting team is that the conversation between the professionals does not centre around their own reactions, but deliberately focuses on the strengths of the individuals or family under discussion, through imagination, a reflecting team searches for multiple perspectives on troubling situations.

To Hoffman, working with, or being a part of, a reflecting team gives shape to many more of her understandings of narrative ways of working than would otherwise be possible. The reflecting team process provides a very obvious forum of preferred versions of the self, so much so, that to Hoffman, consulting without a team can at times be disappointing.

The fact that the individual or the family with the problem are asked to contribute in a critical way makes the therapeutic process much more democratic. But it really is the constant commentary of either side, the family telling their story, the team speaking about the family's story, the family speaking about the team's ideas about their story, that introduces a new realm of possibility. In Hoffman's words, such a layering process seemed to open a window through which the most interesting ideas would stream, as well as creating a sense of trust and shared optimism.

Since Anderson created the concept in 1978 (see Anderson 1987: 415-428) the use of reflecting teams has been enthusiastically embraced in a wide variety of fields, going beyond the initial field of family, and also marriage counselling (Brecher & Friedman 1993). Particularly interesting in this context is the use of reflecting teams in clinical training and counsellor education (see Landis & Young 1994: 210-218, and Paré: 1999: Vol.33, 293-306), and in the education of nurses and family practice residents in medical schools (see Griffith, Griffith, Krejmas, McLain, Mittal, Rains & Tingle (1992: vol. 10, 53-58; also see Lebensohn-Chialvo, Crago, & Shisslak 2000: vol. 32 (8), 556-560). Although there is little systematic investigation of its use in educational systems, reflecting teams have also been used in a course on clinical supervision (Caldwell, Becvar, Bertolino, & Diamond (1997: vol.19 (2), 269-287).

Anderson's prototype from the seventies had been adapted in manifold ways by the different people to the different fields in which it was used, and while the use of therapeutic teams and one way screens is well established in family therapy, the reflecting that Anderson himself engages in nowadays is much more an open conversation than it was before.

One important example is Michael White (1995, also see 1990), the father of narrative therapy. White adapted Andersen's format using anthropologist Barbara Myerhoff's notion (1986) of definitional ceremonies. While he promoted the generation of alternative Knowledges, White had a number of reservations (see 1995, chapter. 7). For one, he was not sure about whether the openness that resulted from the one-way screen was exclusively beneficial for the patient. He had witnessed one too many traditional ward-rounds in psychiatric hospitals, whose honesty had left the patient devastated. Furthermore, White saw that the jargon of the discourse of pathology could not only alienate but also objectify and marginalise the very people that had come to seek help.

Also, we being human beings, it is a very easy and slippery road from alternative knowledge to expert truth status, especially given the penchant of many family therapists for structuralist and functionalist analyses. And given the degree to which psychotherapy is part of mainstream culture, how could a reflecting team refrain from being complicitous in the cultural reproduction of especially negative aspects of society.

White was also aware of one issue, which has been imprinted on my mind long after I left Miles Terrace, namely that trusting the

intuitiveness of team members was not necessarily the way forward. White did take inspiration from Foucault's critique of the notion of an ideal speech community:

“The thought that there could be a state of communication which would be such that the games of truth could circulate freely, without obstacles, without constraint and without coercive effects, seems to me to be Utopia. It is being blind to the fact that relations of power are not something bad in themselves, from which one must free one's self. I don't believe there can be a society without relations of power, if you understand them as means by which individuals try to conduct, to determine the behaviour of others. The problem is not of trying to dissolve them in the utopia of a perfectly transparent communication, but to give one's self the rules of law, the techniques of management, and also the ethics, the ethos, the practice of self, which would allow these games of power to be played with a minimum of domination.”
(Foucault 1988:18, also in White 1995, Chapter. 7)

Drawing up a set of rules of law, techniques of management, ethics, ethos, and practice of self, which would allow power games to be played with a minimum of domination, was quite challenging, and White was the first one to acknowledge this. He was also well aware that his attempt to develop a method of reflecting teamwork did not entirely mute his above concerns. White found a suitable metaphor in Barbara Myerhoff's definitional ceremonies (1986), a notion that centers around the acknowledgement and authentication of people's claim about their histories and identities through outsider-witnesses. Myerhoff had used this metaphor to describe some of the activities of an elderly, poor, and neglected Jewish community in Venice, Los Angeles. Through these

ceremonies, the Jewish people countered the risk of becoming invisible to themselves, the risk of doubting their very existence. These ceremonies provided for these people an “arena for appearing” and for “opportunities for self - and collective proclamations of being”:

“Definitional ceremonies deal with the problems of invisibility and marginality; they are strategies that provide opportunities for being seen and in one’s own terms, garnering witnesses to one’s worth, vitality and being.” (Myerhoff 1986:267)

“Winning outsider-witnesses through the public performance of definitional ceremonies, also contributes a context for reflexive self-consciousness, in which people become more conscious of themselves as they see themselves, and more conscious of their participation in the production of their productions of their lives”. (Myerhoff 1986:267).

Myerhoff’s old Jews perform their definitional ceremonies at Venice Beach “separating the curtains between the real and unreal, imagined and actual, to step across the threshold and draw with them, pulling behind them, witnesses who find, often to their surprise, that they are somehow participating in someone else’s drama ... Having stepped over the threshold, they become the “fifth business”, witnesses who push a plot forward almost unwittingly; their story is not wholly their own but lives on, woven into the stuff of other people’s lives (Myerhoff 1986:284).”

A similar sentiment has been reported in the person in therapy by a number of therapists who use reflecting teams, usually with regard to the emphasis on the strengths people exhibit within their systems – which is entirely different from being positive for the sake of being positive,

which is strongly discouraged. Anecdotal evidence abounds with regard to families leaving the reflecting team process saying that nobody had ever before pointed out strengths about them. But the side benefits are not exclusively on the side of the people in therapy; there are equally abundant anecdotal reports of therapists who have made “quantum leaps” in their level of insight about the therapeutic needs and life direction of the client (Dawson, Lees, Sutherland, Kerr, & Geurtsen 2003).

Back to White, who asks his reflecting team to reflect as “outsider witnesses” to a person’s story. This happens in a four part meeting: first, the reflecting team follow the interview with the people in question from behind a one-way screen, via closed circuit television, or even from the back of the interviewing room. The source from which the team’s reflections flow is of course the interview that is conducted with the individual or family behind the screen. It goes without saying that the more competent the interviewing therapist, the more fruitful the process.

People are given the option of meeting the team members either before the first interview or prior to offering their reflections in the second part, when the interviewer and the people seeking consultation switch places with the team to become themselves the audience, as the team members reflect on, and actively interview each other about their experiences of the preceding interview. Not every member of the reflective team finds grilling each other easy, as the idea of having a conversation about the lives of others in their presence breaks most of the rules about therapeutic encounters. Reflecting team members who might first be tempted to direct their comments directly to the observer tend to become more relaxed with these third-party conversations after positive feedback. Following this, sides are switched again for the

people seeking consultation to be interviewed about their experiences in the first and second interviews. Lastly, all parties, interviewer, reflecting team members and people seeking consultation get together to debrief and engage in a deconstruction of the therapy itself.

Rather than just pointing out positives, the reflecting team process is one in which team members actively interview each other, i.e. I picked up on this, what do you think about it, do you reckon there is any importance in there? which then steers the reflecting interview into a communal direction.

It is not based on the tradition of behaviourism. In White's words:

“Reflecting teamwork based on the notion of positive reinforcement can so easily degenerate into a barrage of disconnected comments which can be confusing and disorientating for people. As well, under these circumstances, reflecting team members can be experienced as patronising and out of touch with the realities of people's lives. Further, it is not at all difficult for people to think that team members are not genuine, just trying to be positive in order to ‘jolly them along’. And as well as all of these hazards, team members usually find it tedious to be operating in this way. In their reflections they frequently find themselves ‘reinventing the wheel’, and that their conversations are reduced to a level of banality, in which one superlative is exchanged for another.” (White 1995, Chapter 7)

This trap is open to everyone who has donned a warm, fuzzy feeling do goody identity, and I am sure I fell into it at Miles Terrace. This trap is particularly luring if you are overly conscious of the inherent power hierarchy that places the practitioner on top in the therapeutic context. With regard to the reflecting team, potentially negative effects of such

power can be counteracted by the reflecting team explaining what had motivated some of their comments, and situating it in their own experience, in a way that is not gratuitous or indulgent.

In addition to keeping a check on the power imbalance inherent in such contexts, the use of reflecting teams also allows therapists to break free from the discourse of pathology, and being forced to de-jargonise and talk straight minimises or counteracts the marginalisation that the patients experience by fitting them into an analytic superstructure. Hand in hand with this comes a challenge of the supremacy of expert knowledges, along with privileging alternative knowledge systems.

Based on David Epston's study of the value of therapeutic documents, White undertook an informal study that asked the question: How many sessions worth of good therapy is a good reflecting team discussion? At 4.7 sessions of good therapy, White's number is similar to David Epstein's figure of 4.5.

This evaluation referred to the above structured approach to reflecting teamwork, which casts the team members and the people seeking consultation as audiences to each other's conversations without directly engaging in discussion with each other until the last stage. In comparison to unstructured discussions between the people seeking consultation and reflecting team members, people who have experienced both arrangements, their preference is invariably for the more structured approach. The following reasons were given:

- getting into a discussion with the team deprives you of the option of standing outside of your life and experiencing it from a different perspective.

- Sitting back from one's life as an audience to the team is more helpful than sitting in my life in direct discussion with the team.
- Interacting with the team in the second part didn't yield the same experience. One possible reason for this may be that attention is drained by editing, and at times censoring of what people said.
- Talking to the team and listening to the team is not the same. Listening to the team evoked the feeling of being someone else, not with the problem, i.e. it was possible to see that one didn't have to be with the problem. This didn't happen when talking with the team.
- There is something that is so much more powerful about listening to a conversation about your life that is acknowledging and respectful of who you are.

This is what a reflecting team could have been like. The version we operated at Miles Terrace went like this:

REFLECTING TEAM AS IT WAS

While gender was not a factor and sexual orientation only moderately so, according to the forever fluctuating environment, the power dynamics that were created along the lines of ethnicity were more pronounced. Similar to the way along which gay and 'hetti' camps would wax and wane according to the overall population during a particular shift, black and white camps would form. Whenever there were more black women in crisis, the black staff would be more critical of the white staff. Sensitive to prevailing power patterns, the white staff as a group would however never be critical of the black staff.

There is in fact one incident when the senior staff were unhappy with a black member of staff; Dinah had just acquired senior status, and the other senior staff found her quite lazy. One Sunday afternoon I had swapped my shift with her. When I arrived at Miles Terrace, Pat and Nat, both senior members of staff, were on shift, and they were not happy with me turning up in Dinah's stead. This is Dinah's shift, she should be doing it, you go home, Salma, Pat the Spanish senior told me in her usual brash manner. I had just spent a good hour on the South East England Underground, and there was no way I was going. I was going to do the shift I had swapped for, and do at least some tasks, no matter how junior they were. Pat was not happy with the situation and it came up in the next session of our monthly support group.

Once a month all the staff would meet for two hours, while agency staff covered the shifts. Jane, the manager felt it was important that everyone

could offload as freely as possibly, and to that end an external psychotherapist who I always called Daphne du Maurier came in as a facilitator. That month, the issue of my turning up instead of Dinah was raised and Pat, who felt Dinah was defying the other seniors worked herself into a bit of a lather. My side of the story wasn't really reaching her, and she said "Salma disobeyed me" and stomped out of the meeting. In order to conclude the issue, the concept of an empty chair was put into action: after Pat had run off, I was asked to address her empty chair⁷⁴ with whatever I had to say. I got as far as I am sorry you feel this way, and I think you shouldn't have left, before bursting into laughter. I can't believe I'm talking to an empty chair. Everyone else on the team could relate to this point, and after a chuckle things moved on to the next issue.

Pat later said she felt even because I had been embarrassed to talk to an empty chair.

CONCLUSION - THE LONG VIEW: ALONG WITH ANOTHER AUTOBIOGRAPHICAL NOTE

My fieldwork took place in Britain's first all female crisis centre. I had been working at Miles Terrace for the past years, but only for the duration of the summer and winter term breaks. As I have said, my fieldwork lasted from December 1999 to October 2000, during which time I had a contract as a research project worker, rather than as an agency worker, the role of my earlier work there. Since Miles Terrace had been conceived as an alternative to acute hospital admission, it was more comfortable than the hospital setting: with their own en-suite bathrooms, for example, the women had considerably more freedom than they would have if within a hospital. There was a genuine idealism underlying the structure of care at Miles Terrace. The care was to be more forward looking, subtle, more effective and kinder than that of a hospital environment. And in many respects such goals were reached - and in some respects not. As would be the case with any institution, not all could be perfect. There are always pros and cons.

For instance, let us consider the policy of Miles Terrace regarding the children of patients. One of the unique selling points of Miles Terrace was that it provided space to cater for the children of the patients. Given the evidence of the trauma experienced by children isolated from their parents, as Robertson's research on the distress of unaccompanied children in hospital made clear (see Chapter II: Parental Panics and Other Crises), this would seem to be a very beneficial policy, for parent and child alike. While I did not have massively much to do with any of the children who stayed at Miles Terrace⁷⁵, the presence of children

there warrants a look at Robertson's attachment theory as it might have relevance for children whose parents are in the situation of crisis.

As I have already noted, it was through film that Robertson powerfully captured the children's distress. His films also spoke to the necessity of the strong empathy that would be crucial to the children's well being.. Robertson's films capture this point much better than words could ever do. It was, for instance, empathy that the children were conspicuously not being given, and they were indeed deeply distressed. It was my understanding of the importance of Robertson's work on the origin of 'attachment theory', with his communication to the world about the distress of small, unaccompanied children in hospital, that became the central theme for me while writing the ethnography of Miles Terrace. It was understanding that empathy is so crucial to the success of the medical encounter, and to any human encounter for that matter. The medium of film, in Robertson's hands, delivered this lesson far better than words could do.

It has also been my aim to unfold the limitations of the teaching power of grand theory, particularly in the teaching of the merits of using medical narratives in the clinical situation. I have stressed the fact that use of medical narrative has been necessarily interlinked with the medical humanities, and thus largely inspired by the empathy that underlies the work of practitioners involved in mental health, as well as in health at large. Indeed, without such empathy social life itself would be much poorer, and the personal experience more detrimental to the health of patients than engendering of it (see recent work (e.g. Overing & Passes (eds.) 2000) on the social philosophies of native Amazonian peoples, who are deeply aware of the dire dangers to the health of those

social relations that are not acted out through convivial and empathetic intentions).

The decision of the Miles Terrace crisis project to accommodate the children of patients was clearly based on Robertson's research on early childhood attachment. This project is unique in its policy to include the children of patients, the intent being to provide an environment that actively works against the damage that can spring from early childhood separation. However, there are subtleties to this situation of acute crisis that the *theory* of childhood attachment cannot really handle. The theory aimed at providing practices that would work toward undercutting history repeating itself does have its feet of clay, as the very reason the women are at Miles Terrace is because they are in acute mental health crisis, which compromises their ability to provide mature parental care that is responsive to the children's emotional needs.

In addition to providing space for children, Miles Terrace caters for other gender-specific needs of women, specifically designed as the all female place that it is. In my ethnography I looked at the interactions of the women users of the service as well as interactions between the staff. Inspired by Behar's 'anthropology that breaks your heart', I have come to realise how blinkered I was with regard to mental health crises at the time of my fieldwork. A recent crisis which occurred while writing up my thesis placed me in the position of understanding the uncomfortable point that during my research sojourn at Miles Terrace, I had not only been blind to the experience of suffering a mental health crisis, but more importantly I was also emotionally closed to the understanding of it. Only when personally experiencing a breakdown at the job I was recently doing was I able to see how far I had distanced myself from the understanding of pain and distress. I only began to have insight into such

distancing when the doctor, who gave me my sick note, questioned me about why I could not own up to my own experience of stress, given that I had such a lengthy experience in mental health. It was getting that sicknote for my own breakdown at work that triggered an entirely new direction for my ethnography to develop. I began to see that the topic of 'empathy' was really crucial to these discussions about the Miles Terrace crisis project. I finally understood that empathy is much easier communicated through art, literature, film or any other media that might grant the receiver the room for their own experience to unfold in the ways that it has to in order to lodge itself in their own memory and reach their core - it is only then, when one can make use of one's own memories of suffering, that the practitioner can experience (have empathy for) the pain and suffering of others. I also discovered that the struggle to wring an ethnography from notes and memories of the field is parallel to the ways in which empathy must enter the depths of the practitioner's emotional experience in medical and mental health settings. The more the practitioner is aware and reflexive about such experience the more able he or she will be in understanding the experience of others.

I was comprehensively equipped with all the propaganda material that praised Miles Terrace as close to the perfection that mental health services were going to get in this country. During my work there, I had also lived through it and seen the principles put to action in a multitude of ways. Yet it was only recently, as I came to understand my own mental health situation better than I ever had before, that I was able to see that I hadn't really taken in much at all. I began to realise that I had kept whatever happened at Miles Terrace, be it with regard to the women users of the service or the staff, at arm's length. I began to realise how I was wearing my experiences of the crisis centre as my

outermost outer clothing: I was in my own aquatic bubble, watching the goldfish. Only now could I see how uncomfortable I had been to allow myself to engage emotionally with understanding other peoples' experiences of the world, especially experiences that might be painful, or exhilarating. Only recently have I realised that the reason that I kept others' at arm's length was because I could not bear my own distress. These realisations finally pushed me into the route of reflexivity.

However, this reflexivity road is long, leading directly into the horizon of my interactions with the world at large as well as with myself. Given the short amount of time that I have been on this course, the autobiographic aspect of my ethnographic insights only reaches so far. And my sheltered Muslim background is hardly the easiest of stomping grounds for openly reflexive steps within an ethnography. Only a few months ago I had seen my thesis as firmly located in the mentally ill Other: I had not dreamed of how far I would have to reach within myself to arrive at a higher level of appreciation of that Other. For a full appreciation of that otherness, I did of course have to look at how it was contextualised in society at large, how mental ill health had been othered by the DSM, the Diagnostic and Statistical Manual of Mental Disorders, and how societal approaches to managing society as well as to managing care had contributed to shape how mental illness is perceived.

Looking back at my time as a research project worker in an acute mental health crisis setting, I now see in many instances completely different things from what I saw then. And it is such contradictions that have inspired my argument. I had called my master's thesis 'Mind the Gap'. While it was also about mental health, I had concentrated on the gaps in understanding that were caused culturally. In this thesis, my focus emerged to be the Mind, or rather the benefits of mindfulness in mental

health practice and medical practice at large in fact. Where previously it was the cultural gaps that had stood out to me, those gaps that required careful investigation and codification so they could be passed on to professionals and other interested parties to absorb, transform and apply, the understanding I am now beginning to gain reaches far beyond such 'cultural' gaps. Without meaning to make light of their existence and importance in bringing about understanding, and a greater appreciation of mental health issues, I feel I have now begun to tap into a territory that is more transcendent (e.g. of cultural matters in certain respects). This new territory grants a more profound access to understanding as it does not shy away from or rather begins where all understanding begins, namely the self - in its relations with others. I am acutely aware of the fact that I am by no means the first person to arrive at this place. Indeed I have been so concerned - on a theoretical level - since at least the second year of my undergraduate studies. It is, however, precisely this gap between theory and practice, between theory and application, that will continue to fuel misunderstandings, and when bridged, even if only temporarily, call forth epiphanies.

My understanding and appreciation of mental health at Miles Terrace crisis centre was shifted light years by my GP pointing out that I myself had experienced a crisis. The fact that my crisis was nowhere near the same level of the women at Miles Terrace is not the point. What mattered was the mere acknowledgment of it on my part. I began to understand that on some level, I was on the exact same level as they. That in some weird way, I was at eye-level with the women in the precise territory that I had gone out to explore, armed with my anthropological theories and superiority. The fact that my personal situation was much less conducive to a crisis than theirs was irrelevant. Even though the conditions of the job I was in made me feel caged, I

did have a job, and beyond that, an application for a job that I now love was in the pipeline. I had social recognition for the work I had done, I was in the mental health field and that mattered to me, I had a car, I owned a home and I was a part of a strong community network which would support me through any crisis I would go through. Most of the women at Miles Terrace had very few or none of these things. But while these things cushion you, they don't make you look at yourself in a way that allows you to look people in the eye on eye-level. It was only when I acknowledged a part of me in myself that I had never allowed myself to truly see in others, that understanding was possible.

I am by no means the first person to realise the importance of such a personal journey. But this is something you cannot read in text books. Although every age has a zeitgeist that builds on advances of previous eras, a person has to actively discover these realisations in their own lifetime. And this is just as well.

Whatever it is that you're tuned into, it is that which you will find. There's a story of an American walking down the street with his native American friend in Manhattan. At one street corner, the Native American says, I hear a grasshopper. No way can you hear a grasshopper with all this traffic around you. The Native American takes a dime out of his wallet and drops it on the sidewalk. And people turned around. At the beginning of my fieldwork, if anything I turned away from mental health. Now I'm beginning to turn to myself asking why I hear what I hear. And this opens my eyes and ears to many other things that previously I was blind and deaf to.

Whatever your mind it set on, will stand out to you from all the other things that are also there. And it is the things that slipped below our

threshold of consciousness that guide our vision most powerfully. It's easy to say I'm Pakistani Muslim, dyslexic woman . But it is the little things that might not strike you as important, or the ones you don't want to admit, maybe not even to yourself that perhaps are more important than such cultural labels. But it is not until you put those things to peace, that one is truly able to see what is important to the Other. Buddhist therapy has long been aware of this important point, actively urging their practitioners to look inward, with therapists having to undergo therapy themselves before they can work with other people.

A Sri Lankan anthropologist Sumi whom I met at a conference two years ago, had 'broken down' over her own thesis and had to go into therapy for four years before she could continue with it. Her understanding of that experience was that the anthropological gaze, her being a black woman, as she was writing up her fieldwork, through her writing of culture she was re-colonialising herself and creating the Other, with the people she identified with. Sumi blamed this on writing the thesis in English, the language of the oppressor, her being the informant's pen and disclosing secrets of the oppressed. "Looking at myself through therapy, gave me an opportunity to make a breakthrough and break this unhealthy dynamic, and I was able to write a thesis which I was proud to own, and the people I was writing about were equally proud to own." Maybe less eloquently, I too have been on a similar journey, being an Asian Other for so long in my white anthropology class.

Marius Romme, a Dutch psychiatrist, who, together with the journalist Sandra Escher founded the "accepting voices" network (Romme & Escher 1994). It is believed that there are many people who hear voices. But not all voice hearers mind their inner voices. It is the others that

mind. In the film, *The Gods Must Be Crazy*, one character asks another one whether the voices in his head are bothering him. It is acceptance of these voices, or any other mental health matters, that matters, not the issues in themselves. In Romme's opinion, voice-hearers don't need to be freed from their voices. Rather than being cured, like homosexuals of the 1950s (it was only in 1973 that the American Psychiatric Association decided that homosexuality was not a mental illness and took it off the DSM (Spiegel 2002)), what voice-hearers need is to be liberated (Bentall 2004):23). And this can only happen in conjunction with liberating the Others, and this includes therapists, doctors, carers and family as well as the general public. And I wrote this thesis from a multiple of positions which I occupied simultaneously. It was in this spirit that the narrative of my thesis moved from a person-centred ethnography to a practitioner-centred practice across disciplinary divides. Attaining such an understanding is thrilling, but, like fieldwork, it cannot be taught.

Carl Rogers realised this a long time ago, as he wrote in the introduction to *Client-Centered Therapy*:

“This book is about the highly personal experiences of each one of us. It is about a client in my office who sits there by the corner of the desk, struggling to be himself, yet deathly afraid of being himself – striving to see his experience as it is, wanting to be that experience, and yet deeply fearful of the prospect. This book is about me, as I sit there with that client, facing him, participating in that struggle as deeply and sensitively as I am able. It is about me as I try to perceive his experience, and the meaning and the feeling and the taste and the flavour that it has for him. It is about me as I bemoan my very human fallibility in understanding that client, and the occasional failures to see

life as it appears to him, failures which fall like heavy objects across the intricate, delicate web of growth which is taking place. It is about me as I rejoice at the privilege of being a midwife to a new personality – as I stand by with awe at the emergence of a self, a person, as I see a birth process in which I have had an important and facilitating part. It is about both the client and me as we regard with wonder the potent and orderly forces which are evident in this whole experience, forces which seem deeply rooted in the universe as a whole.” (Carl Rogers, 1990, Introduction, 3-4: Kirschenbaum & Henderson, *The Carl Rogers Reader*).

During my time at Miles Terrace I gathered experiences, on the basis of which I managed to gain understanding in my own time. This is how mental well being is achieved– it is created and understood in a person’s own time and way. The joke I often use to communicate this phenomenon to my students is: How many therapists does it take to change a light bulb? The answer is none – the bulb needs to want to change.

The same is true of teaching: You can drag a student to the class, but you cannot make them understand it. All you can ever do is facilitate in an enabling environment – maybe that is what humane anthropology strives for. Or, in Rogers’ words: “My experience has been that I cannot teach another person how to teach. To attempt it is for me, in the long run, futile (1990:301, in Kirshenbaum & Henderson).”

As the Sri Lankan anthropologist said to me when she completed her thesis, "I feel things aren't as complete for me and I'm going to spend time writing and rewriting. Once I spoke about this to a friend⁷⁶ and she said, every point of change in your life comes from some destroying of

something and rebuilding it. A few days later, she send me this postcard about the Grand Opera House in Belfast by night. That again made me aware of key narrative themes of creation, preservation, destruction, delusion within my work and life – Lord Shiva’s dance from Hindu cosmology which leaves us between cultures trying to get even, to find one's own balance.



Grand Opera House by night, Belfast, N.I.

John Hinde
ORIGINE
NORTHERN IRELAND



5 099563 002083

To Selma

The Opera House in Belfast was
bombed and rebuilt — bombed and
rebuilt — bombed and rebuilt.

I suppose the message is that in
the face of destruction,

remain creative!!

GRAND OPERA HOUSE, BELFAST: Belfast's famous Opera House, designed by the celebrated theatre architect Frank Matcham (1854-1920), has been restored to its dazzling former glory. Its reopening in September 1980 signalled a remarkable revival of night entertainment in the city centre.

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ENDNOTES

1 Drinking an excessive surplus of water can lead to over-hydration or hyponatremia. Hyponatremia, also known as water intoxication, is defined as an abnormally low concentration of sodium in the blood. Sodium (salt and chloride) is an electrolyte, which helps the body distribute water. This is essential for water balance and for muscles and organs to function effectively. Electrolytes are lost through sweat, which is compounded through excessive intake of water. Then, the body's salts are diluted and washed. When the blood has too much water and too little sodium, brain cells absorb too much water and the brain swells, pushing against the skull (hyponatraemic encephalopathy).

The symptoms of hyponatremia are very similar to the symptoms of heat illness, and include fatigue, light-headedness, weakness, cramping, weight gain, nausea, bloating and/or swelling, dizziness, headache, confusion, fainting, disorientation, and in severe cases seizures, coma and even death.

Hyponatremia is rare and seen primarily in serious endurance athletes, such as marathon runners, who have overdone the dehydration prevention. The death of a female athlete at the 2002 Boston Marathon was caused by hyponatraemic encephalopathy. She had reportedly ingested excessive amounts of fluids before and during the race.

The world-famous South African exercise physiologist Professor Tim Noakes made the provocative claim that current guidelines on hydration, which have been in existence for the past 30 years, do not take into account athlete's individual needs, and have led to the over-consumption of fluids during exercise as a result of being biased by sports drink sponsorship. NOAKES, T. D. (2003) Overconsumption of fluids by athletes. *BMJ*, 327, 113-114

1 Between its opening in 1995 and 2002, 44 children stayed in the project - alongside 620 adults.

3 DEPARTMENT OF HEALTH (1998) *Modernising Mental Health Services*. London: Department of Health. Followed by DEPARTMENT OF HEALTH (1999) *Mental Health. National Service Framework*. London: Department of Health.

1 DEPARTMENT OF HEALTH (1999) *Mental Health. National Service Framework*. London: Department of Health.

1 MILMIS PROJECTS GROUP (1995) *Monitoring inner London mental illness services*. *Psychiatric Bulletin*, 19, 276-280.

6 Mind's 'Stress on Women' Campaign IN SAYCE, L. (1996) *Campaigning for women*. IN ABEL, K., BUSZEWICZ, M., DAVISON, S., JOHNSON, S. & STAPLES, E. (Eds.) *Planning Community Mental Health Services for Women*. London, Routledge.

HENDERSON, C. & REVELEY, A. (1996) *Is there a case for single sex wards?* *Psychiatric Bulletin*, 20, 513-515.

7 ROYAL COLLEGE OF PSYCHIATRISTS (1992) *Report of the General Psychiatry Section Working Party on Post-Natal Mental Illness*. *Psychiatric Bulletin*, 6, 519-522 IN KOHEN, D. (2001) *Psychiatric services for women*. *Advances in Psychiatric Treatment*, 7, 328-334.

8 The seven projects supported in the programme were:

Anam Cara - a four-bed crisis house plus drop-in day support, which also runs crisis sponsor homes in Birmingham.

Nile Centre - a nine-bed crisis house plus home-based support for African Caribbean adults in Hackney, London.

9 the Nile Centre and Anam Cara

10 Highbury Grove, which was not part of the Crisis Programme.

11 MENTAL HEALTH FOUNDATION AND SAINSBURY CENTRE FOR MENTAL HEALTH (2002) *Being There in a Crisis*.

12 MELTZER, H., GILL, B. & PETTICREW, M. (1995) *The Prevalence of Psychiatric Morbidity among Adults Living in Private Households*. London, HMSO, OPCS (Office of Population Censuses and Surveys) of Psychiatric Morbidity in Great Britain. Report 1.

13 HEYLIGHEN, F. & JOSLYN, C. in the *Cambridge Dictionary of Philosophy*

- 14 PALAZZOLI, M. S., BOSCOLO, L., CECCHIN, G. & PRATA, G. (1978) *Paradox and Counterparadox: A New Model in the Therapy of the Family in Schizophrenic Transaction*, New York, Jason Aronson, Inc.
- 15 BEHAR, R. (1996) *The Vulnerable Observer: Anthropology That Breaks Your Heart*, Boston, Beacon Press, 5.
- 16 How judgmental I was, and still am, as I am still in the process of discovering how my own biases have shaped my view.
- 17 MCLEOD, J. (1994) *Doing Counselling Research*, London, Sage.
- 18 Tim, research participant of ETHERINGTON, K. (2004) *Becoming a Reflexive Researcher - Using Our Selves in Research*, London, Jessica Kingsley Publishers, 30.
- 19 TAYLOR, C. & WHITE, S. (2000) *Practising reflexivity in health and welfare. Making knowledge*, Buckingham/Philadelphia, Open University Press, 6.
- 20 Schultz and have eliminated empathy from their anthropological vocabulary on the grounds that "recognizing the humanity of one's informants has nothing to do with trying to empathize [sic] with and reproduce their inner psychological states. It is concerned with intersubjective meanings..." SCHULTZ, E. & LAVENDA, R. (1987) *Cultural Anthropology*, St. Paul, West Publ. Co, 46.
- 21 ZWEIG, A. (1967) Lipps, Theodor. IN EDWARDS, P. (Ed.) *The Encyclopaedia of Philosophy*. New York, Macmillan IN POEWE, K. (1996) *Writing Culture and Writing Fieldwork: The Proliferation of Experimental and Experiential Ethnographies*. *Ethnos*, 3-4, note 5.
- 22 POEWE, K. (1993) *Theologies of Black South Africans and the Rhetoric of Peace versus Violence*. *Canadian Journal of African Studies*, 27(1), 43-65. IN POEWE, K. (1996) *Writing Culture and Writing Fieldwork: The Proliferation of Experimental and Experiential Ethnographies*. *Ethnos*, 3-4, note 4
- 23 who thought that infants did not have a sufficiently developed ego to mourn when a parent died; provided an adequate substitute caregiver was available, the way Freud saw it, bereaved infants experienced nothing more than brief bouts of separation anxiety provided
- 24 Such traditional publications in academic journals did of course follow, but their job was to supplement and underline the message they had packaged into the more powerful medium of the film. BOWLBY, J., ROBERTSON, J. & ROSENBLUTH, D. (1952) *A two-year old goes to hospital*. *Psychoanalytic Study of the Child*, 7, 82-94.
- 25 <http://www.concordvideo.co.uk/ch45m240.html>
- 26 I have to point out that while Bowlby, in line with the era he was working in, emphasised the mother over the father, he had no problem with well-run day care whatsoever. It was the fact that his work was used to support governments eager to encourage women to return to the home and leave the workplace after World War II that gave him a bad press and inspired feminist anthropologists to quote research from all over the shop that showed that exclusive mothercare was a recent Western invention.
- 27 Five Complementary Films are available from Concord Video and Films Council:
28. JOHN, 17 months, for 9 days in a residential nursery.
29. KATE, 2 years 5 months, in foster care for 27 days and JANE, 17 months, in foster care for 10 days.
- 30 Draft of Chapter Five How Society Responds IN ROWE, D. (2002) *Beyond Fear*, London, HarperCollins.
- 31 One example that illustrates one child's innate access to the mother's moods is Julianne Moore's LA housewife of the 1950s in *The Hours*, which portrays different facets of Virginia Woolf's bipolar disorder through narratives that interlink
33. The Liverpool Mental Health Crisis Service Operational policy by Liverpool City Council, Liverpool City Social Services Directorate/Liverpool Health Authority, Liverpool, 1995.
- 34 AMERICAN PSYCHIATRIC ASSOCIATION (1994) *Diagnostic and Statistical Manual for Mental Disorders*. (DSM IV) 4th ed., American Psychiatric Association.
- 35 Slater had asked a friend with a psychiatric record to use her name as to be able to later retrieve the hospital records
- 36 The word nigrescence is derived from French and refers to the process of becoming Black Taken up widely in theoretical circles, nigrescence is sometimes referred to under the alternative spelling of negrescence.

37 The six stages of homosexual identity formation are differentiated on the basis of a person's perceptions of his or her own behaviour and actions that arise as a consequence of their perception as a homosexual: Identity Confusion (Who am I?) is followed by Identity Comparison (Maybe this is just temporary, or I am the only one in the world like this.). The sense of alienation and non-belonging then leads to Identity Tolerance (I probably am a homosexual), which, similar to Cross' Nigrescence seeks out homosexual subculture, only that the markers of this culture-club are somewhat less palpable than those of Black culture. Tolerance finally leads to the point where the individual can say "I am a homosexual". Identity Acceptance (Homosexuality is OK) leads to Identity Pride (These are my people) and Identity Synthesis (I am Homosexual.. and). Similar to Cross' final stage of internalisation-commitment to society at large, Cass' last stage realizes that the "them-and-us" attitude of the previous stage views all heterosexuals negatively and thereby is no better than heterosexuals viewing homosexuals as negative. Now supportive heterosexuals are valued, while unsupportive heterosexuals are further devalued. The individual's personal and public sexual identities become synthesized and the homosexual identity is integrated within the larger fabric of the person's overall identity.

38 SANTROCK, J. (1997) *Adolescence*, New York, McGraw-Hill.

39 Xhosa is a language of South Africa. It is spoken by approximately 7.9 million speakers (about 18% of South Africans). Click consonants feature prominently in the sounds of this language, and even the name, "Xhosa", begins with a click. In IPA, the name of the language is pronounced approximately [xhosa]

40 Anderson proposes the following definition of nationalism: it is an imagined political community that is imagined as both inherently limited and sovereign. It is imagined because members will never know most of their fellow-members, yet in the minds of each lives the image of their communion. It is limited because it has finite, though elastic boundaries beyond which lies other nations. It is sovereign because it came to maturity at a stage of human history when freedom was a rare and precious ideal. And it is imagined as a community because it is conceived as a deep, horizontal comradeship. BENEDICT ANDERSON (1991) *Imagined Communities: Reflections on the Origin and Spread of Nationalism* Verso; Revised edition

41 Bruce Tuckman's simple four-stage model of model of the development in small groups has become a staple in thinking about teams since its publication in 1965. In his article *Developmental sequence in small groups*. *Psychological Bulletin*, 63, 384-399, Tuckman outlines four stages of team development as forming, storming, norming and performing.

Forming denotes either the formation of the whole team from scratch or the introduction of new members into an existing team, which was my particular case. The transition is one of individual to team. Successful forming is followed by storming, which is a result of potentially clashing opinions as to how the team should operate. As the team emerges with an agreed *modus operandi*, it advances to the next level, the norming, when the conflict and mistrust of the previous phase are replaced with co-operation and collaboration, and individual team members reconcile their views with the greater needs of the overall team. And then, when interpersonal differences are settled and a basis for loyalty has been created, the emphasis in the final phase shifts from working on team process to performing ever more complex tasks. From there, further stages can include a return to forming, through the introduction of a new team member, dorming, with the team resting on their performing laurels and getting complacent or adjourning after a goal has been reached successfully and the team has completed its task. Tuckman reckons that a successful team knows which stage they are in and manages the respective transitions accordingly.

42 Haley did more than just recapture the history of his own family. He popularised genealogy for black people. Haley Alex(1980) *Roots Dell Book*

43 "With things going so well I distributed my letters in the mornings, and saw the city during the afternoons. Walking about the streets, sitting on subways beside whites, eating with them in the same cafeterias (although I avoided their tables) gave me the eerie, out-of-focus sensation of a dream. My clothes felt ill-fitting; and for all my letters to men of power, I was unsure of how I should act. For the first time, as I swung along the streets, I thought consciously of how I had conducted myself at home. I hadn't worried too much about whites as people. Some were friendly and some were not, and you tried not to offend either. But here they all seemed impersonal; and yet when most impersonal they startled me by being polite, by begging my pardon after brushing against me in a crowd. Still I felt that even when they were polite they hardly saw me, that they would have

begged the pardon of Jack the Bear, never glancing his way if the bear happened to be walking along minding his business. It was confusing. I did not know if it was desirable or undesirable..."Elison R, (1995) *The Invisible Man* Vintage 8-9

44 FRENCH JR, J. P. R. & AND RAVEN, B. (1960) The bases of social power. IN CARTWRIGHT, D. & ZANDER, A. (Eds.) *Group dynamics*. New York, Harper and Row.

45 This notion is explored in Ian MCEWAN (2004) *Enduring Love*, London Vintage, where a handful of people witness a fatal balloon accident, and different characters return to their last memory of the balloon, replaying it over and over in their minds.

46 At least when... his grievous malady needed more food, the wretched man began to tear his limbs and rend them apart with his teeth and, by consuming his own body, fed himself.

47 Rachel <http://www.madnotbad.co.uk/poetry/poetryhome.htm> accessed on 05December2003

48 Current thinking on self-mutilation can be summarized under the following points: It is best regarded as a morbid form of self-help. While self-mutilation as such is seen as antithetical to suicide, mentally ill self-mutilators are at increased risk of suicide. Culturally sanctioned mutilative rituals are linked to physical healing, spiritual salvation, and social orderliness. Pathological self-mutilation not only reduces troublesome and painful symptoms temporarily but also serves the deeper purposes of healing, salvation and order. Pathological self-mutilation is classified into three basic clinical categories (major, stereotypic, moderate/superficial), which remain subject to change with new discoveries. Major self-mutilation is most often, but not exclusively, associated with psychosis and intoxications. Stereotypic self-mutilation is most often, but again not exclusively, associated with severe mental retardation. Moderate/superficial self-mutilation is most often, but not exclusively, associated with borderline, histrionic, and antisocial personality disorders. The syndrome of repetitive self-mutilation is a distinct disorder of impulse dyscontrol, the biological underpinning of which may be lowered functioning of serotonin, a neurotransmitter in the brain. A psychiatric diagnosis cannot be presumed in persons who engage in body piercing, branding, tattoos, and so forth, although as a group such persons probably have increased levels of psychopathology.

49 CRABTREE, L. H. & GROSSMAN, W. K. (1974) Administrative clarity and redefinition for an open adolescent unit. *Psychiatry*, 37, 350-359.

50 ROSS, R. R. & MCKAY, H. B. (1979) *Self-mutilation*, Lexington, MA, Lexington Books, 130 IN FAVAZZA, A. R. (1996) *Bodies Under Siege*, Johns Hopkins University Press, 315.

51 One patient of Favazza's fits in perfectly: "It was a patient whose impulsive behaviours were so prodigious that no professional caregiver could deal with her for more than a month at a time. She was a human cutting machine. When a therapist told her to go for long drives in her car to avoid cutting, she gladly complied stating, "Great! Now I can use the cigarette lighter to burn myself in the peace and quiet of my car!" She also devoured entire boxes of doughnuts as well as Ex-Lax in quantities so gigantic as to defy belief. Discontent with laxatives, she developed a novel scheme to lose weight – eating tapeworms gathered from repugnant sources. She also drank vodka instead of water and took 1000 milligrams of Benadryl (an antihistamine whose usual dose is 25 mg) to help her sleep. To top it off, she was arrested several times for shoplifting items she did not need. Psychology be damned, nothing short of a straitjacket could stop her impulsive actions. Then along came Prozac. A lot of it, and even more. The result: all the impulsive behaviours ceased. Just like that."

FAVAZZA, A. R. (1996) *Bodies Under Siege*, Johns Hopkins University Press, 321

52 HAWTON, K. (1990) Self-cutting. IN HAWTON, K. & COWEN, P. (Eds.) *Dilemmas and Difficulties in the Management of Psychiatric Patients*. Oxford, Oxford University Press: Hawton1 identifies further principles: First, the precipitating events should be analysed, and thoughts such as I hate myself, emotions, and associated behaviours should be identified. Also, considering the goals and benefits of the act of self-harm may be useful, as well as the negative consequences. It is important to gain control over the cutting, initially through a change in thinking and while later stages of treatment can be supported through physical exercise, physical contact with another person and medication. Once control is achieved, underlying problems can be examined, focusing on improving the patient's self-esteem and mood disturbances. And last, but by no means least, Inpatient treatment should be brief.

- 53 WALSH, B. W. & ROSEN, P. (1985) Self-mutilation and contagion. *American Journal of Psychiatry*, 142, 119-120. identify four categories of thought that lead to self-mutilation: 1. self-mutilation is acceptable. 2. One's body and self are disgusting and deserving of punishment. 3. Action is needed to reduce unpleasant feelings. 4. Overt action is necessary to communicate feelings to others.
- 54 TEMPLE, B. & HARRIS, J. (2000) The devil in the detail: Producing an account of self-harm. *The Qualitative Report*, 5(1/2).
- 55 VAN GENNEP, A. (1977) *The rites of passage*, London, Routledge & Kegan Paul.
- 56 <http://www.theweb.com/Shows/Show/0%2C7353%2C||1490%2C00.html>
- 57 MUSAFAR, F. (1996) *Body Play: State of Grace or Sickness?* IN FAVAZZA, A. (Ed.) *Bodies Under Siege*. Baltimore/London, Johns Hopkins University Press, 333-334.
- 58 DAVIDOFF, F. (1996) Who has seen a blood sugar? Philadelphia PA, American College of Physicians, CITED IN ELWYN, G. & GWYN, R. (1999) Stories we hear and stories we tell: analysing talk in clinical practice. *BMJ*, 318, 186.
- 59 The independent on Sunday ABC magazine 11th September 2005
- 60 HEATH, I. (1995) The mystery of general practice. 17-21 IN GREENHALGH, T. (1999) Narrative based medicine: narrative based medicine in an evidence based world. *British Medical Journal*, 318, 323-325.
- 61 GRIMLEY EVANS, J. (1995) Evidence-based and evidence biased medicine. *Age Ageing*, 25, 461-464, ASCH, D. (1995) Why some health policies don't make sense at the bedside. *Ann Intern Med*, 122, 846-850, GREENHALGH, T. (1998) Evidence-based medicine. IN HALL, M., DWYER, D. & LEWIS, T. (Eds.) *GP training handbook*. 3rd ed. Oxford, Blackwell Scientific.
- 62 69Ethnic and Cultural Considerations
- Special efforts have been made in the preparation of DSM-IV to incorporate an awareness that the manual is used in culturally diverse populations in the United States and internationally. Clinicians are called on to evaluate individuals from numerous different ethnic groups and cultural backgrounds (including many who are recent immigrants). Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behaviour, belief, or experience that are particular to the individual's culture. For example, certain religious practices or beliefs (e.g., hearing or seeing a deceased relative during bereavement) may be misdiagnosed as manifestations of a Psychotic Disorder. Applying Personality Disorder criteria across cultural settings may be especially difficult because of the wide cultural variation in concepts of self, styles of communication, and coping mechanisms.
- AMERICAN PSYCHIATRIC ASSOCIATION (1994) *Diagnostic and Statistical Manual for Mental Disorders. (DSM IV)* 4th ed., American Psychiatric Association.
- 63 Any such classification system is used for many different purposes, a clinical diagnosis is only one of its purposes; furthermore, there is a difference as to whether that diagnosis is made in primary care, which many psychiatric diagnoses are, and which is different from psychiatry. Any nosology is also used for epidemiology, which can work with a broadly defined group, for research, where it is important to get a homogeneous group, it is used for forensics and of course for administrative purposes, for insurance and billing, all of which have different concerns. So even no diagnosis becomes a diagnosis.
- 64 ... There is no doubt that scientific progress and experience with the use of these guidelines will ultimately require their revision and updating. I hope that such revisions will be the product of the same cordial and productive worldwide scientific collaboration as that which has produced the current text." Norman Sartorius in the Preface to *The ICD-10, Chapter V: Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines*, Geneva, World Health Organization, vii
- 65 BRODY, H. (1987) *Stories of sickness*, New Haven CT, Yale University Press.

66 PARSON, T. (1951) *The social system*, Glencoe IL, Free Press.

67 This point had been made before by Arthur Kleinman. In KLEINMAN, A. (1988) *The Illness Narratives*, New York, Basic Books, 211-222. he points out the importance not only of the explanatory model of the patient, but also of the healer, and he lists eight different types of healers, all prone to pick up on different points in the patient's narrative: First, there is the wounded healer, who needs to be of use, who stands out through his humaneness and dedication, often chronically ill himself, and his work is a main source of his identity and sense of self in the world. The next healer type perceives care as a burden, rather than the opportunity for growth the wounded healer sees. The burdened type chose his profession primarily or financial reasons, and would rather do research than deal with the patients. Then, there is the type that sees healing rooted in archaic human endeavour, whose ancient lineaments of shamanism and priestly functions and poetic insights are more part of religion, philosophy and art than of science. Then there is the healer whose medical experience has been deeply influenced by seeing conditions other than medical ones that need to be addressed and more so, revolutionised. There is, of course, also a cynic on Kleinman's list. Furthermore, he lists a healer who has been disenchanted with the degree to which health care has been commoditized, who is now managing clients instead of caring for patients. A sensitive neophyte is also included in the list, as is a Chinese healer.

68 emotikons -An emoticon is a short sequence of keyboard letters and symbols, usually emulating a facial expression, that complements a text message. An abbreviation itself (of emotion icon), the term is sometimes referred to by the name of the original emoticon, the smiley. the first smiley was posted on 1982.

:-)Smile

:;)Smile with a wink

:<)User with moustache, smiling

:|Mad

:(Sad

:'-(Crying

:~Also crying

69 SILVERMAN, D. (1987) *Communication and medical practice: social relations and the clinic*, Bristol, Sage.

70 The term pathography was originally defined in 1853 in Duglison's *Medical Lexicon* as a description of disease, and later as "the study of the effects of any illness on the writer's (or other artist's) life or art, or the effects of an artist's life and personality development on his creative work." The word was probably first used in this sense by Sigmund Freud, in *Eine Kindheitserinnerung des Leonardo da Vinci* (1910), and Oliver Sacks in the 1990 revised edition of *Awakenings* said that "the most perfect examples of ... pathography are the matchless case-histories of Freud" (although in earlier editions he wrote "pathology"). ARONSON, J. K. (2000) *Autopathography: the patient's tale*. *British Medical Journal*.

71 It is point that is very specific to Western culture, and has been illuminated beautifully by Mark Epstein, notably in his book *Thoughts Without A Thinker*, in which he develops a psychotherapy from a Buddhist perspective. EPSTEIN, M. (1995) *thoughts without a thinker*, New York, Basic Books.

72 CHAMBERS, T. S. (1994) The bioethicist as author: the medical ethics case as rhetorical device. *Lit Med*, 13, 60-78. examines the inherent value biases in bioethics and shows how the style choices bioethicists make in constructing their cases, i.e. choice of point of view, diction, images, and other features of style, lead the reader to come to particular logical conclusion.

73 By narrative competence Bolton understands the mastering a wide array of narrative skills, ranging from active listening and empathic responding in the client-practitioner interaction to reflective writing about one's professional experience. Her central scenario envisions a group of health care professionals who write reflectively about their own practices, and who then share this writing in a group setting that includes a preceptor or mentor.

74 The empty chair method is used in Gestalt therapy. Literally translated from German, "Gestalt" means shape or form, but with regard to gestalt therapy it implies wholeness, paying attention to the fact that there are feelings in the background as

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