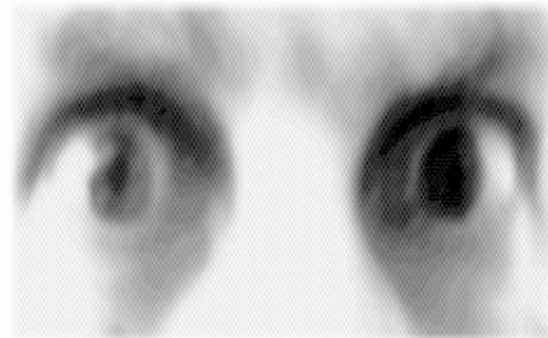


RAZOR'S EDGE

# IMPACT

Training & Consultation Ltd

responding to  
violence  
suicide  
psychosis  
and trauma



[www.dangerousbehaviour.com](http://www.dangerousbehaviour.com)



## RAZOR'S EDGE

Working with people who  
deliberately self-harm

"TRAINING WITH A TOUCH OF THEATRE"

**For further information contact:**

**IMPACT Training & Consultation Ltd**

Dr. Iain Bourne  
Beverley House,  
Old Chelsea Lane  
Bristol  
BS8 3UQ  
Tel & Fax: 01275 394774  
e-mail: [impact@dangerousbehaviour.com](mailto:impact@dangerousbehaviour.com)  
Web: [www.dangerousbehaviour.com](http://www.dangerousbehaviour.com)

Got a question? Then go to the  
Violence, Suicide & Trauma Forum at

<http://members3.boardhost.com/disturbing>

**Training, Consultation, Supervision, and Psychological Services  
to individuals, teams, and organisations, who come in contact  
with violence, suicide, self-harm, psychosis, and/or trauma.**

## RAZOR'S EDGE

### WARNING

Dear Colleague

These handouts are in note form and are only intended as a memory aid for people who have attended the "Razor's Edge" workshops run by IMPACT Training & Consultation Ltd. As such they are not sufficiently detailed to constitute guidance or advice. It is our hope to illustrate some real, effective and practical pathways available in working with people who self-harm. Ultimately, however, whatever anyone does having read these notes or attended one of our courses is beyond our control, and IMPACT Training & Consultation Ltd cannot take any responsibility for their actions.

In using these handouts, apply commonsense. If it feels like following any of the ideas in a particular situation makes you feel more vulnerable, don't do it. If your team or organisation have guidelines of their own, then follow those—or if they seem inadequate, discuss this with your manager.

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Dr Iain Bourne

Director, IMPACT Training & Consultation Ltd

16th August 2005

## RAZOR'S EDGE

# **“Razor’s Edge”**

## **working alongside deliberate self-harm**

### **TRAINER**

Dr Iain Bourne

### **TARGET GROUP**

All staff working with people who repeatedly inflict injuries upon themselves

### **STYLE**

This is a practice-based workshop employing theatrical devices to bring to life the dilemmas facing staff in assisting people who self-harm. The trainer dramatises critical moments from real life case studies and uses these as springboards to explore and discover good practice.

### **OBJECTIVE**

To increase participants confidence in working alongside people who self-harm, and to extend their repertoire of effective assessment and intervention skills.

### **LEARNING OUTCOMES**

By the end of the course participants should:

- Be able to differentiate suicide intent from self-injurious behaviour
- Have a good understanding of the various pathways that lead onto self-harm
- Be able to respond appropriately to clients who threaten imminent self-harm
- Be able to effectively engage clients in exploring their self-harm
- Be able to assist clients in developing strategies to feel in control of their self-harm
- Be aware of other resources available to people who self-harm

Director: Dr Iain Bourne  
IMPACT Training & Consultation Ltd  
Beverley House • Old Chelsea Lane • Failand • Bristol • BS8 3UQ • Phone & Fax 01275 394774  
impact@dangerousbehaviour.com  
www.dangerousbehaviour.com

Registered Company Number: 4590972

VAT Number: 650 5540 54

## **RAZOR'S EDGE**

### **PROPOSED GROUND RULES**

This can be a demanding and evocative course. It is essential, therefore, that all course participants understand the ground rules and that everyone undertaking the course adheres the following ground rules, and any others that the group agrees:

#### **Confidentiality**

It is important that participants feel safe to address practice issues without feeling judged or disadvantaged. To learn it is often necessary to try new roles, and argue from positions that are not always personally owned. Participants' behaviour and apparent attitudes on the course should not be confused with their attitudes and behaviour at work.

Nothing that is said by any course participant should be disclosed to, or discussed with anyone who is not part of this course. When participants talk about issues, experiences, or events involving others (e.g. clients, colleagues, friends etc.) – care should be taken not to divulge details that might reveal their identity.

Confidentiality may only be breached if

- A course participant's safety may be of serious concern
- The safety of another individual is at risk
- A criminal offence has been committed, or may be about to be committed

Any breach of confidentiality should be discussed those who may be affected beforehand, and with the trainer.

#### **Safety**

The course focuses on areas that are emotionally charged, often frightening, and potentially distressing. It is not however the intention of the course to cause distress. In terms of the participation in the exercises, the following guidance is offered:

Every effort will be taken to alert participants to the content of each session in order that it is possible to judge the extent to which they wish to participate. Opportunities will always be made for participants not to participate, or opt out of exercises without having to notify the trainer or explain their reasons.

During the "Scenario" exercises participants should not sit in the front row if they:

- would rather not
- feel tired, agitated or unwell
- have any serious concern about the nature of the exercise and what it may evoke in them
- have been involved in an assault that continues to affect them (flashbacks, ruminations, nightmares, avoidance or phobic reactions)
- feel the incident about to be acted out has significant similarities to one in which they have been personally involved

Guidance will be offered as to how participants can emotionally protect themselves should any of the scenarios portrayed begin to feel 'too' real. The trainer will be available after each session and the end of each day should any participant wish to talk about how the course has been affecting them.

#### **Respect**

Participants have the right to express their view, and be heard. Participants should respect themselves and other course participants. The trainer and participants have a responsibility to challenge oppressive and discriminatory attitudes and behaviour. Participants are reminded that this is a training course, and not an adjunct to personal therapy. Disclosures of sensitive material cannot be worked on, nor should interpretations be offered of other participants' behaviour. Disagreement and debate are welcomed, but personal attacks are not.

#### **Time**

The trainer will ensure that the course will finish on time, and will not extend the course beyond the times laid down. The exact timing of sessions may vary, and when this occurs, the trainer will clarify the new timings. Participants should take responsibility for returning to the training room in good time to start the next session. If participants have to leave, or cannot return to the course, it is requested that the trainer be informed of this. This will avert concerns being raised, or the sessions being delayed

#### **Mobile Phones**

These should be switched off or on "Silent" mode. Calls should not be answered during sessions unless specially agreed with the trainer

## RAZOR'S EDGE

### THE SCENARIOS

The incidents may involve WEAPONS, and be alarming, but no physical contact will take place. You will only be shown one critical phase of the incident – the fact that physical violence towards the worker is not acted out (for obvious reasons) does not mean that it did not occur. Other aspects of the incident will be talked through later. During the incident no one is to speak. Group 1 may move away, but should not move toward the actor. Groups 2 & 3 may stand or move to ensure that they can view the incident. The incident is over in one episode and ends when the actor leaves the room (2-7 minutes). Once the actor has left (i.e. at the end of the incident), each group should cluster into sub-groups of 3-6 (the trainer will indicate the size) to share reactions and observations. When the trainer returns the incident will be discussed in depth, and practical guidance offered in relation to the critical issues arising.

#### GROUP ONE

Remember that you don't have to be in this group if you don't want to. You will be closest to the 'action' and it is likely that your reactions will be more intense than those sat in groups 2 or 3. As far as you are willing, try to imagine yourself as being the worker involved in the incident. Do not, however, respond. You are really only an observer. Your task is to focus on your own personal reactions to the incident as it unfolds. It is understood that these may be different in a real incident. Never-the-less, notice your:

- heart rate and breathing
- physical sensations (e.g. feeling hot, cold, prickly, etc.)
- muscular tension
- eye gaze
- impulses to act (regardless of whether you would)
- thought processes, and their content
- emotional reactions
- coping mechanisms

In the 'wrap-up' you will be asked to relate your own personal experience of the episode. You can say as much, or as little as you wish. The trainer will facilitate this process by asking you specific questions.

#### GROUP TWO

You are asked to consider the story leading up to the incident, the incident itself, and consider what may follow from the incident. Your task is to try to make sense of

- what might have triggered it off
- what was going on
- the client's behaviour

Additionally, you are asked to evaluate the dangers to the worker, client, and others:

- which factors increased the danger (prior to the incident, during the incident, following the incident)
- which factors lessened the danger (prior to the incident, during the incident, following the incident)
- where in the incident do consider there to be the greatest/least danger & where were the vacuums?

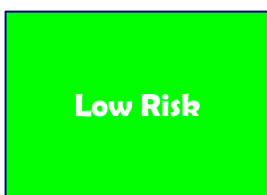
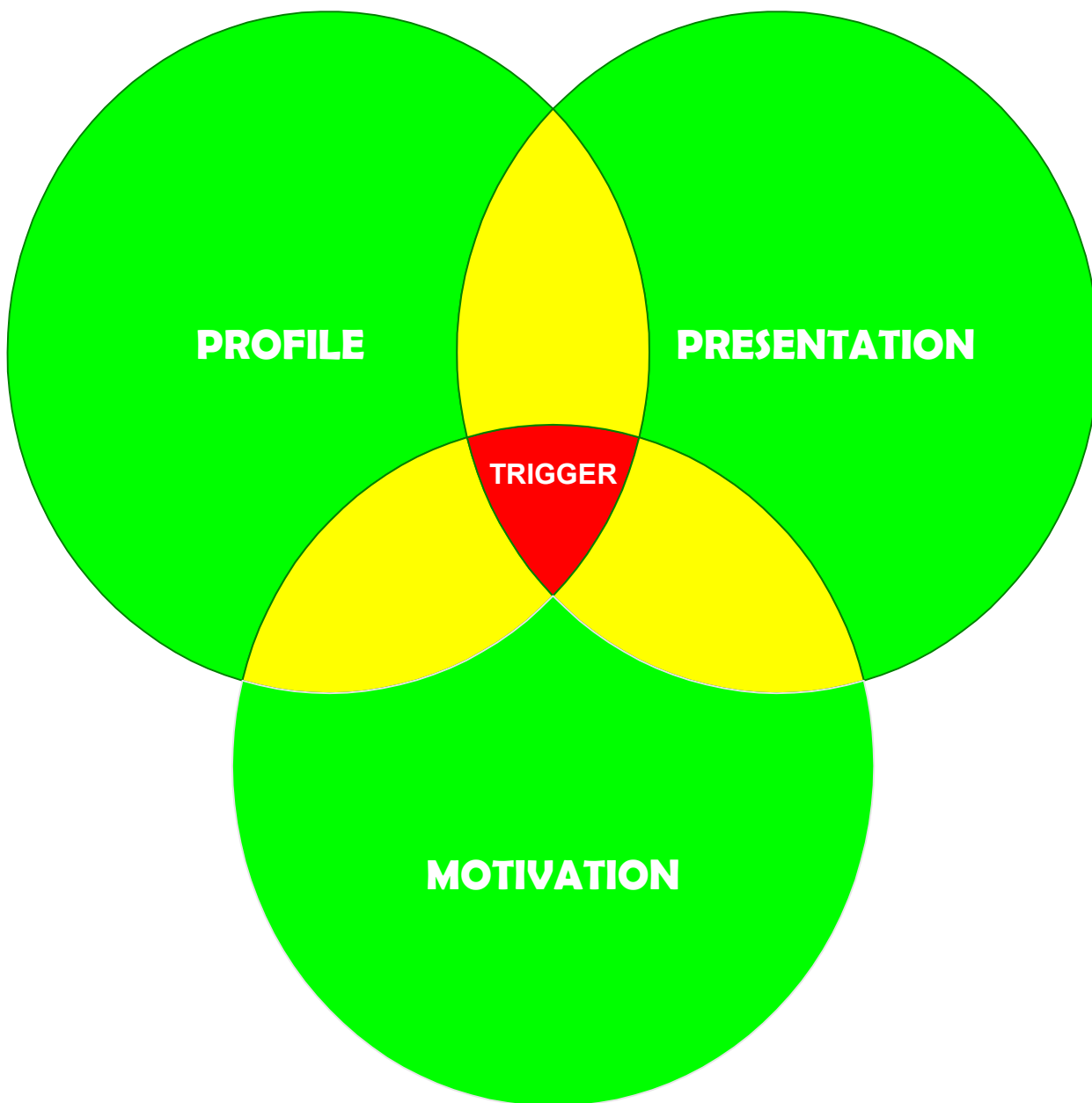
#### GROUP THREE

You are asked to consider how the worker directly involved in the incident, and where applicable, other workers might effectively and appropriately respond:

- what might they say, when and how might they say it
- what might they do, when and how
- how might the worker manage themselves, even if they are to do 'nothing' (e.g. where do they look, how do they position themselves)

You are not asked to present 'the solution' only to highlight the possibilities and practice dilemmas.

**SUICIDE RISK ASSESSMENT**  
**The Gunpowder Model**  
**(Bourne, 2003)**



## RAZOR'S EDGE

### Suicide Risk Factors

PROFILE	PRESENTATION	TRIGGER
Prior suicidal behaviour	Isolation-Withdrawal	Loss of an appeal
Psychiatric history	Unexplained improvement	Being bullied
Poor coping style	Giving things away	Access to lethal method
Hopelessness	Talking in the past	Substance misuse
Impulsivity	Talking philosophically	Loss of someone close
Substance misuse	Distracted	Conflict with someone close
Few friends	Disoriented	A suicide plan
No family supports	Shame, Guilt, Worry	Change in circumstances
Poor social skills	Inability to problem-solve	
Unstable life-style	Suicidal thoughts	MOTIVATION
Destructive behaviour	Crying	- to escape unbearable psychological state or situation
Poor health/chronic pain	Lack of emotions	- to gain revenge by inducing guilt in others
Early loss of a parent	Lack of verbal expression	- to punish oneself for being bad
	Absence of help-seeking	- to gain help and attention
	Surges of anger	

The client's *Profile* should be available if they have been involved with either psychiatric or social services. The Profile will indicate not so much the current level of risk, but the ongoing level of risk. Obviously the more profile risk factors identified, the more likely it will be that at some point the client will make a suicide attempt. The *Presentation* is only available by direct observation, and inquiry. The more presentation risk factors that are identified, the more likely it will be that a suicide attempt will occur in the near future. The *Trigger* will normally be discovered by knowledge of recent events and changes in the client's life – this may come from talking to the client directly, or from other sources (other clients, staff, family, other agencies). It may take only one trigger risk factor to be present to result in a suicide attempt if significant Profile and Presentation risk factors are present. It is also important to assess the prisoners *Motivation* to die, and this can only be achieved by interviewing them.

There is no score placed on this assessment. Simply, the more factors identified the greater the risk, and the risk is further increased if these factors are spread across all three columns.

People who self-harm are likely to score highly in terms of Profile, Presentation and Trigger. The important thing to assess is the Motivational risk factors. Self-harm is often an attempt at survival rather than death. None-the-less it is essential that the worker takes care in ascertaining whether this crisis is the same as all the previous ones, or in fact whether the motivation has changed.

The assessment of suicide risk is important because it will determine what happens next. If the risk is medium or low there is time to work on the underlying issues. If it is high, the priority is to avert a fatality. Sometimes community based support staff experience difficulty in getting mental health professionals to respond to their concerns. If, however, you can explain exactly why you feel a client is at risk, you are more likely to elicit a helpful response.

## RAZOR'S EDGE

### ASSESSING SUICIDE RISK

#### Style

1. It is important to prepare yourself emotionally before beginning the assessment. You will need to be clear about how you will go about it, and be able to convey genuine interest and concern. You may also have to “hold hope” for the client, illustrating by your style that there may be a way forward.
2. Do not shy away from words like using words like “death” “to be dead” “suicide” “killing yourself” “wanting to die” etc. It is important for the client that you do not walk on eggshells. They need to know that they can talk about these feelings without embarrassment or punishment.
3. Also challenge any or flippant colloquialisms about death (going to see my maker, going to a better place, popping off, topping myself). Simply paraphrase accurately (e.g. “you are talking about killing yourself”).
4. Do not wait for the client to raise the subject of suicide. Introduce as soon you get a sense that there may be a risk. “Have you been thinking about killing yourself?” “It sounds to me like you’d rather be dead”
5. Ask “Socratic” Questions to establish the level of suicide risk. Not “How are you feeling” (sinking spiral) but “How far have you gone into planning your death?” Socratic questions are open-end but focussed and investigative. Avoid “why” questions—usually unanswerable and mostly blaming and shaming.
6. Don’t go through the risk factors like you are asking them to fill out a Cosmo’ questionnaire. With self-harmers it’s important that their experience is treated as real, when they often feel too unreal themselves.

### NOTES

### RESPONDING TO IMMIMENT RISK

1. Mobilise all other resources (manager, ambulance, GP, police, crisis team, emergency duty team, relations etc)
2. Explore with the client an “Anti-Suicide Contract”
3. Explore “reasons to die, and reasons not to live”
4. Problem-solve around the critical issues that make them want to die now, rather than at other times
5. Help them to construct a narrative of the period from not feeling suicidal the point of feeling actively suicidal.
6. Very gently introduce “normal” things into the conversation. “Wasn’t it funny earlier when ...?”

### NOTES

# CLASSIFICATION OF SELF HARM (FAVAZZA & CONTERIO, 1988)

## MAJOR

Drastic acts of self-injury such as self-castration, amputation of a limb, removal of an eye. Most often associated with a psychosis, acute intoxication. Often has religious and sexual undertones (e.g. they may believe they were directed to act this way by God as penitence for sexual sins).

## SUPERFICIAL

This is the most common type and is the major focus of this course. Usually (although by no means exclusively) involves a variety of sharp implements to carefully make controlled and relatively shallow cuts to the skin. Favazza further categorises this type of self harm as below

## STEREOTYPIC

Includes head banging, biting, and skin scratching. Rhythmic and monotonously repetitive behaviours are commonly associated with severe learning disabilities, autism and Tourette's syndrome. It is thought that the repetitive behaviour is an attempt to either induce or reduce stimulation.

## EPISODIC

Here the self-injury isn't ongoing but occurs in response to moments of personal crisis and stress. The self-injury is seen as a survival mechanism rather than something that identifies who they are.

## REPETITIVE

Here the self-harm is ongoing even if there isn't a particular crisis. It becomes their identity - that of a "cutter" - and it is difficult for them to conceive what life would be like without self-injury.

## COMPULSIVE

The most repetitive and ritualistic of the three sub-types. Compulsive hair pulling and skin picking are the most common form, and once started may go on for long periods at a time (unlike repetitive self-harm which may happen daily but only for short periods).

## FOOD FOR THOUGHT

Favazza & Conterio's Study (1988) of 240 chronic self-harmers found that ...

Think of the number of people who die as a result of road traffic accidents. Now double it, and that's the number of people who kill themselves. (Not reported by Favazza et al., but quoted by MIND and based on figures by the National Statistical Office.)

For every one person who attempts suicide, 30 people will self-harm

For every one person who commits suicide, 140 will self harm

12% or 1 in 8 undergraduate psychology students admitted to deliberately having harmed themselves at least once

The vast majority said they grew up in families full of anger and double messages, in which they were told to be strong and prevented from expressing their feelings.

62% of people who self harm report childhood abuse

50% report sexual abuse (but remember 50% don't!)

71% considered their own self harm to be an addiction

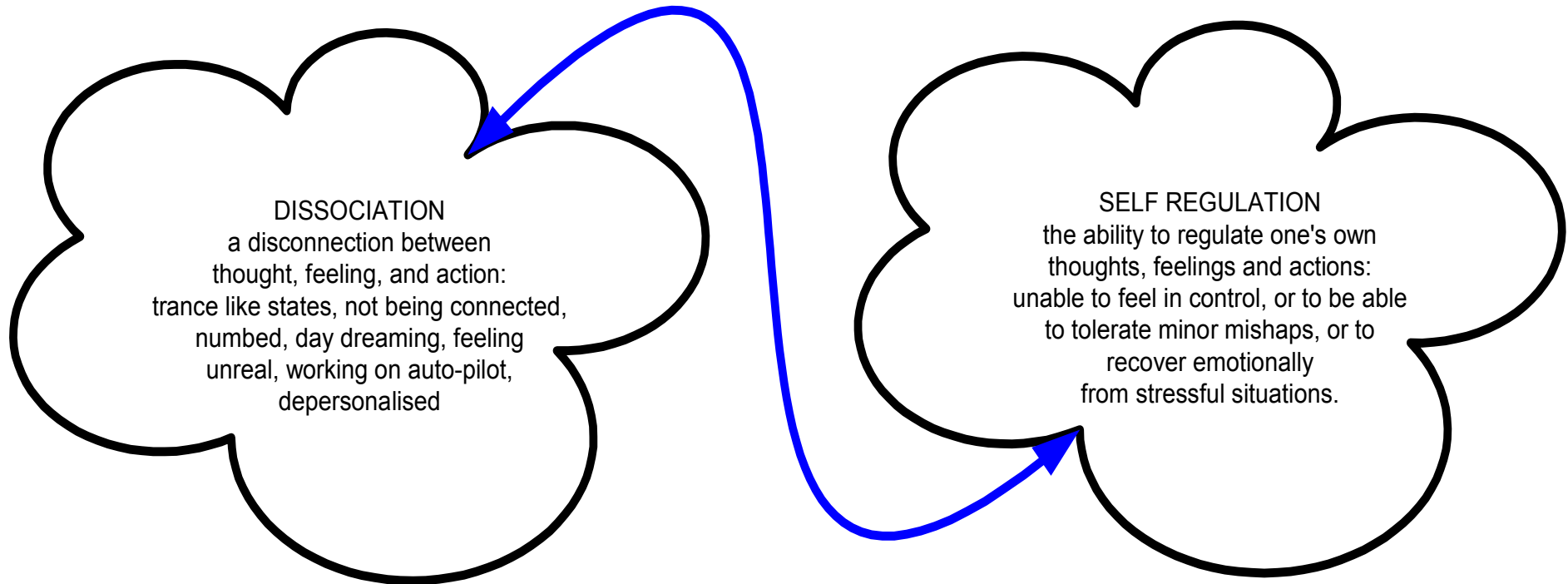
33% report the death of a close family member in their childhood

Over half describe their childhood as "miserable"

Most described themselves as as feeling empty inside, unable to express their feelings in words, afraid of getting close to anyone, and desperately wanting to stop their emotional pain

Over half were troubled by sexual feelings and a large number hated their body

## TWO BIG CLUES TO SELF-HARM

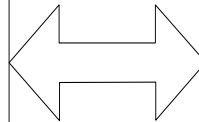


**NOTES:** We all dissociate and we all have struggle to keep in control of ourselves. Its more about how extreme , enduring and incapacitating these struggles become.

## MORE ON THE CLUES TO SELF-HARM

### DISSOCIATION

Dissociation is a defence, and a means of surviving. The brain allows you to be somewhere else when something unbearable is happening to you. We all do it, but for someone who self-harms it has often become a habit, not a way of surviving. Because dissociation may be linked with earlier repeated experiences where they may have felt helpless in the face of danger, when they dissociate later in life it can have either a terrifying quality, or a feeling of being numb and unreal. Harming oneself can make them feel "real" again, or take them away from the terrifying feeling.

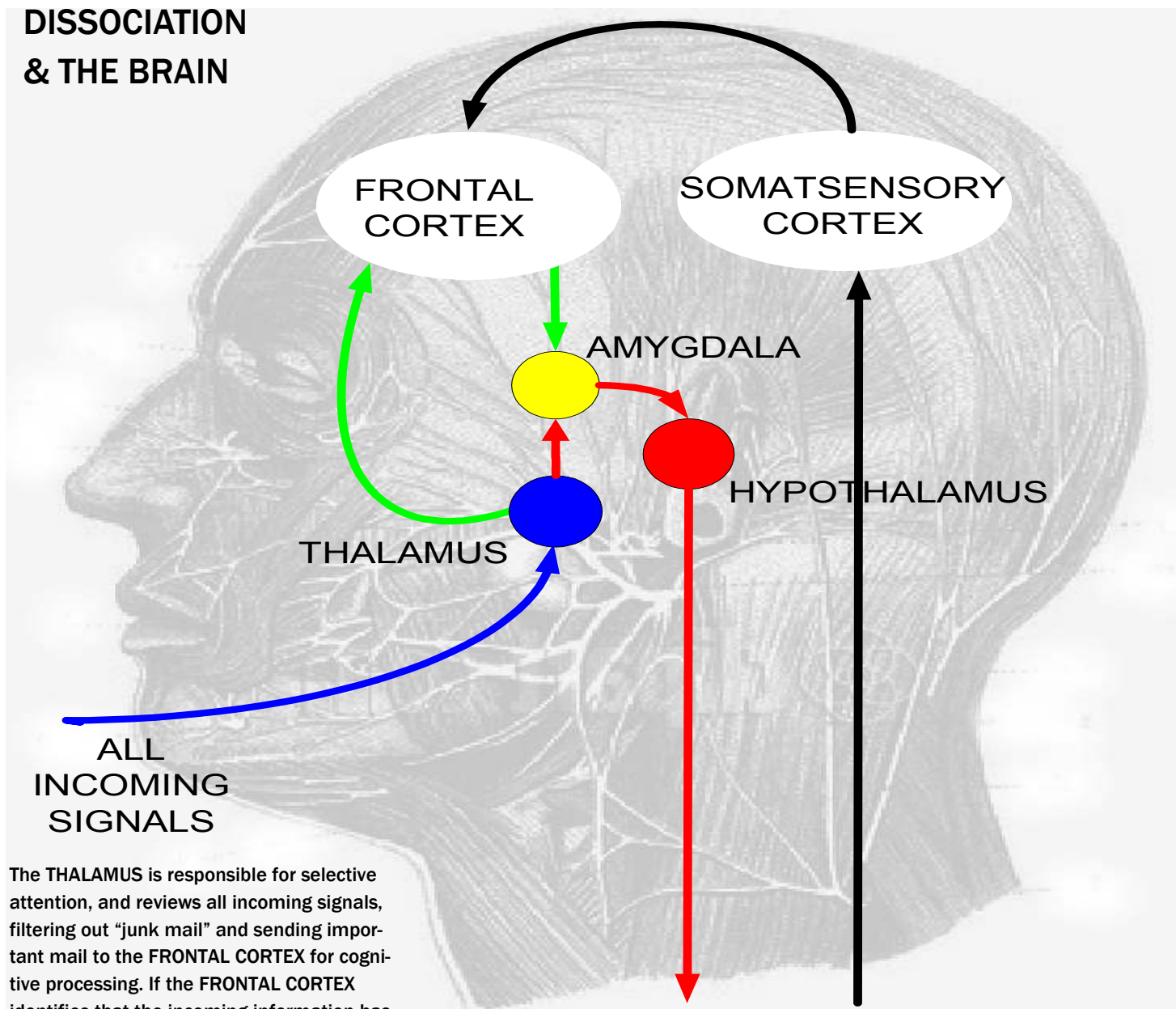


### SELF REGULATION

From birth the key to psychological growth is the ability to master control over your emotional and behavioural states. Initially the child learns how their carers comfort them when upset. Then they discover that when their carer isn't around, they can comfort themselves. Initially these will be physical methods (rocking, sucking their thumb, humming, stroking their hair), but later there will be cognitive strategies. If these skills are not developed then when a crisis occurs the person will feel helpless and out of control - and self-harm may be the only way they can find to restoring control.

NOTES: This does not mean that everyone who self-harms has been abused as a child. Other causes can be poor or chaotic parenting, or the prolonged illness of a key carer.

DISSOCIATION & THE BRAIN



The THALAMUS is responsible for selective attention, and reviews all incoming signals, filtering out “junk mail” and sending important mail to the FRONTAL CORTEX for cognitive processing. If the FRONTAL CORTEX identifies that the incoming information has an emotional component (any signal that requires a bodily response) this is then sent to the AMYGDALA which identifies that bodily response and then informs the HYPOTHALAMUS. In the case of perceived threat, the HYPOTHALAMUS would send hormonal signals to the adrenal glands creating changes in muscular contractions, heightened blood pressure, increased heart rate, narrowing of the visual field, and drying of the mouth.

The somatic changes are picked up by the SOMATOSENSORY CORTEX which in turn feeds this back to the FRONTAL CORTEX where this is recognised as an emotion.

This is a normal but (relatively) long process,

SIGNALS SENT TO THE BODY      FEEDBACK FROM THE BODY

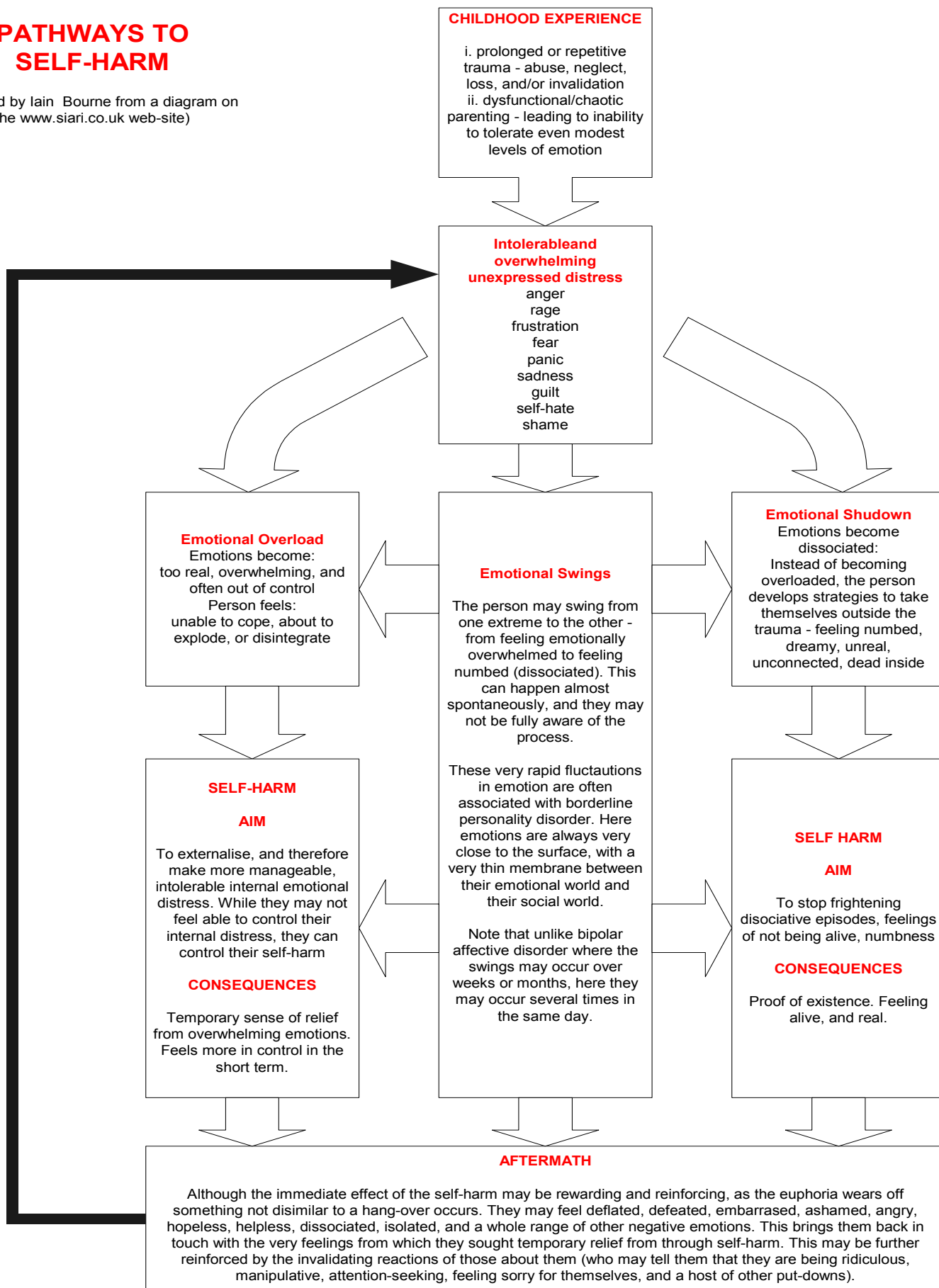
Dr Iain Bourne, IMPACT Training & Consultation  
01275 394774 impact@dangerousbehaviour.com

and not always fast enough for a crisis. Instead, if the THALAMUS identifies incoming stimuli as dangerous, that information is sent directly to the AMYGDALA, by-passing the FRONTAL CORTEX, and action takes place before thought. These are DISSOCIATIVE experiences. During violent episodes, the volume of information that needs to be processed immediately is too much for the cortex to handle and DISSOCIATIVE PROCESSES take over. For many self-harmers, due early repeated traumas, their thalamus has learned to label a much greater amount of incoming stimuli as a threat even when there is none. As a result, they are far more likely to dissociate—but this sends them directly to the amygdala, without conscious thought. And it is in the amygdala that emotionally laden traumatic memories are kept.

# RAZOR'S EDGE

## PATHWAYS TO SELF-HARM

(adapted by Iain Bourne from a diagram on the www.siari.co.uk web-site)



## TRAUMA RE-ENACTMENT SYNDROME

Earlier Trauma is associated with specific feelings

Ross acts to protect his mother from his father, but he is beaten up himself. The primary feelings are of rage towards his father, fear for himself, protectiveness towards his mother, and helplessness in the situation

Later Ross finds himself in a situation where he experiences rage, fear, protectiveness, and helplessness. He does not, however, have the skills to put this into words.

Later, when similar feelings are evoked, the client is consciously or unconsciously reminded of the earlier unresolved crisis

Unwittingly, the client may begin acting as if the original unresolved crisis is occurring again, but as the original players are no longer present, aspects of this will be projected, other aspects introjected.

Ross feels rage similar to that he experienced with his father, but his father is not there. He therefore chooses himself as the target - thus reenacting the original trauma. He becomes his father as the aggressor, his 'younger self' as the victim, and the worker becomes his mother who feels helpless.

Dr Iain Bourne  
IMPACT Training & Consultation Ltd  
impact@dangerousbehaviour.com  
www.dangerousbehaviour.com

## RAZOR'S EDGE

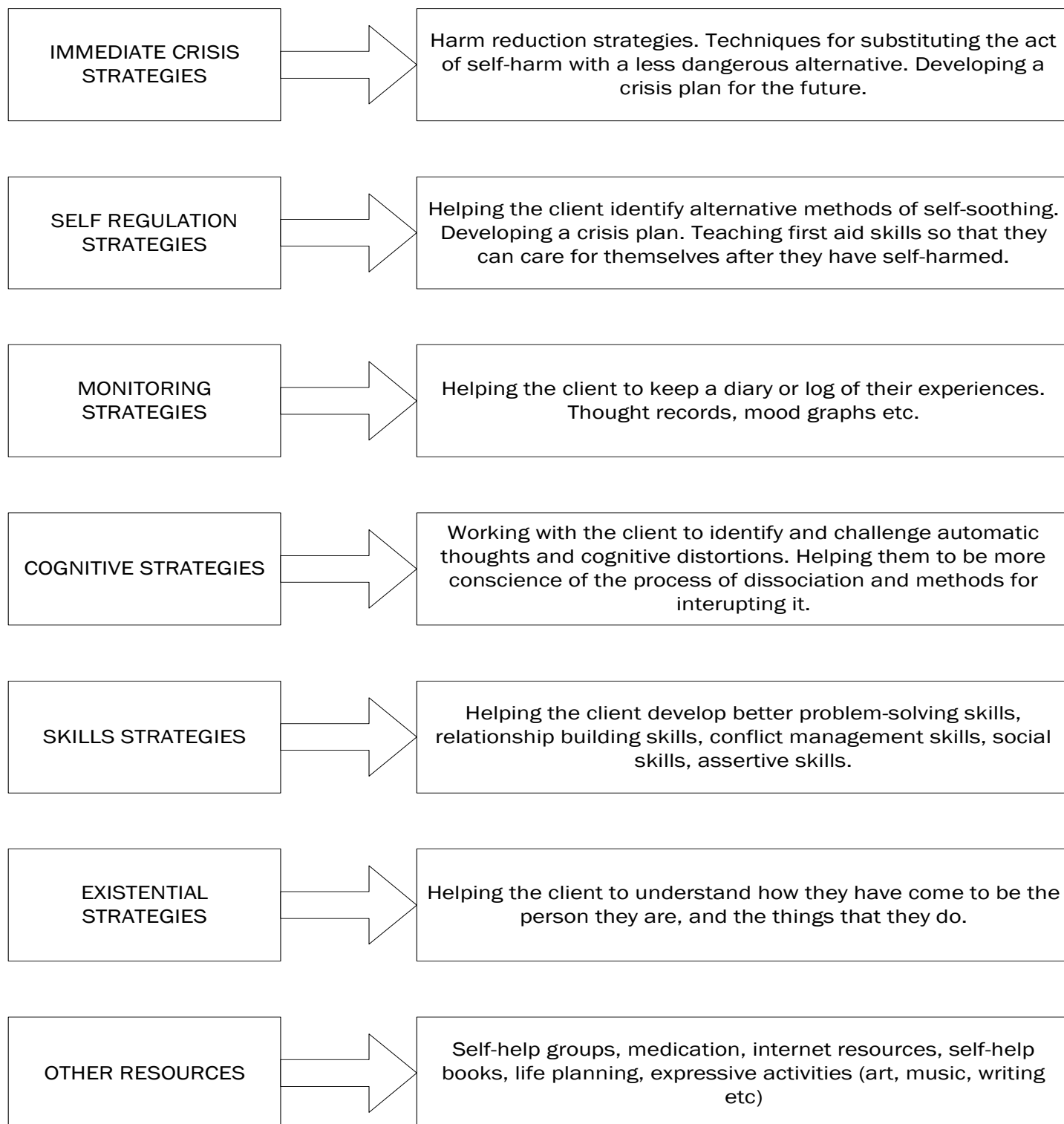
### SOME IMPORTANT POINTS

1. Most but not all self-harmers have experienced significant physical or sexual abuse in childhood. And for most it has not been a single act, but a recurrent one.
2. It has been shown that a single secure attachment bond is the most powerful protection against traumatisation. At times of crisis most young people can draw on an internalised representation of a parent to comfort them. Often people who self-harm are unable to do this.
3. Studies of maternal deprivation showed that monkeys deprived of maternal contact in the first year started to bite and otherwise mutilate themselves. Further studies showed that these deprived monkeys would attach to anything the researchers could devise—including a wire doll that hurt them when they got close!
4. Cutting usually starts at puberty, and for girls, especially those that have been abused, can lead to feelings of alienation from their bodies (numbness), but also self-hatred (somehow a feeling that they must have allowed this to happen.)
5. Most of us when distressed will either talk to someone about it, or if words fail, will cry— a natural cleansing, restorative and cathartic process . However, if as a child a person has been instructed by an abuser not to talk or to keep secrets, talking may not be easily available. Furthermore, crying may not be available to them because the numbing and dissociative defences that they have built up won't allow them access to tears. In desperate need of relief, and angry with themselves they have discovered that harming themselves can provide temporary relief,
6. The relief, however, is not only by way of a distraction. The body protects itself from excessive pain by releasing a natural analgesic, beta-endorphin, which is chemically very similar to morphine. Some people believe that people who self-harm are literally addicted to it. Its harder to give up because it is already in you and a part you, rather than like heroin which comes from outside and has to be put into your body.
7. Serotonin , a neurotransmitter linked with aggression, impulsivity, anxiety, depression, and suicidal tendencies—that is, self regulation - has been found to be less active in groups of people that self-harm. SSRIs have been found to be helpful for some, particularly compulsive people who self-harm.

### NOTES

### NOTES

# STRATEGIES FOR ASSISTING PEOPLE WHO SELF HARM



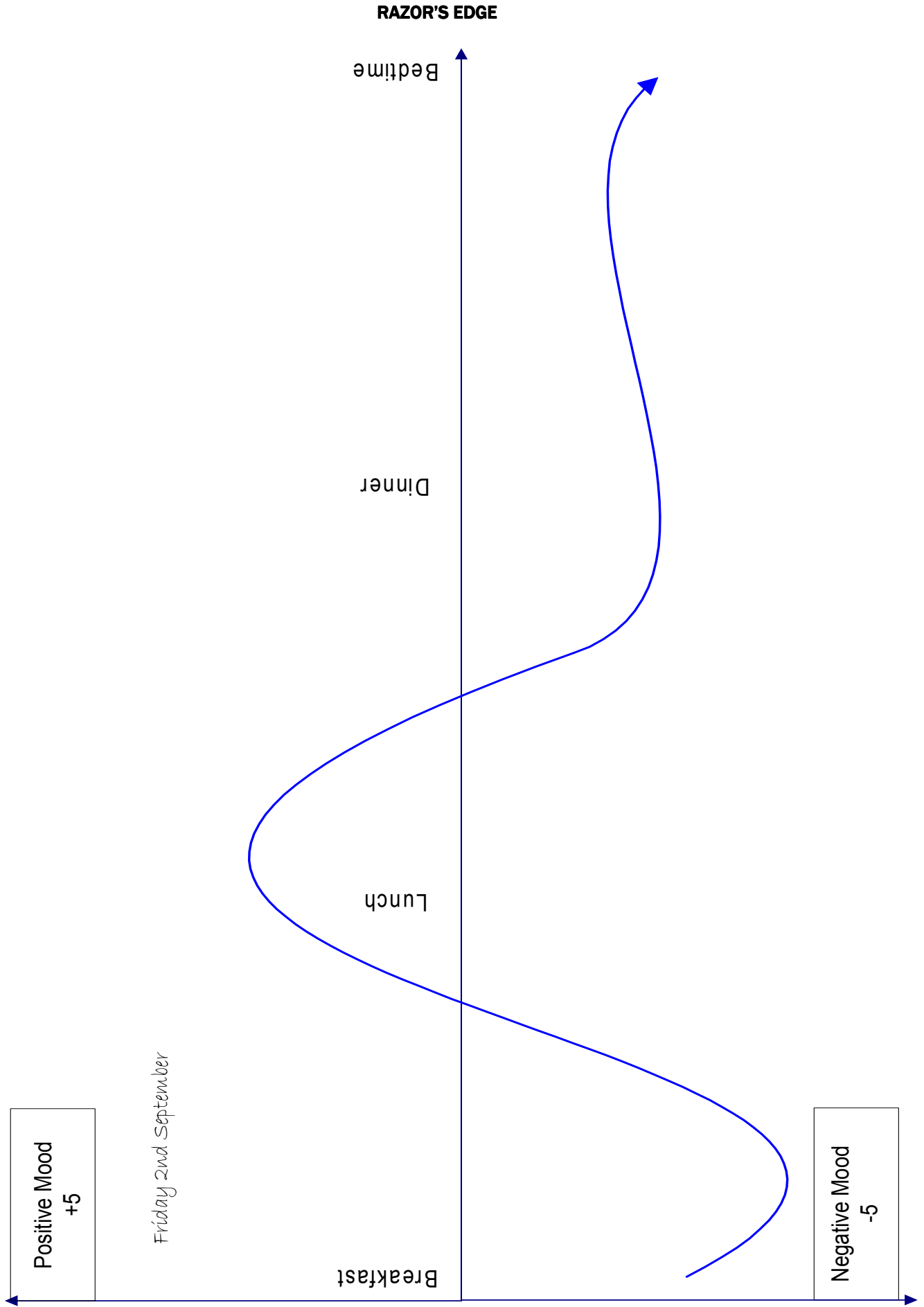
## An Example of a Self-Harm Thought Record

Triggering Events (a)	Self-Harming Thoughts (b)	Severity (1-10) (c)	Duration (d)	Feelings (e)	Severity (1-10) (c)	Duration (d)	Behavioural Response (f)	Change +/- (g)
Friday, 2nd September, 7.30 p.m. Had a row with Andy, my flatmate over the mess they left in the kitchen. Smashed a plate against the wall. Told them that I hated them and wished they were dead. They laughed at me and said I was mad.	Thought about going to the bathroom and cutting myself with a razor - but then I thought if I did Andy would have won, so I told myself not to give him the satisfaction.	9	20 mins	angry, embarrassed, stupid, ugly, frustrated, like a bomb exploded	9	1 hour	Went to my room, played my music loudly, thought about getting paralytic but didn't. Drew a picture of my flatmate and then poked holes in it and set it on fire	++

RAZOR'S EDGE

- a) Provide as much detail as possible; what day, time, who was present , what happened, what did you do?
- b) Describe the specific thoughts that you had at the time
- c) Describe the intensity of those thoughts on a scale from 1-10 (10 being overwhelming)
- d) Note how long you had thoughts. Be as precise as possible
- e) Describe all the feelings you had at the time.
- f) Describe what you did in response to the triggering event, and the thoughts of self-harm.
- g) How did your behaviour change the way you felt. Just note it as positive (+) or negative (-).

# An Example of a Mood Map



# COGNITIVE DISTORTIONS

## Dichotomous Thinking

All-or-nothing thinking. Only clarity of extremes are tolerated rather than the murky middle ground where there may be ambivalence and confusion. Since few things are wholly positive, it inevitably leads to a negative perspective on the world

## Selective Abstraction

Information is selectively chosen, so that it reinforces and supports the person's already formed negative views. Information that challenges the person's perceptions is carefully selected out.

## Arbitrary Inference

Theories about themselves, others and the world, are chosen despite the evidence, because they reinforce their own negative feelings and views .

## Minimisation & Magnification

Personal successes and positive feedback are minimised and rejected, while insignificant errors or failings are magnified out of all proportion

## Overgeneralisation

Global assessments are made on the basis of single or unrepresentative experiences or events.

## Labelling

The person accepts and lives according to labelling that has either been given to them, or they have given themselves. All incoming information is filtered through this label.

## Fortune Telling

The person develops a script about their life, and then begins to play out that script. The script is often tragic.

# CHALLENGING COGNITIVE DISTORTIONS

## Amplified Curiosity

Also known as the "Columbo Technique." The worker goes one down, and deliberately doesn't understand. The hope is that in trying to help the worker, they may find themselves challenging their own distortions. to evoke explanatory help from the client that will help them challenge their own distortions

## Examining the Evidence

The worker tries to discover what evidence the client has to support their distorted view. The client may even be encouraged to devise a real life experiment to test their views.

## Double Standards

Most people are far more critical and damning of themselves than others. The client is invited to consider their own judgements of someone who they like who was in the same situation as they are themselves. Why are they less condemning?

## Shades of Grey

Dichotomous thoughts are plucked out, and the client is invited to give an alternative non-absolute assessment - e.g. "on a scale of 0-100, how bad was it?" This is the beginning of an exploration about handling ambivalenc.

## Defining Terms

Global assessments are plucked out - lile "I am stupid" - and the client is invited to explain exactly what they mean when they say they are stupid. This avoids the tendency to to run themselves down too quickly.

## Semantic Reattribution

The person is invited to consider alternative explanations for situations that they blame themselves for. This invites a less egocentric view of the world.

## Cost-benefit Analysis

The person is invited to consider what they gain from holding a current belief or thought, and what price they have to pay to keep it.

## An Article on Self-help Strategies

<http://www.palace.net/~llama/psych/self.html>

### How do I know if I'm ready to stop?

Deciding to stop self-injury is a very personal decision. You may have to consider it for a long time before you decide that you're ready to commit to a life without scars and bruises. Don't be discouraged if you conclude the time isn't right for you to stop yet; you can still exert more control over your self-injury by choosing when and how much you harm yourself, by setting limits for your self-harm, and by taking responsibility for it. If you choose to do this, you should take care to remain safe when harming yourself: don't share cutting implements and know basic [first aid](http://www.palace.net/llama/psych/firstaid.html) (www.palace.net/llama/psych/firstaid.html) for treating your injuries.

Alderman (1997) suggests this useful checklist of things to ask yourself before you begin walking away from self-harm. It isn't necessary that you be able to answer all of the questions "yes," but the more of these things you can set up for yourself, the easier it will be to stop hurting yourself.

While it is not necessary that you meet all of these criteria before stopping self harm, the more of these statements that are true for you before you decide to stop this behaviour, the better.

- I have a solid emotional support of friends, family, and/or professionals that I can use if I feel like hurting myself.
- There are at least two people in my life that I can call if I want to hurt myself.
- I feel at least somewhat comfortable talking about SI (self-injury) with three different people.
- I have a list of at least ten things I can do instead of hurting myself.
- I have a place to go if I need to leave my house so as not to hurt myself.
- I feel confident that I could get rid of all the things that I might be likely to use to hurt myself.
- I have told at least two other people that I am going to stop hurting myself.
- I am willing to feel uncomfortable, scared, and frustrated.
- I feel confident that I can endure thinking about hurting myself without having to actually do so.
- I want to stop hurting myself.

[Alderman (1997) p. 132]

### How do I stop? And anyway, aren't some of these techniques just as "bad" as SI?

There are several different flat-out-crisis-in-the-moment strategies typically suggested. My favourite is doing *anything* that isn't SI and produces intense sensation: squeezing ice, taking a cold bath or hot or cold shower, biting into something strongly flavoured (hot peppers, gingerroot, unpeeled lemon/lime/grapefruit), rubbing Vap-O-Rub® under your nose etc. [Matching](http://www.palace.net/llama/psych/#match) (www.palace.net/llama/psych/#match) reactions and feelings is extremely useful.

These strategies work because the intense emotions that provoke SI are transient; they come and go like waves, and if you can stay upright through one, you get some breathing room before the next (and you strengthen your muscles). The more waves you tolerate without falling over, the stronger you become.

But, the question arises, aren't these things equivalent to punishing yourself by cutting or burning or hitting or whatever? The key difference is that they don't produce lasting results. If you squeeze a handful of ice until it melts or stick a couple of fingers into some ice cream for a few minutes, it'll hurt like (to quote someone I respect) "a cast-iron bitch" but it won't leave scars. It won't leave anything you'll have to explain away later. You most likely won't feel guilty after -- a little foolish, maybe, and proud that you weathered a crisis without SI, but not guilty.

This kind of distraction isn't intended to cure the roots of your self-injury; you can't run a marathon when you're too tired to cross the room. These techniques serve, rather, to help you get through an intense moment of badness without making things worse for yourself in the long run. They're training wheels, and they teach you that you *can* get through a crisis without hurting yourself. You will refine them, even devise more productive coping mechanisms, later, as the urge to self-injure lessens and loses the hold it has on your life. Use these interim methods to demonstrate to yourself that you can cope with distress without permanently injuring your body. Every time you do you score another point and you make SI that much less likely next time you're in crisis.

## RAZOR'S EDGE

Your first task when you've decided to stop is to break the cycle, to force yourself to try new coping mechanisms. And you *do* have to force yourself to do this; it doesn't just come. You can't theorize about new coping techniques until one day they're all in place and your life is changed. You have to work, to struggle, to *make* yourself do different things. When you pick up that knife or that lighter or get ready to hit that wall, you have to make a conscious decision to do something else. At first, the something else will be a gut-level primitive, maybe even punishing thing, and that's okay -- the important thing is that you made the decision; you chose to do something else. Even if you don't make that decision the next time, nothing can take away that moment of mastery, of having decided that you were not going to do it that time. If you choose to hurt yourself in the next crisis time, you will know that it is a choice, which implies the existence of alternative choices. It takes the helplessness out of the equation.

### So what *do* I do instead?

Many people try substitute activities as described above and report that sometimes they work, sometimes not. One way to increase the chances of a distraction/substitution helping calm the urge to harm is to match what you do to how you are feeling at the moment.

First, take a few moments and look behind the urge. What are you feeling? Are you angry? Frustrated? Restless? Sad? Craving the feeling of SI? Depersonalised and unreal or numb? Unfocused?

Next, match the activity to the feeling. A few examples:

#### **angry, frustrated, restless**

Try something physical and violent, something not directed at a living thing:

Slash an empty plastic soda bottle or a piece of heavy cardboard or an old shirt or sock.

Make a soft cloth doll to represent the things you are angry at. Cut and tear it instead of yourself.

Flatten aluminium cans for recycling, seeing how fast you can go.

Hit a punching bag.

Use a pillow to hit a wall, pillow-fight style.

Rip up an old newspaper or phone book.

On a sketch or photo of yourself, mark in red ink what you want to do. Cut and tear the picture.

Make plasticine or other clay models and cut or smash them.

Throw ice into the bathtub or against a brick wall hard enough to shatter it.

Break sticks.

I've found that these things work even better if I rant at the thing I am cutting/tearing/hitting. I start out slowly, explaining why I am hurt and angry, but sometimes end up swearing and crying and yelling. It helps a lot to vent like that.

Crank up the music and dance.

Clean your room (or your whole house).

Go for a walk/jog/run.

Stomp around in heavy shoes.

Play squash or tennis.

#### **sad, soft, melancholy, depressed, unhappy**

Do something slow and soothing, like taking a hot bath with bath oil or bubbles, curling up under a comforter with hot cocoa and a good book, babying yourself somehow. Do whatever makes you feel taken care of and comforted. Light sweet-smelling incense. Listen to soothing music. Smooth nice body lotion into the parts or yourself you want to hurt. Call a friend and just talk about things that you like. Make a tray of special treats and tuck yourself into bed with it and watch TV or read. Visit a friend.

#### **craving sensation, feeling depersonalised, dissociating, feeling unreal**

Do something that creates a sharp physical sensation:

Squeeze ice *hard* (this really hurts). (Note: putting ice on a spot you want to burn gives you a strong painful sensation and leaves a red mark afterward, kind of like burning would.)

Put a finger into a frozen food (like ice cream) for a minute.

Bite into a hot pepper or chew a piece of gingerroot.

Rub liniment under your nose.

Slap a tabletop hard.

Snap your wrist with a rubber band.

## RAZOR'S EDGE

Take a cold bath.

Stomp your feet on the ground.

Focus on how it feels to breathe. Notice the way your chest and stomach move with each breath.

[NOTE: Some people report that being online while dissociating increases their sense of unreality; be cautious about logging on in a dissociative state until you know how it affects you.]

### wanting focus

Do a task (a computer game like Tetris or minesweeper, writing a computer program, needlework, etc) that is exciting and requires focus and concentration.

Eat a raisin mindfully. Pick it up, noticing how it feels in your hand. Look at it carefully; see the asymmetries and think about the changes the grape went through. Roll the raisin in your fingers and notice the texture; try to describe it. Bring the raisin up to your mouth, paying attention to how it feels to move your hand that way. Smell the raisin; what does it remind you of? How does a raisin smell? Notice that you're beginning to salivate, and see how that feels. Open your mouth and put the raisin in, taking time to think about how the raisin feels to your tongue.

Chew slowly, noticing how the texture and even the taste of the raisin change as you chew it. Are there little seeds or stems? How is the inside different from the outside? Finally, swallow.

Choose an object in the room. Examine it carefully and then write as detailed a description of it as you can. Include everything: size, weight, texture, shape, colour, possible uses, feel, etc.

Choose a random object, like a paper clip, and try to list 30 different uses for it.

### Try some of these distractions

#### Wanting to see blood

Draw on yourself with a red felt-tip pen.

Take a small bottle of liquid red food colouring and warm it slightly by dropping it into a cup of hot water for a few minutes. Uncap the bottle and press its tip against the place you want to cut. Draw the bottle in a cutting motion while squeezing it slightly to let the food colour trickle out.

Draw on the areas you want to cut using ice that you've made by dropping six or seven drops of red food colour into each of the ice-cube tray wells.

Paint yourself with red paint.

#### Wanting to see scars or pick scabs

Get a henna tattoo kit. You put the henna on as a paste and leave it overnight; the next day you can pick it off as you would a scab and it leaves an orange-red mark behind.

Another thing that helps sometimes is the fifteen-minute game. Tell yourself that if you still want to harm yourself in 15 minutes, you can. When the time is up, see if you can go another 15. I've been able to get through a whole night that way before.

### I tried all of that. I still want to hurt myself.

Sometimes you will make a good-faith effort to keep from harming yourself but nothing seems to work. You've slashed a bottle, your hand is numb from the ice, and the urge is still twisting you into knots. You feel that if you don't harm yourself, you'll explode. What now?

Answer these as honestly and in as much detail as you are able to right now. No one is going to see the answers except you, and lying to yourself is pretty pointless. If, in all honesty, you see no other answer to #8 but yes, then give yourself permission, but set definite limits. Do not allow the urge to control you; if you choose to give in to it, then choose it. Decide beforehand exactly what you will allow yourself to do and how much is enough, and stick to those limits. Keep yourself as safe as you can while injuring yourself, and take responsibility for the injury.

The questions

1. Why do I feel I need to hurt myself? What has brought me to this point?
2. Have I been here before? What did I do to deal with it? How did I feel then?
3. What I have done to ease this discomfort so far? What else can I do that won't hurt me?

## RAZOR'S EDGE

4. How do I feel right now?
5. How will I feel when I am hurting myself?
6. How will I feel after hurting myself? How will I feel tomorrow morning?
7. Can I avoid this stressor, or deal with it better in the future?
8. Do I need to hurt myself?

### Staying safe while hurting yourself

A few things to keep in mind should you decide that you do need to hurt yourself:

- Don't share cutting implements with anyone; you can get the same diseases (hepatitis, AIDS, etc) addicts get from sharing needles.
- Try to keep cuts shallow. Keep first aid supplies on hand and know what to do in the case of emergencies.
- Do only the minimum required to ease your distress.
- Set limits.
- Decide how much you are going to allow yourself to do (how many cuts/burns/bruises, how deep/severe, how long you will allow yourself to engage in SI), keep within those boundaries, and clean up and bandage yourself later.

If you can manage that much, then at least you will be exerting some control over your SI.

### What is "fake pain" and why does it matter?

The concept of "fake pain" helps to explain why distress-tolerance skills are so crucial.

Observation of myself and interviews with others have convinced me that one of the reasons people self-injure is to deflect unknown, frightening pain into understandable, sort-of-controllable "pseudo" or "fake" pain. Calling this phenomenon "fake pain" is in no way intended to suggest that it doesn't hurt; it hurts like hell. When memories or thoughts or beliefs or events are excessively painful, instead of facing them directly and feeling "genuine" pain, we sometimes deflect distress into pain that seems understandable and controllable, like that of self-injury. The real feelings associated with the event you're avoiding get overridden by those of the situation you create to distract yourself. It still hurts like hell, but it's a controllable familiar hell, whereas the real pain you're avoiding seems scary and poised to take over your world like the monster who ate Detroit.

It's easy to revert to "fake" pain. Trying to find the source of your distress can be scary as hell, because you often don't know what you're going to unleash. Fake pain, although very painful and traumatic, is something that you understand and can control and can handle. It's familiar, not mysterious and scary like the real pain behind it. You might feel that if you ever exposed yourself to the real pain you'd lose control: "If I ever start crying, I'll never stop" or "If I let myself get mad about that, I'll never stop screaming."

Instead, you unconsciously deflect the distress away from the memories or feelings that generated it and into self-injury. SI is seductive: you control it. You know the boundaries, even when you feel out of control. It makes sense and it makes the distress go away, at least for a while. It's a clever mechanism – it takes what seems unbearable and transforms it into something you can control. The only problem is that when you deflect pain, you never face up directly to what it is that has caused this much tumult in your life. So long as you channel distress into fake pain, you never deal with the real pain and it never lessens in intensity. It keeps coming back and you have to keep cutting.

You *have* to deal with the unbearable if you ever want to make it lose its power over you. Every time you can meet the real pain head-on and feel it and tolerate the distress, it loses a little of its ability to wipe you out and eventually it becomes just a memory. The process is like building tolerance to a drug. Narcotics users take a little bit more of their drug every day as tolerance builds, until eventually they're routinely taking amounts of drug that would kill an ordinary person. The poisonous events in your past work in a similar way. Exposure (with the help of a trained therapist) over time will build your tolerance to these events and enable you to lay them to rest. The key is learning to tolerate distress.

### DBT-related skills

Marsha Linehan's [Skills Training Manual](#) has several helpful worksheets for getting through crisis situations. Though they are best used as part of a DBT program with a trained therapist, you might find some of them helpful.

#### Accepting Reality

This concept focuses on learning to accept reality as it is. Accepting it doesn't mean you like it or are willing to allow it to continue unchanged; it means realizing that the basic facts of the situation *are* even if they aren't what you'd like them to be. Without this kind of radical acceptance, change isn't possible.

#### Letting Go of Emotional Suffering

In this worksheet, you learn ways to observe and describe your emotion, separate yourself from it, and let go of it. One of Linehan's basic principles is that emotion loves emotion, and this worksheet is designed to help you experience your emotions with amplifying them or get caught in a feedback loop.

#### Distraction

Distraction is simply doing other things to keep you from self-harming. Most of the techniques mentioned above are distraction techniques; you bring something else in to change the feeling. Using ice, rubber bands, etc, is substituting other intense feelings for the self-injury. Other things Lineman suggest substituting include experiences that change your current feelings, tasks (like counting the colours you can see in your immediate environment) that don't require much effort but do take a great deal of concentration, and volunteer work.

#### Improve the Moment

This worksheet focuses on ways to make the present moment more bearable. It differs from distraction in that it's not just a diverting of the mind but a complete change of attitude in the moment.

#### Evaluating the Pros and Cons of Tolerating Distress

As the name implies, this worksheet leads you through an evaluation: what are the benefits of doing this self-harming thing? What are the benefits of not doing it? What are the bad things about doing it? About not doing it? Sometimes writing this down can help you make a decision not to harm.

#### Self-Soothing

This, like improving the moment and distracting, is a distress tolerance technique. It's pretty straightforward: use things that are pleasing to your senses to soothe yourself. Some people find that active distraction works better for violent angry feelings and soothing is more effective for soft, sad ones.

#### Reducing Vulnerability to Negative Emotion

Prevention of states in which you are likely to self-harm is covered in this worksheet, which suggests ways of taking care of yourself in order to minimize the times when you feel the urge to hurt yourself. If you're balancing eating, sleeping, and self-care, you're less likely to be overwhelmed by emotion.

#### Interpersonal Effectiveness

Being clear about what you want and about your priorities in an interaction are crucial to good communication, and this worksheet offers a series of questions and steps to follow to help you determine how to approach a difficult interpersonal interaction. It is truly amazing how much going through these steps can help.

### I still keep obsessing about hurting myself. Help?

It's not uncommon for people to continue thinking obsessively about self-injury for a while after they've made the decision to stop. Hurting yourself has been a huge part of your life up until recently, and you're used to dwelling on it. You might think that you're supposed to be "cured" now and that all thoughts of SI should magically vanish from your head, so when you catch yourself thinking about that blade or lighter or whatever, you get angry and frustrated and shove the thought away.

Foa and Wilson (1991) deal with intrusive thoughts by a combination of giving you permission to think about it and exposure/habituation techniques combined with ritual prevention. Exposure refers to repeatedly presenting someone with the situation about which they obsess, and habituation happens when, after much exposure without resulting to usual actions, the person gets used to the situation and it no longer distresses them.

To adapt these techniques, first make yourself safe. If you're in a mindset in which self-injury seems very very likely, it might be

## **RAZOR'S EDGE**

better to use distraction techniques to get past that place. Line up a support person whom you can call if you get overwhelmed by this technique. Try to tolerate it for as long as you can, even if you're uncomfortable.

First, designate two 10- or 15-minute time periods daily. Choose times when you will be alone and able to think without being interrupted. To begin, set a timer for the designated amount of time. Then obsess about hurting yourself. Think about what it would feel like, how you would feel afterwards, how much you want to do this – all those thoughts you've been trying to suppress. Get as distressed as you can, and stay focused on the topic of injuring yourself. You may find, especially after the first few times, that you get really bored toward the end of your time period. That's a good sign – you're becoming habituated.

When the time is up, stop thinking about SI. If thoughts of wanting to harm come into your mind at other times during the day, acknowledge them and remind yourself that you will think about them later, when it's time. Then let them go. If they come back, repeat the process. Don't shove them away or try to ignore them; just acknowledge, remind yourself they have their time soon, and let go.

After a week or so you will notice an improvement (maybe even after just a few days). One crucial thing: no matter what, do not act on the thoughts of SI. They are just thoughts, and you can use the skills that you used to stop harming to get through these times. In order for habituation to occur, you have to get through the exposure without resorting to the old behaviour. Use distraction and substitution for SI (ritual) prevention.

### **NOTES**

**SOME POINTS ABOUT WORKING WITH PEOPLE WHO SELF HARM**

1. The goal should not be to get them to stop harming themselves, but for them to feel in control of their feelings and their behaviour. If they choose to stop harming then that's great.
2. The client may have great difficulty in expressing how they feel. That may be why they self harm. Use props to help them— have a list of feelings written down so that they can read through them to see which ones fit. If they can't verbalise their feelings, see if they could draw them.
3. Because talking about their harm can feel shameful use work books so that they don't have to look you in the face the whole time.
4. Don't push them to talk about their experience of past abuse, and specifically do not infer that they must have been abused. Its up to the client if they want to explore their past.
5. Agree on tasks for them to work on between sessions. These tasks may be focussed on
  - Challenging some of their assumptions about themselves, others and the world,
  - Practice skills in self-regulation, relationship building, assertiveness etc
  - Monitoring their thoughts (SH Thought Record), or their emotions (Mood Maps)
6. These tasks can provide a focus for your explorations the next time you see the client.
7. Be explicit with the client about what you are trying to do and why. If something is troubling you it is almost always best to "go public."
8. Establish a Crisis Plan—what they should do if they feel like seriously injuring them before you see them next.
9. Hold very clear boundaries. Many people who self harm have difficulty with attachment and separation.
10. For the same reason issues of closure should be worked through very clearly well before your involvement is about to end.
11. Make sure you have very good supervision!

**NOTES**

**NOTES**

## **USEFUL CONTACTS**

### **National Children's Bureau**

8 Wakley Street, London, EC1V 7QE

telephone: +44 (0)20 7843 6000

Email: [selfharm@ncb.org.uk](mailto:selfharm@ncb.org.uk)

Website: [www.selfharm.org.uk/database](http://www.selfharm.org.uk/database)

### **NHS Direct**

Telephone: 0845 4647

Website: [www.nhsdirect.nhs.uk](http://www.nhsdirect.nhs.uk)

### **Bristol Crisis Service for Women**

P.O. Box 654, Bristol BS99 1XH

National Helpline: 0117 925 1119

Website: [www.users.setnet.co.uk/bcsw/](http://www.users.setnet.co.uk/bcsw/)

### **National Self-Harm Network**

P.O. Box 7246, Nottingham NG1 6WJ

Email: [info@nshn.co.uk](mailto:info@nshn.co.uk)

Website: [www.nshn.co.uk](http://www.nshn.co.uk)

### **42nd Street**

2nd Floor, Swan Buildings, 20 Swan Street, Manchester M4 5JW

Helpline: 0161 832 0169

### **Self Harm Alliance (SHA)**

P.O. Box 61, Cheltenham, Gloucestershire, GL51 8YB

Tel: 01242 578820

Email: [Selfharmalliance@aol.com](mailto:Selfharmalliance@aol.com)

Website: [www.selfharmalliance.org](http://www.selfharmalliance.org)

### **Colchester Rape Crisis Line**

P.O. Box 548, Colchester, Essex, CO3 3JX

Helpline: 01206 769795

Website: [www.crcl.org.uk](http://www.crcl.org.uk)

### **Childline**

Tel: 0800 1111

Website: [www.childline.org.uk](http://www.childline.org.uk)

### **Samaritans**

Tel: 08457 90 90 90

### **Mind**

Tel: 08457 660 163

### **YoungMinds**

Tel: 0207 336 8445

Parents Information Service: 0800 018 2138

<http://www.youngminds.org.uk/selfharm>

## **USEFUL BOOKS**

The Basement Project have published 3 excellent booklets by Lois Arnold & Anne Magill "The Self-harm Help Book", "What's the Harm" and "Making Sense of Self-harm"

Marilee Strong (2000) wrote "A Bright Red Scream; self-mutilation and the language of pain" published by Virago. Very well researched and brilliantly written. A lot of the ideas in these handouts are drawn from her book.

Gerrilyn Smith, Dee Cox and Jacqui Saradjian (1998) wrote "Women an Self-Harm" published by The Women's Press. A good little book covering much of the same ground as Marilee Strong's book but from a British perspective. Particularly good on resources in the UK.

Ulrike Schmidt and Kate Davidson (2004) wrote "Life After Self-Harm" a step by step self-help book. Lots of exercises and worksheets that you could work on together with your client. Published by Bruner Routledge.

"Working with Self Harm; Victim to Victor" by Mike Smith i(1988) is an another self-help resource with a wealth of practical exercises.

"Bodily Harm" by Karen Conterio and Wendy Lader (1998) describes the course of treatment developed by S.A.F.E. (Self Abuse Finally Ends)



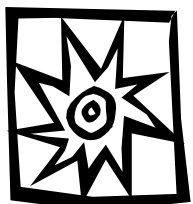
1, 2, or 3 days

9–36 participants

### Difficult, Disturbing & Dangerous Behaviour

A very dramatic, theatrical, intense and evocative course. Great for involving the whole team as it requires no prior training, can be delivered to large groups (30+) and is very engaging. It also provides very specific training on dealing with situations and behaviours which create the greatest concerns for staff.

*When behaviour moves beyond reason—dealing with explosive rage—dealing with psychotic and substance-affected behaviour—centre-based incidents—lone-working, and working away from base—teamwork issues—post-incident support—policy and procedures*



1, 2, or 3 days

9–36 participants

### Experiencing Mental Health Problems

Another good whole team training event focussing on how people who are affected by mental health problems experience their world. The course develops through a series of personal stories, each relating to a different type of problem, and dramatised in “fringe-theatre” style to bring the material to life.

*Ways of understanding mental health problems—schizophrenia – depression – trauma – anxiety states—dementias*



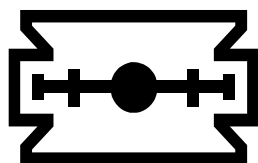
1, 2, or 3 days

9–24 participants

### Suicidal Behaviour

Particularly appropriate for staff and volunteers working with service-users who may talk about suicidal thoughts and feelings, or exhibit suicidal behaviour. This is very much focussed on the practice issues involved in minimising the level of risk, and working through the critical underlying issues.

*Assessing suicide risk and motivational issues – crisis intervention –working ongoing risk— working with self-destructive command hallucinations*



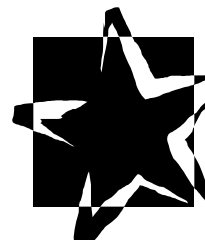
1, 2, or 3 days

9–24 participants

### Deliberate Self-harm

Self-harm can easily leave staff and volunteers feeling helpless and frustrated. Again through a series of unfolding dramatised stories, participants are guided through a deeper understanding of self-harm, and practical skills and empowering approaches.

*Methods and motivations—dealing with the imminent crisis— establishing a therapeutic alliance—trauma re-enactment cycles—alternatives to self-harm—facilitating change*



1, 2, or 3 days

9–24 participants

### Hallucinations, Delusions, & Paranoia

A journey into some of the most difficult to understand aspects of human behaviour. This course explores the experience of psychosis, how to make sense of it, and strategies for helping service-users take control of their world.

*Development of psychotic experiences—helping people in an acute psychotic crisis— assessing the hallucinations, delusions, and paranoia—brief empowering strategies*



5 or 10 days

6–16 participants

### Trauma Counselling

When listening isn't enough, what can we do to assist people whose world has recently been turned upside down through some traumatic experience? This course will primarily of interest to counsellors wishing to explore brief and focussed methods of working with trauma.

*Understanding trauma—adaptive and transitional processes— psychological first aid—defusing and debriefing—therapeutic narratives—mapping—facilitating change—power therapies*



2, or 3 days

6–16 participants

### Staff Supervision & Post-Crisis Support

Exposure to difficult, disturbing, and dangerous behaviour is an occupational hazard for those working in mental health settings. This course is aimed at managers and supervisors who carry a responsibility for the welfare of staff and volunteers following a serious incident.

*Trauma and supervision – organisational, managerial, and supervisory tasks and responsibilities –anticipatory strategies – defusing strategies—the team dimension— ongoing support*



5 or 10 days

6–16 participants

### Perpetrators of Violence

With community mental health organisations increasingly taking on referrals from forensic units, this course aims to help staff to work therapeutically with people who are troubled by their own violent behaviour.

*Types of violence— engaging reluctant clients— boundary issues—developing a model of the client's violence— strategies to assist the client's self-control— working through the critical underlying issues*