Rethink Group of the Year 2023 Issue Twenty Five - Autumn 2024

Borderline Derbyshire

Newsletter of the

Derbyshire Borderline Personality Disorder

Support Group

For anyone affected by

Borderline Personality Disorder (BPD)

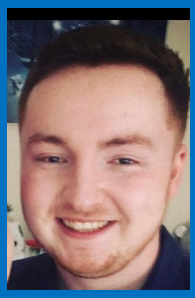
also known as

Emotionally Unstable Personality Disorder (EUPD)

For those in Derbyshire and beyond!

Who we are...



Sue **John** **Jodie** **Ryan**

We all have a connection with BPD

What we do...

Our aim is simple…we want everyone who is affected by BPD to have a safe space in which they can come together to relax, chat, swop stories and discuss coping skills. An official diagnosis is not necessary.

xx

Our groups are also open to those who would like to know more about BPD, including students and support workers.

xx

You do not have to live in Derbyshire to join our support groups

SUPPORT

Group

News

To all members!

Although we have members from all over the world, we are aware that our newsletters sometimes include information relevant only to people in Derbyshire.

If you are in the UK, please note that the services we mention, such as the Emotional Regulation Pathway (p. 6) and Advocacy (pp, 21 & 22) often have counterparts in other counties.

It is our wish that we are able to include information, articles, stories, poems, photos etc. from members worldwide.

If you wish to contribute to the newsletter please email me at

derbyshireborderlinepd@gmail.com

Your contribution can be in your name, or remain anonymous.

Sue X

Vicky was a co-founder of the group and my soulmate of 36 years. Sadly, she passed away just before Christmas 2021.

Sleep tight darling!

Sue xxx

What we offer...

Attachment Group

For those who struggle with severe attachments to others

Run by email with optional zoom meetings

You do not need to have BPD to join this group

Regular Meet-Ups



WhatsApp groups

BPD chat **Positivity** **Virtual walking**

Men with BPD **Parents with BPD**

Parent/Carer/Family/Friend

Crisis Card

Website:

derbyshireborderlinepersonalitydisordersupportgroup.com

In this issue

Update from the Derbyshire Emotion Regulation Pathway (ERP), July 2024

Dave Woods

It's been a busy time in the Derbyshire ERP. In this update I want to highlight the work we are doing in improving access to our interventions, and examining whether these interventions are really making a difference for people.

We have just finished supporting a randomised controlled trial of Structured Psychological Support (SPS), a brief 1:1 intervention for people with likely personality disorder that supports learning skills to address focus areas that are identified by the person. SPS is intended to be a practical and efficient offer that can be accessed by large numbers of people and so addresses the huge problems people with personality difficulties have in accessing appropriate services. This trial is the largest ever trial of a psychological treatment for Borderline Personality Disorder, and so we are very proud to have been involved, and await the formal findings next year. In the meantime. our experiences of SPS in Derbyshire have been good, and we will continue to offer this intervention pending the results of the trial (see below). **Derbyshire BPD support group members** have taken part in the trial: so thank you very much for your support.

You may have noticed some changes in language and changes in the Community Mental Health Services across Derbyshire. Health services, Social Care and the Voluntary Community and the Social Enterprise (VCSE) sector are developing new ways of working taking into account the particular needs of each local area, with short-term and long-term teams. In Derbyshire, this is called the Living Well Derbyshire programme. In Derby, it is called the Derby Wellbeing programme. You can find more information at www.livingwellderbyshire.org.uk.

As part of these changes, and again supported by **Derbyshire BPD Support Group members**, we have consulted with people using and providing services for people with Complex Emotional Needs associated with Personality Disorder. You will likely hear more of this 'Complex Emotional Needs' language which attempts to address the stigma that can be associated with the term 'personality disorder'. Through this consultation we've identified key priorities for our services including increased access to peer support and increased access to psychologically informed therapies, as well as key principles that shape our services including putting human relationships first, being individualised and trauma informed, being welcoming and with easy access, and providing reliable and consistent support. We have recruited into 5 new Assistant Psychologist posts in the short-term Living Well teams, they will support improved access to psychological therapies. They will be providing DBT informed interventions: 1:1 input using the SPS model and groupwork using either the Managing Emotions Programme or Coping with Emotions programme (which we are piloting in different areas). We have also secured funding for peer support roles that will be coming soon.

Alongside all these developments in the short-term Living Well teams, we continue to provide the longer term interventions: Structured Clinical Management, Dialectical Behaviour Therapy and also a small Mentalisation Based Treatment offers. We are conducting an evaluation of the effectiveness of these offers, using data we have collected over the last 4 years and hope to have the results in September.

Dr David Woods, Consultant Clinical Psychologist & Emotion Regulation Pathway Lead

For more info. go to: *Emotion regulation pathway :: Derbyshire Healthcare NHS Foundation Trust derbyshirehealthcareft.nhs.uk)*

"Trauma survivors are being retraumatised by mental health services"

by

Hannah Green

The UK's mental health system is retraumatising survivors by failing to respond to distress appropriately and humanely

Trauma is an emotional response to an event or series of events. It is deeply distressing and overwhelms one's ability to cope. Roughly one in three adults in England report having experienced at least one traumatic event. Women who have experienced trauma are diagnosed with personality disorders at much higher rates than the general population. According to the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM), 75% of people diagnosed with borderline personality disorders (BPD) are female. 71.1% of people diagnosed with it reported at least one traumatic incident during childhood. Why are services telling people who have experienced unimaginable pain that there is something wrong with them, while failing to address the root cause of their distress?

Unfortunately, the NHS – and other services which people are usually directed to if they are in emotional distress – often misses this. This is because most people who have experienced trauma fit the diagnostic criteria for multiple mental health conditions. There is lots of overlap. There is also a tendency within the mental health system to start with a diagnosis from the first signs of distress. Whilst this might provide some people with validation, it can be unhelpful for many trauma survivors. Complex trauma can lead to shame, guilt, and believing that you are at fault for what you've experienced. When services then diagnose you with mental health conditions, or tell you that you are disordered, you start to believe there is something fundamentally wrong with you.

From the age of 16, I have had several different psychiatric diagnoses – the mental health team settled on 'post-traumatic stress disorder' (PTSD) in 2018. Even the word 'disorder' meant that I started to believe that my trauma responses were the problem. This only made things worse for me. I now know that's not the case, and that my body and brain have simply adapted to extreme circumstances and the ridiculous levels of stress over many years, in a perfectly normal way.

Emotional distress doesn't need pathologizing

There have been many reports of a current mental health crisis among young people during the pandemic. However, the distress that young people are experiencing, and their emotional responses to isolation, loneliness, and fear are completely understandable in this context. Living in poverty comes with constant stress. Whether it's about paying bills you can't afford, attending frustrating social security appointments or living in unsafe or insecure accommodation, poverty is a significant cause of emotional distress – you feel stuck. Not having the money to do things you enjoy, spend time in nature or connect with other people can also lead to an increase in fear or low mood. The type of society we live in is the biggest determinant of mental health: the more inequalities there are, the more people there will be who struggle with emotional distress as a result.

If women experience distress after trauma – but don't have the knowledge or tools to understand it, the chances are that they won't know to question a psychiatric diagnosis. Dr Lucy Johnstone, who is a clinical psychologist, trainer, speaker, writer, and long-standing critic of the biomedical model of psychiatry says: *'The trauma-informed literature is extremely valuable. However it does have some limitations. One is that it doesn't always sufficiently make the links between traumatic events at a personal or family level and the wider conditions of society. The original trauma-informed literature comes from America. It doesn't seem to me that sufficient connections are always made between personal experiences of trauma, racism and discrimination and so on, and the fact is that America is probably the most economically unequal society in the entire world.'*

Continued...

Identifying trauma early could prevent re-traumatisation from the system

Child and Adolescent Mental Health Services (CAMHS) diagnosed me with 'generalised anxiety disorder' and 'depression' when I was 17, after one phone call. I only had a couple of appointments with them before I turned 18. They never asked me what was causing my panic attacks, or why I wanted to kill myself. Dr Johnstone told me: *'A defining moment is the one when you are turned from a person with problems to a patient with an illness.'* One conversation sticks in my mind. I was trying to explain why I kept walking out of lessons at college. I know now that one of my teachers was a huge trigger. But at the time, I didn't understand what was happening. I told her it was because I was "remembering" and "I couldn't stop it happening". She shut me down. She told me that I was walking out of lessons because I was panicking about remembering answers to questions. I didn't have the words to tell her she was wrong. I knew then that I couldn't try to tell anyone else what was going on.

Reframing women's distress

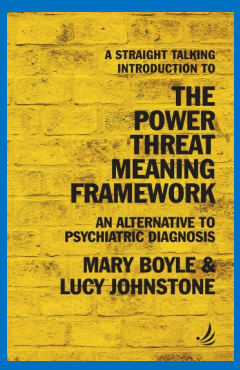
According to Dr Jessica Taylor's book *Why Women are Blamed for Everything*, most women have also experienced some form of sexual harassment, bullying or threats, witnessed something traumatic, or lost someone they cared about. On top of this, women also exist within the patriarchy – a system that has always positioned them as 'less than'. Dr Taylor suggests that by taking a trauma-informed perspective, and given what we know about society, we would understand that behaviours, thoughts, and feelings that women and girls develop, make sense in the context of what they are up against. However, the current system reframes these as mental illness, including personality disorders. By convincing women and girls that their responses are in fact 'disorders' and that there is something wrong with them, isn't this just another form of victim blaming? Until recently, I didn't understand most of my trauma responses. I didn't have enough information about my own trauma responses or coping mechanisms. As Dr Taylor reported in her book *Sexy but Psycho*, once you have a diagnosis of a personality disorder, you are often known to health services as manipulative, deceitful and emotionally unstable. Many health and social services in the UK – including the emergency services – now 'flag' women who have a personality disorder diagnosis as high risk, without their knowledge. This often leads to services believing women are exaggerating or unreliable when they ask for help.

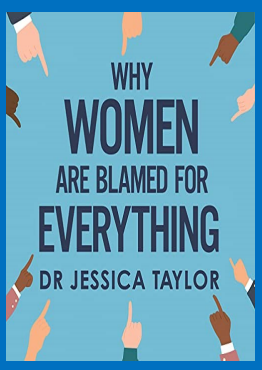
'Too unstable for therapy'

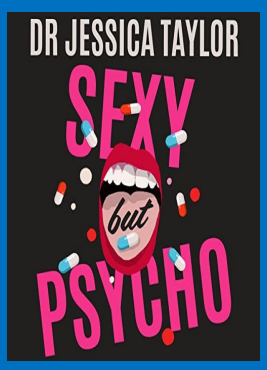
My best friend Leah had been given a diagnosis of BPD because of her frequent self harm, alcohol use, 'risk taking behaviour' and 'difficulty managing strong emotions'. These are all in the diagnostic criteria for BPD. Because of her early experiences of complex trauma, she never gained the skills to manage her emotions. She learnt to hide them, keep secrets and self-destruct – which she carried into adulthood. The diagnosis (among all the others they gave) placed the blame on her for dealing with emotions inappropriately. This meant that professionals constantly put her in this box. They dismissed her trauma and told her she was 'too complex' for help.

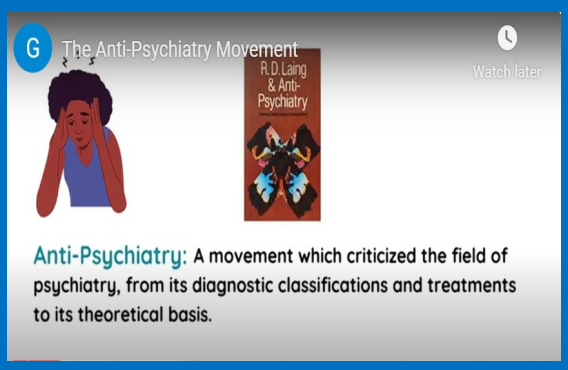
Services told Leah she was too unstable for therapy. But how could they expect her to handle her trauma, when no one would help her? They judged her choices without knowing what options she had to begin with. She did the best she could, with what she had. Ultimately, the lack of support led to her death. My story is very similar to Leah's, and I feel extremely lucky that I wasn't given the same label.

Source: *Trauma: are NHS services merely retraumatising people? (thecanary.co) 27 June 2022*









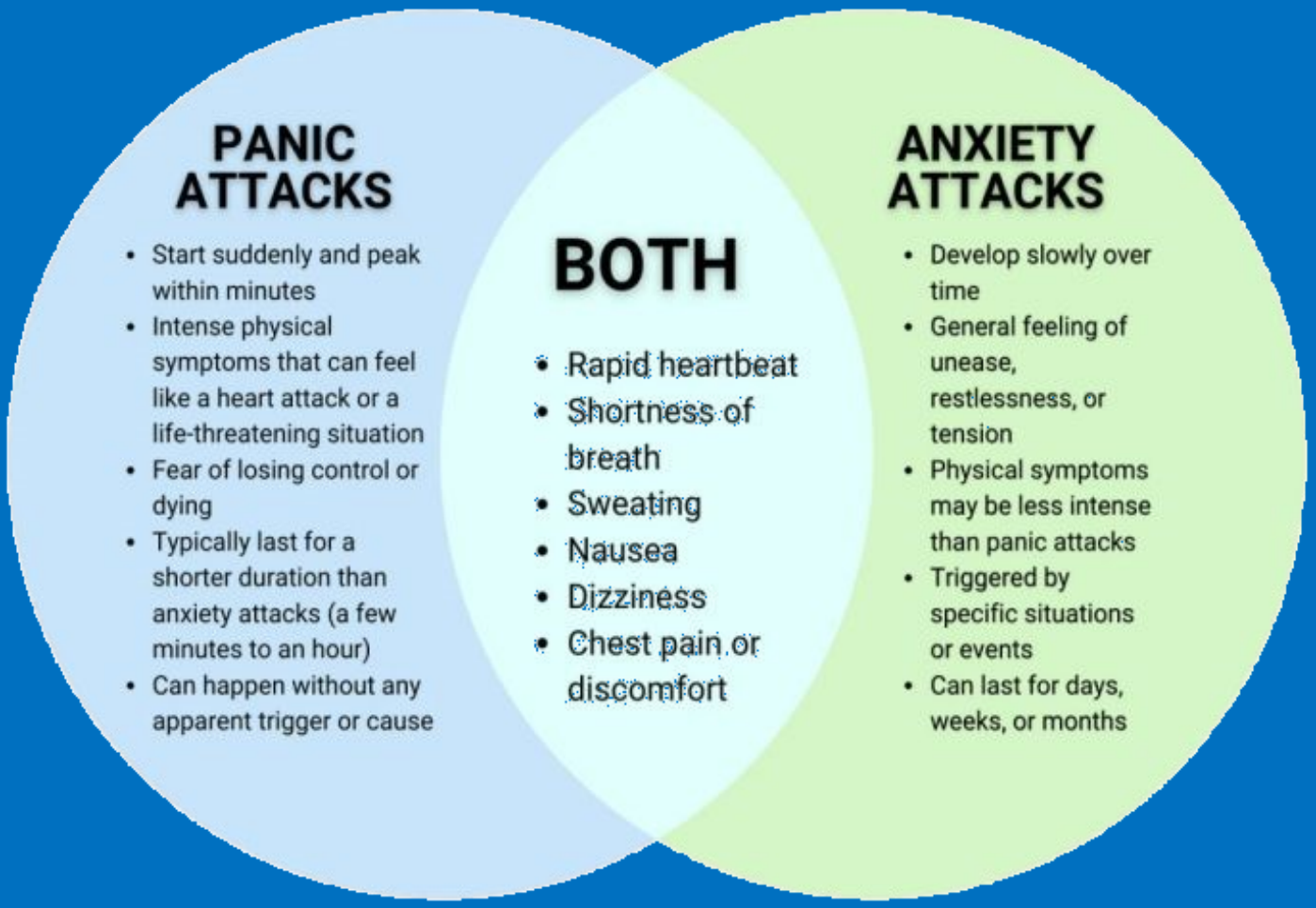
The light

I know it's been painful, I know your heart hurts,
I know it's a struggle, I know it's hard work,
But you must keep going, keep powering through,
Keep fighting your demons, and do it for you.

You are a diamond, that no-one can crack,
You have a strength, to deflect their attack,
Keep walking forwards, and hold your head high,
it's ok to get angry, it's ok to cry.

Trust your ability, keep going for gold,
Know you are worthy, keep being bold,
You know you can do this, keep on with this fight,
You're almost there, there is your light.

Group member



THE WOMEN
BY
SUE WHEATCROFT

I was in Segregation, and I was missing my friends on Lifer's wing. I wasn't a lifer myself, but I had been having problems with various officers and had been placed there because the wing was relatively calm, and the officers more experienced.

I missed the banter. I missed Pat singing dirty songs to me, and sitting with Lynn at bingo, listening to her swear every time she didn't get a number. I missed Charlene coming for a cup of coffee and a chat every evening before lock-up. I missed sitting on the sofa with Elsa2, having a moan and a gossip. And Keely, telling me how much she fancied PO Rob and how it was only a matter of time before she had him, so he might as well give in now.

I missed Tash, who decided every morning whether she was going to be happy or sad for the rest of the day. And Laura, who no-one wanted to share a cell with because she wouldn't let them shit in the toilet. I even missed Angela, who constantly moaned about everything, but especially about in which prison(s) she would be spending the remaining twenty-three years of her sentence. And Helen, who was scared of being on the outside after spending so much time in prison, but who I hoped I had helped persuade to accept release on tag.

I missed Stella, who never gave up asking other people to do things for her, and tall Sue, who I was trying to encourage to stand up to her. And Karen, who was serving twenty-five years, and who had once stood at the gate, rattling it and screaming that she was sick of officers walking in her cell when she was either 'having a shit' or 'washing her fanny'.

I missed the traveller sisters, who shared a cell and who were always upbeat. And Emily, who was only twenty-one years of age but acted like a five-year-old and for months, had carried a security blanket around, until the day she was threatened with a transfer to the Young Offenders Wing. I missed Sheila, who was in her seventies and would probably die in prison, and Kayleigh, who was on the wing next to mine but who I often saw in passing. She had sent me a love letter and had been asking me to write to her, and I would, but I didn't want to hurt her, so would have to word it right.

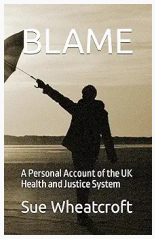
I didn't miss the baby-killers, and I didn't miss Little Sue, who had falsely accused me of bullying her. She had nineteen years left to do but had made life difficult for herself by lying about me and making other prisoners wary of her.

Most of all though, I missed being part of something. There was a kind of camaraderie on a wing that wasn't possible when spending twenty-three and a half hours each day in isolation. I counted the days until I could go back.

More prison stories can be found at:

Sue Wheatcroft – Campaigner for change

...and in the following biographies:



Why do so many ADHD children fail at school and fall foul of the criminal justice system?

by

Kaj Bartlett

(NPAA ADHD Lead & Sussex Police Deputy Coordinator)

Attention Deficit and Hyperactivity Disorder (ADHD) is a neurodevelopmental condition affecting five percent of the UK population. Indications are that it is underdiagnosed. Lack of societal awareness of the condition means that many believe it only affects young boys and they grow out of it during the transition to adulthood. This is a myth. ADHD affects all ages, both genders and across all social classes.

There are many symptoms which affect someone living with ADHD, and like autism, not everyone experiences the condition in the same way. It is now known that there are inattentive, hyperactive and combined type. There are screening tools which help signpost if someone has ADHD; however diagnosis is ultimately based on a psychiatric assessment of behavioural traits according to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM5). It is classed as a 'hidden disability', because many of the challenges faced by a person who lives with ADHD aren't always obvious. There are many positive aspects of living with ADHD, however the purist medical concept of the condition defines it through a 'double whammy' of being a deficit and a disorder. Most often it is the negative behavioural traits which are exhibited and observed, which are impatience, impulsivity, hyperactivity, significant emotional dysregulation, and poor executive functioning skills. ADHD is not a behavioural disorder: neuroscience now proves that it is a difference in brain function for those who live with it.

ADHD, like autism, cannot be cured; however there are psychological, behavioural, educational and pharmacological interventions which can transform lives. There is a genetic basis for ADHD being passed down the generations, although there is currently no definitive genomic variance conclusion which determines a predisposition for ADHD. Symptoms present differently in women and girls than they do in men and boys.

ADHD can be co-morbid with many other conditions including anxiety and depression, and neurodiverse conditions such as dyslexia, dyspraxia and autism. It is more often that not the co-morbid condition will be the one which is identified first, as they are often easier to diagnose. Whilst treatment steps to manage those other conditions will help, a syndrome mix including ADHD will still mean the individual will struggle in life in many ways. Self-medicating can also take the form of substance and alcohol misuse. Adults living with ADHD are 78 percent more likely to be addicted to tobacco and 58 percent more likely to use illegal drugs than those without ADHD. Even food and purchasing addictions are more prevalent. 38% percent of young adults with unmanaged ADHD have been pregnant or have caused an unwanted pregnancy.

**The neurodevelopmental basis of ADHD creates those skills deficits through biology. Neuroplasticity means ADHD biology can be managed and changed with the right approaches. **

Source: Breaking the cycle | National Police Autism Association (npaa.org.uk)

Truths For Survivors Of Childhood Trauma by Jennifer Still

Childhood trauma can leave scars that linger long into adulthood. It can feel like a heavy weight, holding you back from living your life to the fullest. But here's the thing: you're not alone, and you're not defined by your past. These empowering truths are here to remind you of your strength, resilience, and the incredible potential that lies within you.

1. Your trauma doesn't define you—It's a part of your story, yes, but it's not the whole picture. You are so much more than what happened to you. Your experiences have shaped you, but they don't dictate who you are or who you can become. You are a complex and multifaceted individual with dreams, passions, and a unique light to shine.

2. You are not to blame for what happened—Childhood trauma is never the fault of the child. it's important to remember that you were innocent and vulnerable. The responsibility for what happened lies solely with the perpetrator. You did nothing to deserve the pain you endured.

3. It's okay to not be okay—Healing takes time, and it's not always a linear process. There will be good days and bad days, moments of progress and setbacks. Allow yourself to feel the full range of emotions without judgment. Don't pressure yourself to "get over it" or "move on." Your feelings are valid, and your healing journey is unique.

4. You are strong and resilient—You have survived incredible adversity, and that speaks volumes about your inner strength. You have overcome challenges that most people can't even imagine. Your resilience is a testament to your spirit, and it's something to be proud of. You are a warrior, and you have the power to heal and thrive.

5. Your past does not dictate your future—You are not doomed to repeat the patterns of your past. While your experiences may have influenced your choices and behaviours, you have the power to break free from those cycles. You can create a new narrative for yourself, one filled with hope, healing, and happiness. Your future is yours to shape.

6. Seeking help is a sign of strength, not weakness—Asking for support is not a failure; it's a brave step towards healing. Whether it's therapy, support groups, or talking to a trusted friend, reaching out for help can provide you with the tools and resources you need to overcome your trauma. Don't be afraid to ask for the help you deserve.

7. Your voice matters—You have a right to speak your truth and be heard. Don't silence yourself out of fear or shame. Your story is important, and it has the power to help people. By sharing your experiences, you can connect with those who understand your pain, raise awareness, and break the stigma surrounding childhood trauma.

8. You are worthy of love and happiness—You deserve to experience joy, love, and fulfilment. Don't let your past rob you of the happiness that is rightfully yours. You are worthy of a life filled with laughter, love, and meaningful connections. Embrace the beauty that exists in the world and allow yourself to be loved and cherished.

9. Forgiveness is a gift you give yourself—Forgiveness doesn't mean condoning what happened or pretending it didn't hurt. It means releasing yourself from the burden of anger and resentment. It's a personal choice that allows you to let go of the past and move forward with peace in your heart. Remember, forgiveness is a process, and it's okay if it takes time.

10. You are capable of incredible things—Your past does not define your potential. You have the power to achieve your dreams and live a fulfilling life. Don't let fear or self-doubt hold you back. Embrace your strengths, explore your passions, and pursue your goals with confidence. You are capable of so much more than you can imagine.

Source: 10 Empowering Truths For Survivors Of Childhood Trauma (msn.com)

Save our voluntary sector Consultation event 17 July 2024

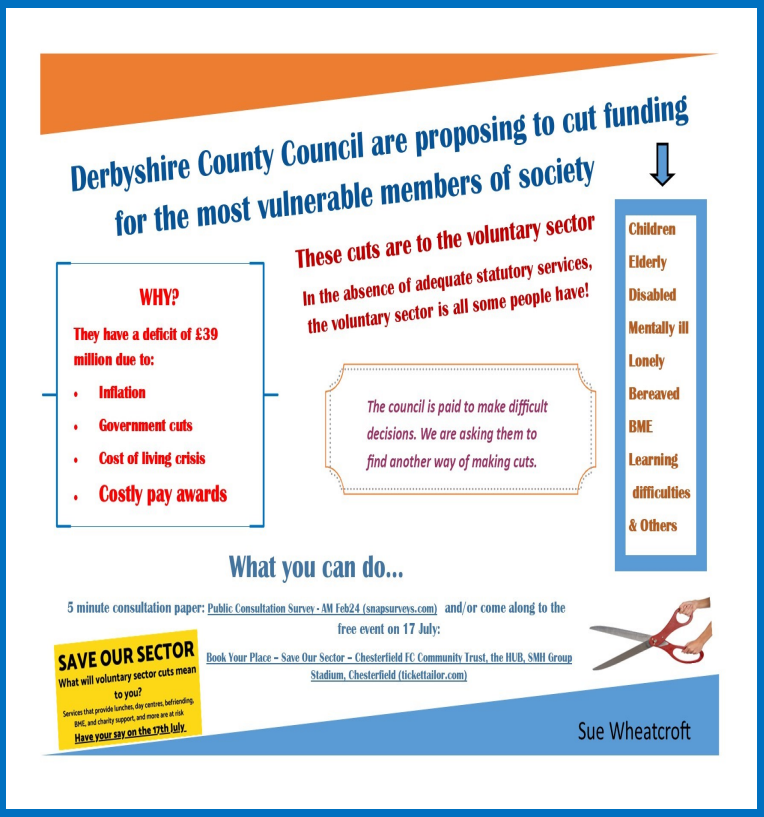
Lud Ramsey

A packed room full of amazing organisations, groups, and individuals making a real difference in our communities.

Standing together to celebrate the Impact we make together and challenging the proposed cuts to the VCSE

Sue Wheatcroft

Wynne Garnett



The consultation period is now over
For more information, go to:

Derbyshire Voluntary Action (dva.org.uk)

We acknowledge that people with BPD may also have traits of other personality disorders. This is the fourth in our series looking at those diagnoses

Paranoid Personality Disorder

People with paranoid personality disorder (PPD) are always on guard, believing that others are constantly trying to demean, harm or threaten them. These generally unfounded beliefs, as well as their habits of blame and distrust, interfere with their ability to form close or even workable relationships.

People with PPD severely limit their social lives. They may:

- Doubt the commitment, loyalty or trustworthiness of others, believing others are exploiting or deceiving them.
- Be reluctant to confide in others or reveal personal information because they're afraid the information will be used against them.
- Be unforgiving and hold grudges.
- Be hypersensitive and take criticism poorly.
- Read hidden meanings in the innocent remarks or casual looks of others.
- Perceive attacks on their character that aren't apparent to others.
- Have persistent suspicions, without justified reason, that their spouses or romantic partners are being unfaithful.
- Be cold and distant in their relationships with others and might become controlling and jealous to avoid being betrayed.
- Not see their role in problems or conflicts, believing they're always right.
- Have difficulty relaxing.
- Be hostile, stubborn and argumentative.

Researchers have found that childhood emotional neglect, physical neglect and supervision neglect play a significant role in the development of PPD in adolescence and early adulthood. Personality continues to evolve throughout child and adolescent development. Because of this, healthcare providers don't typically diagnose someone with PPD until after the age of 18. When a mental health professional, such as a psychologist or psychiatrist, suspects someone might have PPD, they often ask broad, general questions that won't create a defensive response or hostile environment. While PPD generally can't be prevented, treatment can allow someone with PPD to learn more productive ways of dealing with triggering thoughts and situations. Talking therapy, CBT and DBT are recommended. The outlook for PPD typically depends on whether the individual is willing to accept and commit to treatment. Talk therapy can sometimes reduce paranoia and limit its impact on daily functioning. Left untreated, PPD can interfere with a person's ability to form and maintain relationships, as well as their ability to function socially and in work situations.

Source: Paranoid Personality Disorder (PPD): Symptoms & Treatment (clevelandclinic.org)

He told me I was perfect, so I never noticed he was 'spiderwebbing'

by

Anonymous

Spider-Webbing is a relatively new term on the dating scene and describes a combination of manipulative behaviours – such as **breadcrumbing** and **gaslighting** – which a partner might use to entangle someone in a tumultuous and unhealthy relationship. And sadly, it happened to me.

Typically, they reel you in by love bombing. My ex would shower me with compliments, gifts, and endless declarations that I was 'the one'. He'd text me constantly, sometimes more than 40 times a day, and call me every evening to talk. When they have you exactly where they want you – feeling like the most special person in the world – they bread-crumb you, taking most of the affection and attention away but still throwing you just enough to keep you interested and loved-up. My ex would often lash out at me one day by calling me names, which made me question whether I should stay with him. But by the next day he would bring me flowers and chocolates and tell me how beautiful I was. Finally, when your self-esteem becomes as broken as mine was, they will gaslight you so that you are too vulnerable, confused and deflated to leave. I met my ex through a dating app. His polite opening message, asking if I'd like to chat and potentially meet for a drink, was a refreshing change of pace after all the time wasters I had come across – so I agreed. While I wasn't initially attracted to him, he was undoubtedly charming and the chat between us was easy. By our third date he began texting me more than 30 times and calling me several times a day, telling me how amazing he thought I was and how he couldn't stop thinking about me.

Initially I did find his constant attention and contact a little overbearing, but a part of me was also flattered. However, he soon began getting jealous and becoming riled if another man so much as looked at me. One time he accused me of deliberately trying to 'wind' him up because I sent him a picture of me standing next to a young couple (in which the man in question had his arms around his girlfriend). Naturally, I complained to friends about this behaviour, but they said: 'Don't moan – you're lucky he's that into you.' So, I figured I was, believing that this excessive adoration was a sign that he really valued me. Then I discovered *he* cheated on *me*.

Several weeks into our relationship, a message popped up on his phone from another woman he'd been seeing. Hurt, I asked him to leave and immediately cut contact. But two weeks later he began begging for forgiveness, saying he hadn't known if we were going to be serious at that time but now, he was sure he wanted me. Stupidly, I believed him and took him back. From then on he behaved like the 'perfect' boyfriend – cooking for me in the evenings, running me bubble baths, making a huge effort with my friends and hiding love notes in my suitcase whenever I went away for work. I thought it meant that he really loved me. Little did I realise that he was setting me up for a huge fall.

After 15 months together, we moved into a rented flat together, which is when his bread-crumbing phase started properly. Whenever I was on the verge of leaving – sometimes I'd even packed my bags – he'd always turn up with apologies and the cycle would start all over again. Whereas before he hadn't seemed to be able to go an hour without contacting me, he'd now ignore my texts and calls for hours. He'd also belittle me in front of people, even telling shop assistants he was 'stuck' with me, and that the Internet had 'a lot to answer for'. When I'd tell him I found his behaviour hurtful, he'd tell me he was just joking and that I shouldn't be so sensitive. Then he'd be nice for a while, bringing me flowers and chocolates or saying sweet things – always giving me just enough attention or affection to make me stay.

And then came the third phase of spider webbing – gaslighting. This is by far the most damaging stage because it can make the recipient question reality. Gaslighting can take many forms, such as removing objects from your home, then telling you they don't have a clue where they are (yes, he did this). Or pretending conversations you've had never happened (I even began recording some of our chats to prove to myself I wasn't imagining things). And of course, convincing you that you are overreacting when a put-down is disguised as a 'joke'.

Continued...

Spider Webbing is a term used to describe a complex network of manipulative behaviours woven over time, which can entangle individuals in a tumultuous and unhealthy relationship, often leaving them feeling trapped and emotionally distressed. Breadcrumbing is a form of manipulation that occurs when someone pretends they are interested in pursuing or developing a sincere relationship, when in fact, they have no interest. Gaslighting is psychological manipulation when making someone doubt their own reality or sanity . Other methods of manipulation include Ghosting and Love-Bombing.

After several years of tolerating this toxic behaviour, I was a shell of my former self. I never thought of myself as the kind of woman that could be easily duped by a man. But just like spiders take their prey by surprise, spider-webbers entrap you before you even realise you've succumbed to their manipulation. My self-esteem was shattered to the point where I wouldn't even go out or see friends – not that any of them knew what was really going on behind closed doors. In fact, the only person I did confide in about the abuse was my sister-in-law. She kept begging me to leave him but eventually, he somehow managed to convince her I was crazy and making everything up. I now no longer have any contact with her and as a result, rarely see my brother.

Whenever I was on the verge of leaving – sometimes I'd even packed my bags – he'd always turn up with apologies and the cycle would start all over again. I was so confused. Part of me knew that this behaviour was wrong and harmful, but the other part of me loved him and was afraid of being alone. It didn't help that he'd convinced me that I was worthless, and therefore unworthy of love. So, I always stayed.

The turning point finally came one night when he cornered me against the kitchen door. He yelled in my face that none of my friends or family could stand to be around me, and that they had all told him they hated me. Sobbing, I called my mother to ask if what he was saying was true. She begged me to get away from this man – that he was destroying me. Hearing her pleas, something in my head just clicked. I knew that if I didn't get out of this relationship, I would have a breakdown. I mustered the courage to ask him to move out and, to my surprise, he calmly agreed. 'I've realised you're not for me.' He said nonchalantly, as if he'd been the one to make the decision to end things for good. Even then, I endured two weeks of him stonewalling me before he finally left – and that was only after I invited my mother to stay for the week. He couldn't keep up the pretence with a witness there. It took me a while and a lot of therapy to recover from my spider-webber and it's still an ongoing process. But having EMDR therapy – which teaches you to process traumatic experiences and memories by desensitising you to them – has helped a lot.

Just seeing his car drive past used to make me anxious but now, when I see him around as he works near my home, I'm not triggered anymore. In fact, I actually feel sorry for him. I've realised that only someone with cripplingly low self-esteem would need to put another person down or try to destroy them in order to feel good about themselves.

I'm not sure if I'll ever be able to fully trust a man again, and it's taken me three years to even dip my toe back in the dating pool, but at least I know now that huge gestures of love early on in a relationship can be a red flag. Or in this case, a red web.

Source: He told me I was perfect so I never noticed he was 'spiderwebbing' (msn.com)

Domestic Abuse Helplines

If you are in immediate danger call 999. If you cannot talk, dial 55 and the operator will respond.

For emotional support, you can contact the National Domestic Abuse Helpline on 0808 2000 247.

Alternatively, for practical and emotional support, please contact Women's Aid Live Chat 10am – 6pm seven days a week.

You can also reach the National Centre for Domestic Violence on 0800 270 9070 or text NCDV to 60777.

Male victims of domestic abuse can call 01823 334244 to speak to ManKind, an initiative available for male victims of domestic abuse and domestic violence across the UK as well as their friends, family, neighbours, work colleagues and employers.

Alternatively, the Men's Advice Line can be reached at 0808 8010327, or emailed at info@mensadviceline.org.uk.

Matlock June 2024

Insomnia

Insomnia is when you aren't sleeping as you should. That can mean you aren't sleeping enough; you aren't sleeping well or you're having trouble falling or staying asleep. For some people, insomnia is a minor inconvenience. For others, it can be a major disruption. The reasons why Insomnia happens can vary just as widely. Your body needs sleep for many reasons (and science is still unlocking an understanding of why sleep is so important to your body). Experts do know that when you don't sleep enough, it can cause sleep deprivation, which is usually unpleasant (at the very least) and keeps you from functioning at your best.

How sleep needs and habits vary and what that means for you

Sleep habits and needs can be very different from person to person. Because of these variations, experts consider a wide range of sleep characteristics "normal." Some examples of this include:

- **Early birds/early risers**: Some people naturally prefer to go to bed and wake up early.
- **Night owls/late risers**: Some people prefer to go to bed and wake up late.
- **Short sleepers**: Some people naturally need less sleep than others. Research indicates that there may even be a genetic reason for that.

Learned sleep differences: Some people develop sleep habits for specific reasons, such as their profession. Military personnel with combat experience often learn to be light sleepers because of the demands and dangers of their profession. On the opposite end of that spectrum, some people learn to be very heavy sleepers so they can still sleep despite surrounding noises.

Natural changes in sleep needs: Your need for sleep changes throughout your life. Infants need significantly more sleep, between 14 and 17 hours per day, while adults (ages 18 and up) need about seven to nine hours per day.

Types of insomnia

There are two main ways that experts use to put insomnia into categories:

1. **Time**: Experts classify insomnia as acute (short-term) or chronic (long-term). The chronic form is known as insomnia disorder. Both the acute and chronic forms of insomnia are very common. Roughly, 1 in 3 adults worldwide have insomnia symptoms, and about 10% of adults meet the criteria for insomnia disorder.
2. **Cause**: Primary insomnia means it happens on its own. Secondary insomnia means it's a symptom of another condition or circumstance.

Symptoms of insomnia

Insomnia has several potential symptoms, which fall into a few categories:

1. When you have trouble sleeping. There are three main ways this happens, and people commonly shift between them over time:

a. **Initial (sleep onset) insomnia**: This means you have trouble falling asleep.
b. **Middle (maintenance) insomnia**: This form makes you wake up in the middle of the night, but you fall back asleep. It's the most common form, affecting almost two-thirds of people with insomnia.
c. **Late (early waking) insomnia**: This form means you wake up too early in the morning and don't fall back asleep.

2. Daytime effects. Because you need sleep to be your best, disruptions like insomnia commonly cause symptoms that affect you while you're awake. These include:

a. Feeling tired, unwell or sleepy.
b. Delayed responses, such as reacting too slowly when you're driving.
c. Trouble remembering things.
d. Slowed thought processes, confusion or trouble concentrating.
e. Mood disruptions, especially anxiety, depression and irritability.
f. Other disruptions in your work, social activities, hobbies or other routine activities.

Continued...

3. Chronic insomnia characteristics. The characteristics of insomnia symptoms are also important. If your symptoms have these characteristics, you may have chronic insomnia. They include:

a. Circumstances: A chronic insomnia diagnosis requires insomnia without circumstances that would interfere with your ability to sleep (such as changes in work schedule, life events, etc.). Diagnosing
b. insomnia requires having sleep difficulties despite having time and the right environment to do so.
c. Frequency: Chronic insomnia requires you to have insomnia frequently, at least three times per week.
d. Duration: Chronic insomnia lasts for at least three months.
e. Explanation: The insomnia isn't happening because of substances or medications (including both medical and nonmedical drugs) or other sleep disorders. Other medical or mental health conditions also can't fully explain why you're not sleeping.

Causes of insomnia

Experts don't fully know why insomnia happens, but the current understanding is that this condition can involve many factors. Some of these factors could be causes or they could simply contribute to it. More research is necessary to understand exactly how and why insomnia happens. The factors that could cause or contribute include (but aren't limited to) the following:

a. Family history (genetics): Sleep traits and conditions, including insomnia, seem to run in families.
b. Brain activity differences: People with insomnia may have more active brains or brain chemistry differences that affect their ability to sleep.
c. Medical conditions: Your physical health can affect your ability to sleep. This includes temporary illnesses like minor infections or injuries, or chronic conditions like acid reflux or Parkinson's disease. Conditions that affect your circadian rhythm, your body's natural sleep/wake clock, are also factors.
d. Mental health conditions: About half the people with chronic insomnia also have at least one other mental health condition, like anxiety or depression.
e. Life circumstances: Stressful or difficult life circumstances may not necessarily cause insomnia, but it's very common for them to contribute to it.
f. Life changes: Brief or temporary changes are often factors, including jet lag, sleeping in an unfamiliar place or adjusting to a new work schedule (especially shift work). Long-term changes, like moving to a new home, can also affect sleep.
g. Your habits and routine: Your sleep habits (also known as sleep hygiene) can contribute to insomnia. That includes whether or not you take naps, when you go to sleep, if and when you consume caffeine, and other habits.

Risk factors for insomnia

Insomnia is also more likely to happen in people with the following characteristics or circumstances:

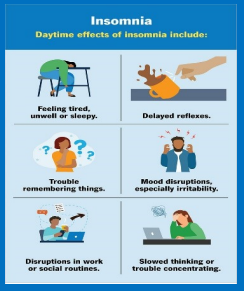
a. Light sleepers.
b. People who use alcohol.
c. People who don't feel safe in their homes (such as situations involving repeated violence or abuse).
d. People with fear or anxiety about sleep, such as those with disruptive sleep issues like nocturnal panic attacks or nightmare disorder.

What are the complications of this condition?

When insomnia is severe or lasts a long time, it causes sleep deprivation. A major concern with sleep deprivation is daytime sleepiness, which can be dangerous if you're driving or doing other tasks that require you to be alert and attentive. Sleep deprivation can also increase the risk of certain conditions:

- Depression; Anxiety; Type 2 Diabetes; High blood pressure (hypertension).
- Heart attack; Stroke; Obesity
- Obstructive sleep apnea.
- Conditions that involve psychosis.

Continued...



How is insomnia diagnosed?

A healthcare provider can diagnose insomnia using a combination of methods, especially by asking you questions about your health history, personal circumstances, sleep habits, symptoms and more. They may also recommend certain tests to rule out other conditions that could cause or contribute to insomnia. There aren't any tests that can diagnose insomnia directly. Instead, tests help rule out other conditions with similar symptoms to insomnia. The most likely tests include:

- Sleep apnea testing involving an overnight sleep study in a sleep lab (polysomnography) or an at-home sleep apnea screening device.
- Actigraphy.
- Multiple sleep latency test (MSLT).

Other tests are also possible depending on your symptoms and other factors.

How do I take care of myself?

Some of the most important things you can do to help your insomnia — and your sleep overall — revolve around sleep hygiene. These include, but aren't limited to:

- **Set and follow a sleep schedule**. For most people, the best thing you can do for your body and sleep needs is to have a routine. Have a bedtime and keep to it as closely as possible, including on weekends, holidays, vacations, etc. Try not to rely on napping and avoid naps in the late afternoon or early evening, as these can affect your sleep cycle.
- **Give yourself time to wind down**. Put aside the concerns of the day before bedtime as best you can. Build in a buffer time between when you finish for the day and when you go to bed. That can help you get in the right frame of mind for sleep. If you can't fall asleep, try to do something relaxing or calming rather than remaining awake in bed.
- **Get comfortable**. Feeling comfortable is very important if you want to get quality sleep. Set your sleeping environment, accordingly, including lighting, sounds and temperature. Some people prefer sleeping with a sound generator that plays a specific part of the sound spectrum, and you may want to try this, too.

- **Put that device down**. Electronic devices typically use types of light that trick your brain into thinking it's not nighttime. That can disrupt the release of chemicals that tell your brain and body that it's time to sleep.
- **Mind what you eat or drink**. Eating or drinking too much and/or too late in the evening can affect your ability to sleep. Eating or drinking certain things can also affect your sleep, especially nicotine products or things that contain caffeine or alcohol.
- **Stay active**. Physical activity, even just walking, can help you get better quality sleep.

What can I expect if I have insomnia, and what's the outlook for this condition?

Insomnia usually isn't a major concern. Most people who experience insomnia may feel tired or not quite their best the next day, but that feeling often gets better once you do get enough quality sleep. Chronic Insomnia is disruptive. While it usually isn't dangerous, it can still negatively affect your life in many ways.

How long does insomnia last?

Short-term insomnia is insomnia that you have for under three months. Chronic insomnia lasts more than three months.

If you consistently have trouble sleeping, talk to your healthcare provider. Your primary care provider is a good resource to help you understand why you aren't sleeping and help you work on improving how you sleep. They can also help detect any health issues that might affect your ability to sleep.

Source: Insomnia: What It Is, Causes, Symptoms & Treatment (clevelandclinic.org)

Derbyshire Independent Advocacy Service

New independent advocacy service appointed

A new independent advocacy organisation has begun work in the Derbys County Council area.

Cloverleaf Advocacy has been appointed as the new advocacy service in the Derbyshire area, which was previously provided by Derbyshire Mind. In the Derby City Council area, the provider remains Citizens Advice Mid Mercia.

Jude Boyle, commissioning manager at Derbyshire County Council, explained:

"Cloverleaf Advocacy is there to support people who have 'substantial difficulty' in being involved in decisions about their care. The advocacy service aims to ensure everyone has a voice and is heard when it comes to decisions that affect their lives. Over time, Cloverleaf Advocacy is looking to increase peer and self-advocacy support within the area."

Cloverleaf's Chief Executive, Suzi Henderson said:

"We will work with people in Derbyshire to ensure they have a voice, whatever challenges they face, and can maintain choice and control over their lives. We aim to empower people, ensure their rights are upheld, and help them to build the skills needed to speak up for themselves wherever possible. For those already receiving advocacy in Derbyshire, we will ensure continuity of support delivered by a team of qualified advocates."

What is independent advocacy?

Advocacy is helping people say what they want, secure their rights, represent their interests, and get the support they need.

An advocate is someone who supports and speaks up for others, often those who are vulnerable, helping them to gain independence and ensuring their rights and needs are recognised and addressed. This can include help with social care services, health services and others.

Continued....

Cloverleaf Advocacy Cloverleaf Advocacy

In many cases, someone's right to advocacy is set out in law:

Independent Mental Health Advocacy

This is for people detained under the Mental Health Act and subject to guardianship or Community Treatment Order. Advocates can help people to:

- understand their rights under the Mental Health Act
- have their say about their care and treatment, prepare for ward reviews and meetings and access legal advice and support.

Independent Mental Capacity Advocacy

This is for people aged 16+ who lack capacity to make decisions about where they live, or serious medical treatment, and who do not have anyone unpaid in their lives who can support or represent them. The advocate will write a report for the professional making the decision in the person's best interests.

Independent Health Complaints Advocacy

This is for anyone who wants to make a complaint about an NHS funded service. Advocates can help people to write complaints letters, put their views forward at resolution meetings, or escalate complaints to the Ombudsman.

Care Act Advocacy

This is for people who have 'substantial difficulty' in participating in local authority-led social care processes, including needs assessments, care reviews, safeguarding and care planning. The person must also have no-one else appropriate who can support them through the process.

Community Advocacy

This provides support to adults with social care or mental health needs on a range of issues that can impact on their day-to-day lives. Community advocates equip those who need their help with information and knowledge, so that they can make more informed decisions and have a better understanding about their human rights.

For more information or to make a referral, please contact Cloverleaf Advocacy by calling 01924 454 874 or

emailing referrals@cloverleaf-advocacy.co.uk

Find out more on Cloverleaf's website

Emotional Intelligence

Do's and Don'ts

Active Listening

Do: Be able to restate someone's point so they say "Yes, exactly!"
Don't: Be so caught up in your response that you forget to listen

Empathy

Do: Seek to understand how a person is really feeling
Don't: Make assumptions or try to make it about you

Self-Awareness

Do: Understand how your actions are perceived by others
Don't: Be arrogant, selfish, or think you're above critique

Emotional Awareness

Do: Pay attention to others' body language, reactions, and mood
Don't: Fail to adjust based on explicit or implicit feedback

Feedback

Do: Give direct, honest feedback
Don't: Think you're being nice by keeping people in the dark

Input

Do: Ask how you can do better
Don't: Neglect acting on it transparently

Motivation

Do: Take the initiative, finding strength within yourself
Don't: Need external validation or constant hand holding

Collaboration

Do: Work well with others, sharing info, ideas, and credit
Don't: Fail to see their needs, inputs, and desires

Diplomacy

Do: Find common ground and lead with mutual respect
Don't: Use insensitive language

Mindfulness

Do: Take actions to improve, like breathing or meditation
Don't: Think the mind is fixed

Appreciation

Do: Recognize great work and say thank you often
Don't: Withhold credit or try to take it for yourself

Adaptability

Do: Change your approach when circumstances change
Don't: Stubbornly stick to your ways, ignoring others

Conflict Resolution

Do: Lean into conflict, looking for a peaceful path forward
Don't: Avoid difficult situations

Influence

Do: Understand others' desires and motivations first
Don't: Try to dictate or coerce

Emotional Control

Do: Maintain composure and take a step back in charged situations
Don't: Get defensive or make hot-headed outbursts

Socialability

Do: Take an interest in others and ask them questions
Don't: Blame others for awkwardness - engage with them

Betrayal

A poem by a group member, about how a most trusted relationship came to an end

Tears are streaming, my heart strongly beating,
My limbs are all shaking, why aren't I waking?,
This can't be true, this isn't you,
You'd never hurt me, it's not what you'd do.

I feel my heart hurting, my mind is alerting,
To pain that is coming, my feelings are numbing,
Protecting my being, from pain that I'm seeing,
As I float above me, i'm dissociating.

I look at myself, she's sobbing and waiting,
To hear it's not real, this hurt she can feel,
But then she realises, as she becomes wiser,
The clues were all there, this isn't fair.

I come back to my body, i hold on to me tightly,
Not feeling like fighting, so I just accept it,
I sit on the floor, I can't take any more.

You knew my pain, you kept me sane,
You were my safety, you made me feel worthy,
But none of it's true, I am now hurt by you.

I couldn't accept it, as you rejected,
My big hearted being, and now you are feeling,
And leaving me here, despite my big fear,
A painful fail, the ultimate betrayal.

POSITIVE MODEL
OF OTHERS
LOW AVOIDANCE

SECURE

ANXIOUS

POSITIVE MODEL
OF SELF
LOW ANXIETY

ATTACHMENT STYLES

NEGATIVE MODEL
OF SELF
HIGH ANXIETY

AVOIDANT

FEARFUL

NEGATIVE MODEL
OF OTHERS
HIGH AVOIDANCE

The saddest thing about BPD (anonymous on Quora.com)

Trigger Warning

The saddest thing is accepting that you have the disorder at all. It is what happens when a naturally sensitive person is abused, traumatized, or repeatedly invalidated because the rest of the world is not as sentimental.

To realize that you will always feel a variety of intense emotions while simultaneously feeling hollow, bored, and apathetic. You begin to feel like a circus monkey. Having to always second guess what is intuition, true perception, and genuine reaction as opposed to emotion. Personality disorders are a flaw in perception. Accepting that whatever you perceive must always be second guessed. The constant internal feeling of being embarrassed for no reason. The stigma that we are manipulative, harmful, heartless. Living with the reality that you can become verbally abusive when angry. Constant thoughts of hurting yourself. Not knowing who you are. Am I good? Am I bad? How can I tell when both sides of me are so real and so very intense. The fact that nobody gets it. The fact that trauma is often a root cause. To accept that you've been damaged permanently to the point of constant agony and not being able to trust your inner most perception. Why did that have to happen? Who could I have been?

Hearing psychiatrists say there is no cure, just treatment. Never knowing how much the treatment will improve you, and how much you must just accept as a part of your fate, like shooting into the dark. The suspiciousness you always have of others, even if/when you've learned to "chill out" and not accuse them outwardly. It's never peaceful inside your head. Nightmares fuelled by constant, subconscious emotions. Dreams of drowning, as water is a subconscious metaphor for drowning in emotions. Wondering if its all worth it or if life is ruined from the inside out. Constantly wondering if your feelings are valid. Feeling burning fury when you're invalidated. Being in a constant, apathetic haze. Wishing every second for a normalcy you cannot define.

People with BPD are not evil or bad. They do not all act like the stereotype. And the saddest thing? Treatment often helps us mask the reactionary behaviours, it does not quail the emotions that fuelled them to begin with. But we can learn to be "tolerable." But never to ourselves. It is a constant form of self-torture. The very things it entails is triggering in and of itself. I sometimes struggle to separate myself from my diagnosis. When I wake up, the first thing I think is that I'm a BPD person and everything I do is automatically cringe, fucked up, or insane.

I'd do anything for a chance to be born again and experience this life not through the lens of this disorder. It's baffling that the human brain can ever even acquire such a disorder. I dream of the next life, relinquished from these chains. Or am I just being too emotional again? I'll never know.

THE 10 ESSENTIAL TRAITS OF EMOTIONAL HEALTH

Dr. Hal Baumchen

STAY HONEST

Stay honest with yourself and others. Personal strength and emotional stability is built on integrity and transparency.

STAY DETERMINED

Find your primary reason for doing the work of emotional recovery and keep it first and foremost.

STAY PEACEFUL

Make every effort to be a peacemaker, overlook offenses, and stay serene and calm.

STAY INTENTIONAL

Get rid of haphazard and random living. Stay deliberate, determined, and purposeful.

STAY GRATEFUL

Remain humble and accepting. Be grateful for another chance to get your life back.

STAY BALANCED

Keep work, love, projects, and people integrated in a finely tuned harmony.

STAY POSITIVE

Keep a positive, upbeat, and optimistic attitude. Smile, laugh, and enjoy your life.

STAY STRONG

Be known for the best attitude, best effort, and best character. Finish strong.

STAY CONNECTED

Stay close to those who support your recovery and distance yourself from those who do not.

STAY HOPEFUL

Remain confident that your future is filled with the promise of good things to come.

Supported by…

Public Health

North Derbyshire CCG

Derbyshire County Council

Derbyshire Dales District Council

Foundation Derbyshire

Derbyshire Recovery and Peer Support Service

Derbyshire Voluntary Action

Lloyds Bank

Active Nottinghamshire

Active Derbyshire

We welcome ex-offenders, and are proud to be a member of…

CLiNKS

Supporting the voluntary sector working in the criminal justice system