

S.I.S

SELF INJURY SUPPORT
IN NORTH CUMBRIA

Registered Charity No: 1106750

SIS News

Welcome to SIS News



Welcome to the third issue of SIS News. It seems that spring has sprung!

It's been a busy start to the year for SIS with Self-Injury Awareness Day and our four one-day training workshops in March. Our new dates for training can be found on the [next page](#) along with lots of other information about what we're up to.

Helen has been busy developing support groups for those who self-harm, and with Ruth has been busy engaging with local secondary schools which is a great move forward. However, unfortunately some schools will not recognise that self-harm is an issue in their school.

In this issue one of our counselors, Helen Damment talks about Borderline Personality Disorder, and Sue offers some tips for caring for a person with an eating disorder. We hope you find it interesting and useful.

Please get in touch if there's anything you'd like to see in future issues!

Mary Hillery

New Trustee

We are pleased to announce that Keith Nightingale is the latest addition to the SIS board of trustees. Keith is a former consultant anaesthetist in North Cumbria hospitals, and now teaches medical students part-time at Glasgow University. He is on the Board of Cumbria Neighbourhood Watch Association and is a committee member and former chair of Brampton Tanzania Trust. He enjoys his small-holding, mountaineering and coaching cricket.

Following our training workshops we've had some interest from potential trustees, so hopefully we'll have some good news in the next issue of SIS News!

With thanks to our funders.



Issue 3

April-June 2009

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(if clicking on hyperlink remove 'mailto', otherwise it won't send)

SIAD 2009 - SIS Open Day



Since 1st March (Self-Injury Awareness Day, or SIAD) this year was on a Sunday SIS decided to open its doors to the public on Monday 2nd March.

Orange balloons (orange is seen as the colour for self-injury awareness) were tied to the door and on a notice on the main street directing people to the office. Orange badges and ribbons were available for donations, and there were loads of sausage rolls, cheese straws, tomatoes and nibbles for people to pick at throughout the day, along with the mandatory tea and coffee!

Over the course of the day we had a good number of visitors, representing various organisations including (among others) the Job Centre, Victim Support, West Cumbria Rape Crisis, Carlisle Diocese, Action for Blind People, and Primary Care Trust NHS.

We also had one person who arrived at the office needing counselling for self-harm which we were able to arrange immediately. This did highlight to us that being out of the way (i.e. off the main high street with no sign), perhaps we are missing people who really do need access to our services.



It was a really positive networking experience, and certainly something that we'll be repeating in the future - the good news is that 1st March is a Monday in 2010 so we can do it on the day - put it in your diaries now!

SIS NEW Training Workshops!

Following the success of our training workshops in March (see page 4 for information about how they went and the comments people made) we have two new training workshop dates arranged—these training days cost just £80 (including VAT) and include comprehensive training materials, refreshments and lunch. Courses run from 10am-4pm (refreshments from 9:30am).

Tuesday 23rd June - Carlisle
Thursday 2nd July - Workington

We are also getting increasingly booked up for in-house training. Please contact Ruth on 01228 515500 if you're interested in arranging training, or if you wish to book a place on one of the dates above.

Notice board



Website News!

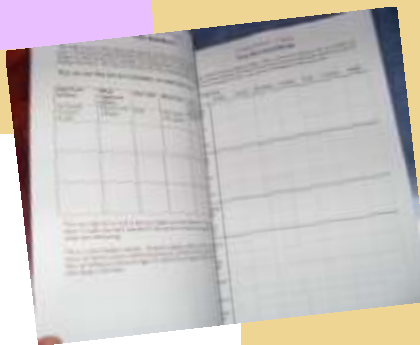
Good news! The SIS website is now up and running - you can visit it here:

www-sis-cumbria.co.uk



Designed and Created by "Bluezon Design' our website is going to develop over time so that we can reach and support even more people who self-harm (and those who support them) in Cumbria.

SIS has developed a Workbook for those who self-harm. This resource is designed for people to work through (either on their own or with help) so that they can begin to understand a bit more about their self-harm. The workbook can be purchased for £10, and can be photocopied for use within your organisation. Contact us to order a copy!



Comments, Complaints and Compliments

SIS is always striving to improve so any feedback - positive, negative or neutral - is much appreciated. We will always do our best to take suggestions into consideration, **and if it's something simple we can often make changes immediately!**



Patient Opinion is an online forum for people to post their views, queries and issues about NHS services, anonymously if they wish to do so. The number of calls about self-harm have surprised the moderators of Patient Opinion. It is a pilot scheme at present but if anyone contacts the forum from an area outside the pilot, the message is forwarded on. Visit the Patient Opinion website: www.patientopinion.org.uk

It provides a way for people who may have a general question, are unhappy about a service, but not wishing to raise a formal complaint or to post a good news story.

SIS Training Workshops...and data projectors

Having never delivered training on any subject before, and having never really spoken out loud about my own personal experiences of self-harm (certainly not to a large group) I was pretty nervous at the prospect of our four training workshops in March, but reassured that Ruth and **Helen would also be there and that with three of us presenting it wouldn't be as daunting as it could be.** Although SIS has delivered training before, previously it has been carried out by completely different people.

We started off in Whitehaven with a fairly small group. Panic set in when I found that the data projector I'd borrowed from work failed to turn on (it had worked fine the night before of course!) However, I muddled through, although thinking that perhaps Ruth and Helen had the right idea by not relying on technology! For a first training session I think we all did well, and feedback was on the whole positive.

Typically the following week in Carlisle we had a much larger group but a much smaller room. Again **an initial problem as my laptop wouldn't connect to the venue's data projector.** Having a bigger



group seemed to generate a lot of conversation, and also differences in opinion!

Penrith the next week, and the technology issues were sorted, using the SIS laptop, and a brand new shiny projector of our own (photo on the left is me presenting). Unfortunately due to a few cancellations this was our smallest group yet, but small as it was, it doesn't mean it wasn't useful.

Cockermouth was our final training workshop. A small, but lively and interesting group of delegates. This time the data projector problems were completely down to my lack of common sense in not connecting the necessary wire. I will get there eventually!

Ruth, Helen and myself have really enjoyed the training experience and I feel we worked well as a team. The amazing thing is how different one session is to the next, based upon the size but more importantly the dynamics of the group. Each workshop taught us something new, and it was probably as interesting for us to learn from the delegates as it was for them to learn from us!

The most important thing I have learnt from the training is that you can never please everyone all of the time. However, we received so much positive feedback (admittedly it was not 100% perfect so there is room for improvement!), and **here's what some of our delegates said:**

The personal experience of the talker was excellent and gave a good understanding from their experience. Enjoyed the day and learned a lot.

Excellent introduction - please keep up the great work!

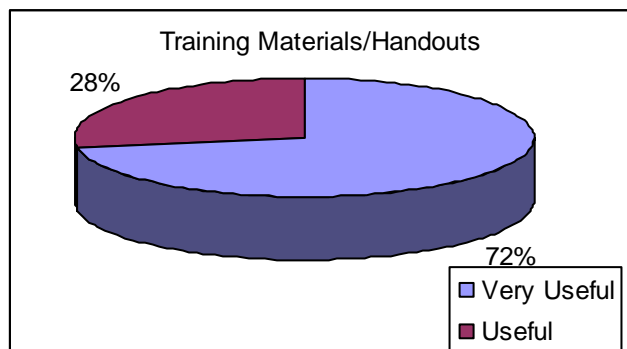
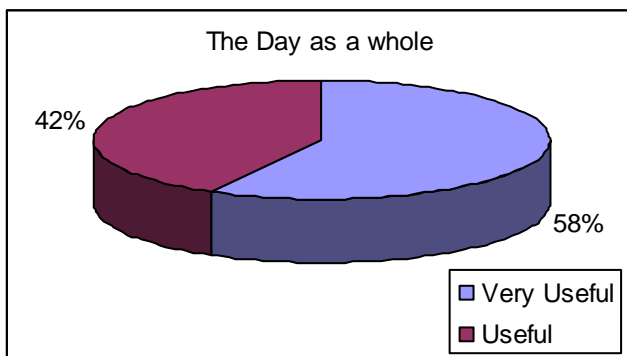
It was helpful to hear a personal experience and relate that to best practice

The day was very useful - informative, well paced, varied delivery method

Found group work a good way to relate to real life situations & problems faced and how to overcome them.

I felt the day covered everything I needed to know.

And here's some pie charts!



Someone asked me at one of the training sessions if I found it hard talking about my personal experience of self-harm. **To be honest I have found it a lot easier than I expected, and I've found that speaking does seem to come naturally (and once I start I just can't stop!).** However, I do find that at the end of the day I am absolutely exhausted and feel emotionally drained. So really the **answer is that it is easy for me, but then it's hard at the same time.** I feel that doing this training has done amazing things for my self-confidence, and I feel really privileged to be able to do this as a volunteer for S I S.

Following the last training session I was honoured to be asked to speak at the Carlisle Samaritan's AGM. I enjoyed the experience and look forward to speaking at other events!

Mary

CCYP Conference

'Self-Harm - an effective response' - 28th February 2009



British Association for
Counselling & Psychotherapy

Ruth, Sue and myself recently attended the CCYP (Counselling Children and Young People) self-harm conference in Gateshead along with nearly 200 other people, the majority being counsellors (The CCYP is a subdivision of the BACP).

Marcia Brophy delivered the first keynote speech of the day, focussing on the National Inquiry into Self-harm among young people which was now 4 ½ years ago. Those who would like more information about the findings of the National Inquiry can find it here www.mhf.org.uk/campaigns/self-harm-inquiry/

It was interesting to hear Marcia's disappointment that the recommendations from the inquiry haven't been taken forward as far as had been hoped (for instance a lack of engagement with the NICE guidelines on self-harm), and how much work there still is to do. However, there has been a website (a 'virtual centre of excellence') created as a result of the Inquiry - www.thesite.org/healthandwellbeing/mentalhealth/selfharm if you want to take a look.

In the morning I attended the workshop **"When Self-Harm is Sexual: A Multi-Agency Approach"**, led by Tim Woodhouse - a play therapist. I had imagined that this would be focussing mainly on forms of sexual self-harm. However, the talk was mainly looking at brain development, and issues of traumatic response. We looked at a case study which did touch upon self-harm, and the importance of a multi-agency approach. Parts of the presentation were very interesting, but **I don't feel really relating much to self-harm specifically.**

In the afternoon I attended **'Am I Bovered?'** delivered by Cathy Bell, a social worker and counsellor who is heavily involved with the Northern Ireland's Children's Strategy. Cathy began by showing us a clip of Catherine Tate playing her famous character of the teenager who isn't 'bovered' - Lauren. There followed a discussion of this, and we all agreed that Lauren actually is bovered - **she's desperate to fit in with her peers and to feel that she belongs. She hates being made to feel stupid, and has trouble expressing how she's feeling, instead sticking to saying "not bovered". Although it's comedy, it was actually quite a powerful illustration of the struggles that adolescents face in today's society.**



This was an excellent workshop (the highlight of the day for me—well, apart from the lovely lunch!), and **Cathy's delivery was witty and down-to-earth.** Various issues were discussed such as **the factors impacting on a young person's ability to cope, and self-harm as a choice people make.** We talked about the role of counsellors, and all agreed that counsellors are there to help people as they find less harmful ways to cope, but that it has to be something that the client wants to change.

Research shows that friends are normally the first port of call for young people who self-harm - they are usually the first people who will become aware of the self-harm. We talked about the importance of peer support, particularly in schools and how peer support programmes can be of enormous benefit to those who are supporting their peers (as well as those being supported) as it builds self-esteem, and a feeling of being able to help others - also, peer support can be accredited, so it can also be useful for young people for their futures.

The final session of the day was a keynote speech from Dr Andrew Reeves, talking about the public consequences of self-harm. Some interesting points were raised, for instance that by remembering that all of us self-harm to a certain extent, connections can be made with young people struggling with self-harm.

I thoroughly enjoyed the day and it was a great networking opportunity for S I S too, meeting people from across England and Scotland.

Mary

In the morning Ruth and Sue attended a presentation by Mike Smith entitled "Making Sense of Self-harm". Mike Smith is a former Director of Nursing, and has written many publications about mental health. He has done a lot of research and work in the area of self-harm.

In his presentation Mike highlighted three major questions facing professionals and service users alike:

- What do we mean by self-harm?
- Can we separate it from suicide?
- How do we work safely with people who self-harm?

Because this topic is so poorly understood there is much confusion over the terms self-harm, self-injury, deliberate self-harm and suicide. Mike defined self-harm as a:

'Repetitive, harmful act or omission to the self whose direct intent is not to end life.'

He believes the concept of safety and risk in self-harm are intertwined, the issue of risk tended to receive too much attention while safety is comparatively neglected. It is easy to lose sight of the need to maintain the safety of the person who harms him or herself as well as assessing whether the self-harm is actually being reduced. He recommends assessing risk and safety together with the person who commits the act of harm.

Mike has devised an assessment tool (SHARS) which separates the various domains relating to self-harm and this, he maintains, is more accurate than others. The tool is based on considering the five domains which are on the next page.

1. Intent,
Clarify the intention in harming oneself

2. Directness,
How directly linked are the life experiences and emotions to current self-harm

3. Potential lethality,
Appraise lethality of method of self-harm

4. Control and Distress,
Compulsion and intensity of their self-harm

5. Repetitiveness
Frequency of the incidence of self-harm

A judgement is reached, based on the guidance notes provided, as to risk and safety for each domain and then an overall conclusion is made about current risk and safety and this informs staff to help them create a plan to work with the client. The full guidance can be downloaded here - www.crazydiamond.org.uk/Self_harm_risk_rating_scale.pdf

Following his research most who used the tool found it more helpful. Staff felt the assessment accurately reflected the risk posed by their client and all of the clients felt it reflected the risks they faced. In particular, it offered an assessment of the current risk of suicide, whereas existing risk assessment tools mainly highlighted the fact that the person had self-harmed at some time in the past and nothing more. Interestingly he found 60% of mental health professionals he interviewed confused suicide and self-harm.

Ruth Lax

Borderline Personality Disorder

Borderline Personality Disorder: what does it mean? - Workshop at Cheshire Therapy Centre

For some time now I have been aware in my own practice, both with SIS and in other contexts, of a growing discomfort around the diagnosis of Borderline Personality Disorder (BPD) as though it explained in some way what is 'wrong' with a client. Self-harm, and particularly self-harm in women, is a 'symptom' more than frequently, in this diagnosis. My own experience with clients with this diagnosis is not extensive but has at times been challenging and at times perplexing but has never lead me to mentally 'group' these individuals or work with them in any way other than from the Person-Centred Approach.

Thankfully, because of the way I receive referrals, I have mostly met this diagnosis after I have

met the person to whom it has been applied, but it has almost always been significant in its presence and meaning to the view a client may have of herself and of her place in the world.

Generally, when I have met professionals involved with individuals with this diagnosis, I have also met with a sense of 'nothing to be done', 'untreatable', 'won't respond to therapy'. The expression 'static condition' had stuck when I'd heard it used. and lately I have questioned my own experience and understanding and had begun to feel in need of some reassurance.



A workshop advertised as 'Borderline Personality Disorder: what does it mean?' seemed to offer an opportunity to address my need to explore this further within a person centred context and with the help of a facilitator whose name I had come across and whose work as far as I was aware of it, I respected.

Gillian Proctor takes a clearly and unapologetically feminist view of this diagnosis. She argues persuasively that the diagnosis is part of the much wider issue of society's reluctance to deal with abuse of women particularly and links BPD to the historical strand from accusations of witchcraft to labelling as hysteric any deviance in behaviour from the 'appropriate' behaviour and demeanour of women.

A clinical psychologist with North Bradford PCT and a Person-Centred activist, she runs support groups and advocates on behalf of individuals with this diagnosis which is both inexact and controversial. When we looked at the 'criteria' for diagnosis, I recognised not only most of the behaviour of my once adolescent children but also myself at various times of my life. I was not the only one! The criteria can be found here - www.bpdworld.org/bpd_diagnostic_criteria.php

What I heard from both Dr. Proctor and other attendees with experience of working with individuals who have this diagnosis, is how disempowering it can feel to be that individual. What I heard most frequently, is that diagnosis did not involve any exploration of experience to which behaviour might be a response: it was all about the behaviour itself. To those working within the Person-Centred approach, taking a phenomenological perspective, this is entirely disrespectful of the individual and is of no help in understanding how to help that individual in her distress. The helplessness and sense of hopelessness that can accompany this diagnosis can not only accompany our clients into the therapy room but is reinforced in the client's interactions with agencies and professionals who may also have power over her life (from involuntary detainment under the Mental Health Act to removing children by the Local Authority).

I found the mix of experiences, from none at all to extensive, lively and useful. Most of the work involved sharing those experiences and what fears and difficulties were encountered by both counsellors and clients. The workshop was to be Person-Centred in its approach to both the experience and the subject - with attendees deciding on how it was to be conducted: power sharing from the outset as it was for us to decide on the usefulness or not of a power point presentation! We decided that it would be an aid in terms of structuring the work and the following information

gives an overview of the main themes and learning from this workshop with case studies for discussion and exploration.

Key Points:

- The existence of a diagnosis implies that BPD is a condition that can be objectively and accurately identified; in fact it is a highly subjective diagnosis
- Diagnosis does not offer any particular treatment. Implies a judgement; labels an individual as 'challenging', 'attention seeking', 'manipulative'. It places the 'fault' within the person as opposed to viewing behaviours as responses to that person's experiences, particularly of trauma or sexual abuse, abandonment or neglect (the effects of childhood neglect have recently been shown to be as devastating but similar to those of other abuse or repeated trauma)
- One of the most frequently raised issues around the treatment of clients diagnosed with BPD is that of 'boundaries'. This is particularly so in orientations and approaches other than Person-Centred. How much more useful and honest might it be for the therapist to take ownership and explore just how many boundary issues are about the therapist's own limitations rather than offer them as being in some way 'for the good or safety of the client'? How much more empowering for clients.
- BPD is much more frequently diagnosed in women and there is a substantial body of writing regarding society's definitions of madness and the political implications and implications for society.
- What is more helpful?: responding with humanity, seeking to understand that individuals have survived experiences which were awful to them as best they could and to honour that survival and their choices; remaining aware of what we are able to offer and what our own needs are in relation to working with these individuals; being as open as we can to what that individual is able to bring to therapy and not be constricted by expectations, particularly in respect of change or how change might be evidenced

A truly Person-Centred Approach with its emphasis on therapist's congruence and trust in the client here has much to offer. The reassurance that I gained from my attendance at this workshop has made significant differences in my understanding of issues around a diagnosis of BPD and strengthened my faith in the power of the Person Centred Approach to meet these clients as any other, without recourse to 'tools' or 'techniques'.

Helen Damment - SIS Counsellor

Tips for caring for someone who has an eating disorder



Families and friends are important when it comes to supporting someone with an eating disorder. I cannot stress that point enough. It can feel like an uphill struggle. Friendships can be put to the test, families can feel as though they are being punished, brothers and sisters can feel as though they are left out, so it is important to keep things in perspective and make time for all family members and yourself.

Talking to someone you think might have an eating disorder can be a very difficult thing to do. It is likely to be the very first step to getting help and the beginning of recovery. Prepare what you will say, and how you will say it. Find a time when it is quiet and you are not going to be interrupted. Be calm and say that you have noticed the changes in their behaviour, that you are concerned and want to help. **They may react angrily at first, but don't be put off by it and do not become angry yourself.**

Remember **it's not about food, it's about feelings, so don't talk about diets and weight loss.**

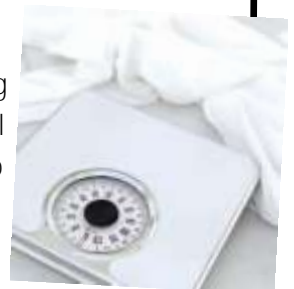
Remember that the person with an eating disorder is likely to be going to go through a range of feelings and emotions from depression, anger, hopelessness and despair. Hold on to the person you know, it is the disorder that is affecting the changes, the ups and downs.

Family and friends will go through periods of feeling helplessness, despair, sympathy, anger or resentment as well. You may feel that you should be able to sort it all out, because that is what parents are supposed to do. The truth is, parents cannot make the sadness and pain go away. What parents can provide is a safe place where the person who has the eating disorder can be themselves and know that they are loved and lovable despite the issues they face.

Parents, partners and friends can help the person they support and themselves by reading about eating disorders, talking to the GP or a counsellor. It helps everyone to understand what is going on. If the person with the eating disorder is getting professional help, be supportive when they are receiving treatment and be patient as it may be some time before there are any improvements or recovery.

Make sure that the eating disorders do not take over normal, everyday life. You must look after yourself and show the person with anorexia or bulimia that taking care of your needs is acceptable. It helps them to see that it is ok to practice self care. If the person is a family member, there may be joint therapy sessions to help the family as a whole cope. You will need to be a good listener. Show you love and accept them for the person they are. Keep things as harmonious as possible. They need to have respect and although they are going through a difficult time, resist the temptation to treat them as if they are incapable.

Reduce stress and anxiety at mealtimes. Include the person with the eating disorder in planning the menu, the shopping and food preparation. The more control they have, the less likely that there will be flashpoints at mealtimes. It helps to establish clear boundaries. Think about anything that may present a problem to them like leaving food around or having a set of bathroom scales. Have a whole family strategy.



It is very important for recovery to offer unconditional love and support to someone with an eating disorder. It is something that comes through from people who have come out the other side from eating disorders. They were loved even when they knew their behaviour was quite difficult to understand.



These tips were tried and tested by our family. We had a family member who went through a number of variations of eating disorders. That was four years ago and now **they are a healthy weight, holding down a good job, settled into marriage. It didn't** happen overnight or by magic and I have learnt so much about the strength we draw from each other. I also have great faith in the power of talking and counselling.

Sue Howard

Do:

- Speak calmly to the person, privately, and allow time for talking
- Tell the person that you are concerned for them
- Allow the person time to respond, and listen carefully, without being judgmental
- Ask them if they want to talk about their feelings
- Be aware of what they are telling you. If they talk about being too fat, not liking their body shape, needing to exercise, not wanting to eat with others, they may be indirectly saying they have an eating disorder **or** if they talk about taking laxatives, avoiding meals, hiding food or making themselves sick, they are directly telling you they have an eating disorder.
- Let them know you will support them
- Ask them if they have thought about getting some expert help
- Look after yourself. You can seek general advice and guidance from a GP, medical practitioner, counsellor without betraying a confidence
- Get help if you are concerned for their immediate well-being e.g. if they are passing out or complaining of chest pains, complaining of severe stomach ache and/or vomiting blood, or suicidal. Talk to the person, say that they need urgent help, call for medical assistance. Stay with them, continuing to talk to them calmly.

Don't:

- Don't show any signs of disgust, shock or panic (what they say might shock or distress you)
- Don't try to force the person to eat. Eating disorders often occur when someone feels that something in their life is out of control, they will not respond well to someone trying to 'control' them
- Don't ask them to get help or eat for your sake. It could add to the guilt and anxiety that they probably already feel
- Don't speak to a professional and name the person without first speaking privately to the person whom you suspect of having an eating disorder (unless the situation is an emergency).
- Don't confront the person when in a group, even if they are all friends - it may feel overwhelming and embarrassing. Eating disorders like all types of self-harm are often a very private thing
- Don't threaten or challenge the person
- Don't feel you have to get the person to talk, just being there for them can make a difference
- Don't be judgmental: The person isn't "sick," "crazy," or "stupid." They are distressed
- Don't give advice about weight loss, exercising, or appearance.
- Don't get into a battle of wills. It won't help either of you
- Don't make promises to the person that you cannot keep. You may have to tell someone else about the eating disorder
- Don't expect the person to agree with you; don't be too discouraged if they reject your concern.
- Don't feel you have to be responsible for them or try to tackle this on your own, even if the person is someone you know or are close to

For further information about eating disorders visit - www.b-eat.co.uk