

Self-injury notebook

Deborah Forte reminds us that self-injury is a reaction more than an action, and reviews the kind of help clients might expect from us if they are to choose more adaptive responses to their distress

The terms 'self-harm', 'self-injury' and 'suicidal' have historically been interwoven. This has resulted in inappropriate responses to, and treatment of, the self-injurer. Many sources of reference do not distinguish between them, and although there are some blurred boundaries whereby self-harm may lead to self-injury, just as self-injury might lead to suicide, there are differences that need to be clarified so that supportive services ensure they are responding to their clients' needs.

Self-harming involves a vast range of activities that *can* ultimately end up causing harm to self. Smoking, sunbathing, drug taking, over- and under-eating, overworking, not exercising and so on will fall into this category, as all can be interpreted as risk-taking activities. That is, the outcome is not controllable and can be detrimental to one's wellbeing. However, the way we define these activities will be determined by our own socialisation, which can serve to validate the self-harming activity. For example, 'this helps me cope better with stress', 'I feel healthier when I am browner', 'I don't do anything else' and 'I need the money to survive' are perfectly good justifications – we all self-harm in some way.

Self-injury is when someone deliberately and directly injures the body. Examples of this include biting, pulling out hair, burning, cutting, scrubbing, overdosing on non-fatal amounts, hitting self, swallowing and insertion of foreign objects. People who use self-injury as a coping mechanism may sometimes experience feelings of wanting to die, but the general sentiment is usually survival, while wishing the emotional pain would stop.

Suicide is the deliberate attempt to end one's own life.

Statistics regarding self-injury have until recently been thin on the ground. The National Self Harm Enquiry¹ set up in 2004 believes that one in 10 young people between the ages of 11 and 25 self-injures – which is likely to be an underestimation, since many incidents are not reported.

Statistics gathered by Lois Arnold, from Bristol Crisis Service for Women, in 1995² showed that children as young as six were self-harming. Many people I have trained³ seemed shocked that children so young deliberately hurt

themselves; I, however, am shocked that self-injury displayed by even younger children is rarely acknowledged. I have seen many toddlers biting and hitting themselves, or banging their heads against walls, for example. From many years of observing children and young people, I believe that self-injury is an innate form of communicating distress to self, and sometimes others, when ability to communicate is impaired or words unavailable. This demonstrates why emotional literacy and support are prerequisite to developing emotionally healthy humans.

When young people have been asked about their lives, they often tell of traumatic experiences in connection with why they self-injure. Some of those experiences include: sexual abuse, neglect, emotional abuse, extreme lack of communication, physical abuse, loss and separation, parental or childhood illness, domestic violence, excessively high expectations, bullying and rejection, racism and fear/shame about puberty or sexuality². Whatever the life experience, it is important to remember that self-injury is a *reaction* not an *action*.

Responses to self-injury

Responses to those who self-injure can give mixed and confusing messages. In the past, self-injurers were seen as deviants or labelled mentally ill and given electro-convulsive therapy, antipsychotic medication and even frontal lobotomies. Now, many young people who self-injure are labelled attention seeking, manipulative, selfish or suicidal, or are diagnosed and treated for behavioural or psychiatric disorders. Restraint and punishment such as withdrawal of privileges, services and affection have been frequently written into care plans, service agreement and working procedures. Given some of the previously mentioned events that lead to self-injury, it is imperative to acknowledge that the majority of self-injurers are not mentally ill. They are *responding*, and we need to ensure we respond in turn in a respectful and non-abusive way.

As we investigate and gain more insight, responses are becoming less hysterical and more understanding, but there is a long way to go. Much of the turmoil in service response stems from duty of care, rights of protection and

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Case study 1: CBT Work with Peter and Jane, by Alastair Black

Self-harm, self-injurious behaviour and parasuicide are complicated behaviours to completely categorise. But in addition to these categories, a third broader category of self-harm exists among the child and adolescent population but may go undetected within treatment. These case vignettes show how two such instances were broadly addressed within the CBT model.

Peter was 10 when he was a front seat passenger in an accident in which the driver of the other car was killed. Peter escaped major physical injury but was referred due to experiencing post-trauma symptoms, mainly intrusive images and nightmares of the face of the deceased driver, which Peter saw clearly just prior to the collision. Peter was also consumed with guilt that this accident was his fault even though neither he nor his driver played any part. Peter had developed depressive symptoms and the negative self-referencing belief 'I should have died, not him, because he was a good person'.

Treatment comprised EMDR within a CBT framework, and while the symptoms appeared to decrease during sessions they returned as intensively as ever between sessions. Eventually, after I reflected this trend back to Peter, he disclosed he had kept a newspaper clip of a picture of the wrecked car hidden in his bedroom. When Peter experienced a benefit in treatment and his symptoms reduced, his irrational guilt was triggered, as he 'did not deserve to feel better'. Peter then effectively self-harmed by staring at the picture until he triggered intrusive thoughts and distressing affect.

This subtle variation of self-harm, once disclosed, was targeted by assisting Peter in the challenging of his negative beliefs around wishing he had died. Peter's cognitions were traced back from 'he (the deceased driver) was a good person and father' to a contrasting pre-existing belief 'I am a bad person'. Once this belief was challenged, Peter's treatment was able to be completed successfully.

Jane, 13, was referred by her parents after they found out Jane was cutting her arms and legs. Jane felt this was a major invasion of her privacy and stated this in no uncertain terms! Following some time spent establishing a therapeutic alliance, Jane agreed there were drawbacks

to this particular means of coping and we worked together to identify what the core of her presenting problem was with the aim of finding a more efficient means of coping generally. Following a number of critical events in Jane's life prior to age 10, her cognitions had evolved to view the world as a dangerous and specifically 'uncontrollable' place. Jane had found that by physically harming herself, initially by nipping, she could control this physical and emotional aspect of her life. As we examined Jane's beliefs, she identified that they were based on 'old information' and were no longer accurate. The frequency of Jane's cutting began to decrease dramatically and she reported better ways of coping and her self-esteem began to improve. However, Jane attended one session with a number of fresh lacerations and despite reviewing all of our work to date Jane continued to report being happy and her negative cognition regarding the 'uncontrollable and unsafe world' had stayed away.

On viewing Jane's problem afresh, we identified that Jane's reason for cutting had changed from a negative one which we had resolved in treatment to a 'positive' one. Jane disclosed that she now believed that cutting was an important part of her that made her 'special and different' among her peers. Jane's self-harm, which had developed pre adolescence, had become part of her subsequent adolescent personality development. Having identified this issue, we were able to work together to help Jane explore who she was as an individual. She did eventually stop cutting but even at discharge she reserved the right to keep her blades wrapped up and hidden away, not because she wished to return to cutting but because this was an important part of her that she wished in some way to retain.

These cases remind me that self-harm and its driving cognitions are often subtle, constantly changing and most of all unique and personal to the individual. By ensuring each treatment intervention is tailor-made for each client, we can ensure we don't get distracted by this often distressing behaviour from the important child or adolescent behind it.

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concern that the line between hurting oneself and wanting life to end is inconsistent in its width. Risk assessing and reality checking are therefore essential, as is working to a clear contract and self-harm policy. Counsellors and young people need to be clear about their service's definition of 'significant harm' or 'hurting oneself'. Also, the severity of wound should not dictate the level of support offered. The differences between what humans can tolerate physically and emotionally can be immense. Each case needs to be assessed on its own merit.

An old friend with a 'before' and 'after' life

One-off incidents of self-injury are rare. When Lois Arnold undertook her study², she asked 76 women how long they had self-injured. The responses were:

<i>Duration of self-injury*</i>	<i>% of sample</i>
Less than 5 years	30%
5-10 years	22%
10-20 years	33%
Over 20 years	14%

**mostly intermittent*

Case study 2: Integrative Work with Jason, by Val Taylor

Working with Jason was a salutary lesson in how I could have missed self-harming, as it was not being presented in the usual way. Jason is 12 and was referred for 'uncontrollable anger' after being excluded from primary school.

At our first meeting he sat hunched, saying little. My psychodynamic background has trained me to focus on unconscious communication and feelings in the room. While Jason's body language seemed to portray what others had said about him, the feeling of being in the room with him was very different. He looked around the room, picked up the whiteboard and pens and drew a picture of a dinosaur with large, jagged teeth and blood dripping from its mouth. Turning the board towards me he said: 'This is my Dad and I'm going to kill him.' He then drew a small, stick figure to represent himself holding a dagger, which was plunged into the dinosaur's throat. Rather than being struck by the violence of the act, I noticed how small the stick figure was and how vulnerable it seemed. I wondered to myself at how powerless Jason felt in his situation. He suddenly seemed to be physically smaller in the room. Most of this first session was spent in silence with me sitting alongside him watching him draw. At the end of the session, he agreed to return the following week.

I believe the non-intrusive nature of this first meeting and the holding of feelings rather than story did much to help begin to build a trusting relationship between Jason and me, as he had little confidence in adults. Our sessions followed a similar pattern but I was very careful to allow Jason to

go at his pace as I realised that power and control were very much an issue with him. Jason's parents were separated and he had been living with his mother for several years. He had rarely seen his father until recently, when he had suddenly reappeared on the scene wishing to have custody of Jason. From then on, Jason had been used as an emotional football. Each parent tried to turn Jason against the other. The matter had gone to court several times. Custody had eventually been given to Jason's father, whom Jason hated. He desperately missed his mother and this was the point when school behaviour deteriorated. Jason felt he had not been consulted and everyone had 'let him down'.

As therapists, we are aware that such feelings of powerlessness and anger usually have some outlet. It seemed that Jason, as well as externally showing his anger, was also turning it inward and he was harming himself. Jason was a diabetic and, rather than turn to cutting or self-injury, Jason would binge-eat on sweets until he induced hyperglycemia. On one occasion, he was hospitalised and very ill. Jason was intelligent and aware of the highly dangerous nature of such action.

Work with Jason has been very slow and has involved patiently building trust. Initially, his attendance at sessions was erratic. I maintained contact and always held a slot open for him. It was made clear that attendance was his choice. Initially, he would stay in the room for 10 or 15 minutes. We always negotiated how to use the sessions and we often played paper and pencil games. I believe these turn-taking activities helped maintain a neutral power balance. His way of telling me his anxiety was increasing was that he would come into the room

clutching a handful of chocolate bars – which became his signal that he wanted me to help him explore his feelings. Once he had calmed, the chocolates would be put away. After six months of work, he was asking to see me and would stay for the full session. He is now able to voice his feelings and the incidents of self-harming are significantly reduced.

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Many young people self-injure for several years, turning to it at stressful times and describing it like 'an old friend'. Familiar coping mechanisms come into force when the going gets tough. If someone has been using self-injury as a coping mechanism for a long time, they will know exactly how much pressure to place on their trusted tool (for instance) to achieve the required result. Taking away implements used to self-injure will not address the emotional need of the young person to express their pain. Removal will invoke the need to be more creative, and can result in the

young person having to improvise, which is far more risky. Without this outlet, suicide will often be interpreted as the only remaining option.

In order to fully grasp that fact, it is useful to understand the feelings that precipitate and are subsequent to self-injury. Young people have shared that before they self-injure, there is a build-up of feelings that become intolerable to cope with. These include sadness, hopelessness, fear, anger, panic, powerlessness, anxiety, tension, self-hatred, guilt, shame, grief, desperation, and feeling unheard and unsupported. Not feeling real or alive, and feeling intense numbness, is not uncommon⁴.

What is gained through self-injury is in direct response to this build-up. Like taking the valve off a pressure cooker, feelings are released and communicated, whether to self or others. Many of my clients speak about feeling alive, human and real when they feel the pain and/or see the injury. Some have felt little pain, but, as the brain acknowledges the injury, the act serves as a grounding technique, taking them away from their emotions and into the body. Therefore it can serve as a distraction or become a visual metaphor for their emotional turmoil and pain. A feeling of calmness can ensue in response, and physical treatment of the wounds or internal damage can be correlated to nurturing the emotional being.

Control is a constant theme. When young people feel in control of their self-injury and the results are consistent with what they wished to achieve, risk of suicide is far less than originally perceived. I do challenge the perception of control, and reality-check with clients that they're aware of the impact on their physical body. It is when they question that control and are fearful about what they are doing that there is a foundation for alternatives to be considered. Offering alternatives when a client is not in a position to consider them will leave them feeling judged. Alternatives should not be the major focus or else they can become a boundary between therapist and client instead of a nurturing gift. It is also imperative that support services acknowledge and convey to young people, how frightening it is to even consider giving up a coping mechanism that has served its purpose well⁵.

So what are young people saying they need?

To have someone to talk to, to explore, share and have their pain heard, to not be judged by what they do to themselves, to feel supported, to be able to work at their own pace, to remain in control of how they choose to express their pain, to be offered alternatives at a time when they feel able to accept that they have done the best they could in order to survive but now need other strategies, to be and feel respected, to be seen as a whole human being not merely a self-injurer, to feel they deserve to live, kindness and compassion but only when it is genuine, to be spoken to honestly, to have practical advice on care for the injuries, to feel they are cared for by someone, to tap in and out of support services rather than feel

forced to deal with everything in one go, help to feel good about themselves, for the focus to not always be self-injury, to accept they have something to give, to have an occasional hug when distressed as long as it is checked out beforehand, to laugh, have fun and have consistency of service provider.

In an ideal world, it would be wonderful to be able to provide all of this. However, it is important to know that providing a service based on respect and understanding can be offered whether there is opportunity for one meeting or 30. Many of these needs are human ones, provided through a respectful, supportive and non-abusive environment, so counselling can be an ideal space, as can many other youth provisions. Evidence suggests that specialist groupwork can assist in supporting young people, so long as this is proficiently run. But it is not appropriate for young people who are in crisis and are just beginning to share experiences.

There are many tasks a therapist can assist with and promote to young people. The following are offered as a guide and are by no means an exhaustive list.

- **Provide a safe space with clear boundaries. Introduce self-injury into the confidentiality aspect of your contract. I make it clear that in the one hour I am with my client, they are not allowed to self-injure as it is my job to hold them emotionally for that time.**
- Facilitate the sharing of experiences but only when required by the client. Some young people just wish to move out of the bog they are in as opposed to analysing its contents.
- **Keep up to date with alternatives, such as cutting less frequently and or less deeply, keeping journals, using red ice or toothbrushes to burn the skin, engaging in sporting activities, learning relaxation techniques etc.**
- Work on raising self-esteem.
- **Celebrate each tiny step of risk reduction, self-nurturing and control.**
- Do not be afraid to bring up self-injury but do not over-focus on it.
- **Explore ways and provide strategies for expressing anger, sadness and other emotions.**
- Acknowledge your client has been doing the best they could to survive. Even though this has involved hurting themselves, they are alive and kicking and are now being heard.
- **Explore and risk-assess how much control is**



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Case study 3: Play therapy Work with David, by Kathryn Hunt

Ten-year-old David attempted to take his life due to feelings of deep despair at the imminent loss of his dying mother. In the early sessions, we worked tirelessly to hold a sinking sandcastle together. He painted a seascape in which a sun rose above the horizon. He had difficulty with the horizon and said that he did not like what was on it. He also talked about the tide coming in on the beach and the power of the waves. There was a castle made of sand. David was aware of the inevitability of the tide coming in and the castle being destroyed.

A couple of months later, David noticed the sand tray. The sand was dry and warm. He put his hand into the sand and said, 'Do you remember when I used to try and stop the water from running away?' He smiled at the memory. He filled his palm with sand, gently kissed his hand, and softly blew the sand across the tray. Then he said, 'Mortal combat.' He continued: 'With a soft kiss she blew the sand, and every grain exploded into the world.' He smiled again. It was a very calm moment. This felt to me like a strong metaphor for the impact of the death of a soft gentle mother and the effect on his whole world. I was aware of a wounded young man, both physically and mentally, who had been through a battle to keep his mother alive and lost it.

Later, David sought to bring his mother back using magic. He tried to conjure her up and was advised by his aunt that he was meddling in a dark area. David became aware that he was being followed by a female sparrow hawk – a large bird of prey. The presence of an all-knowing and all-seeing spirit mother might be intrusive and could produce a conflict within the grieving young man who so desperately wanted his loving mother back in his life.

At the 34th session of therapy, David arrived with 'Kes', the tumbler pigeon he had hand-reared. I was impressed with the gentleness and the care he showed towards her. The bird was real and in the room with us and he wanted me to hold her and get to know her. He was in control of her. I thought about the bird following him and his irritation.

The following week, David brought two birds to the session. The birds were mother and son. Son of 'Kes' was named 'Houdini'. Houdini escaped. Kes flew after him. David told me that Houdini's mother always flies after him. The safety we had built up in

our relationship was mirrored in the contained safety for the mother and son. Houdini was always flying off and finding places to hide. David's aunt spoke of David running away from home when things got tough. David spoke of Houdini as 'a terror'. He said it gleefully, like a parent who is proud of a mischievous child. He hated Houdini's cry. Houdini, like his namesake, was a great escapologist and the mother bird, Kes, could never track him down and bring him out of flight. The room was full of frenzied action as Kes and Houdini battled out the question of power. Finally, the son won the battle and both birds were returned to the box. I sat stunned at the event that had unfolded, and became aware of the amazing way in which David resolved his feelings of powerlessness.

David offered me a way of meeting him, through his birds. We rarely spoke about the loss of his mother and yet we spoke of it constantly.

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actually administered during and after the process of self-injury, and challenge denial respectfully.

- Provide or find assertiveness training, as unknown needs cannot be met.
- The way in which a young person chooses to self-injure and how they nurture the wound can often be very telling. Presenting the opportunity for them to 'create' a wound

using various media and speak as the wound can help them understand themselves on a deeper level.

- Many young people do not seek medical attention due to fear of what may happen. Helping them put together medical kits for cleaning and stitching their own wounds when necessary and encouraging them to use sterile implements is a big step towards risk reduction.

When counselling traumatised people, it is essential that counsellors keep themselves informed and safe. We are not responsible for what young people do to themselves and it seems obvious that while a person explores painful memories and experiences, they may need to lean on their coping mechanism harder, so self-injury may worsen for a while with the onset of therapy. Secondary post-traumatic stress disorder is not uncommon in this arena and we are role models to those who come to us in need of nurturing the self, so good supervision is essential. ■

Deborah Forte works as a private humanistic integrative counsellor and holds a postgraduate certificate in counselling children and adolescents. Self-injury is a topic close to her heart – she has spent seven years delivering specialised training packages for Quality Training UK, and 15 supporting young people who self-injure. Her training work provides the perfect base for encouraging services and carers to deliver appropriate, sensitive and proactive responses, and to campaign for change.

References

- 1 www.mentalhealth.org.uk/campaigns/self-harm-inquiry
- 2 Arnold L. Women and self-injury: a survey of 76 women. Bristol Crisis Centre for Women; 1995.
- 3 As a trainer for Lynn Martin's Quality Training UK course 'Working with young people who self-injure', I acknowledge the debt I owe to her training materials.
- 4 Arnold L, Magill A. Making sense of self-harm. Bristol: Basement Project; 2000.
- 5 Arnold L. Working with people who self-injure: a modular training pack. Bristol Crisis Centre for Women; 1997.

Resources

Websites

www.selfharm.uk.org
www.nshn.co.uk/resources.html

Policy making

Arnold L, Magill A. Getting it right – a guide to creating a self-harm policy. Bristol: Basement Project; 2001.

Case study 4: Gestalt Work with Belinda, by Andrea Campbell

Belinda (not her real name) is a 22-year-old white, heterosexual woman. She first came for counselling to talk about her depression and self-reported feelings of low self-esteem. After a little while, she told me about her frequent self-harming, in which she would cut her upper arms and thighs with a razor blade. As she was telling me, I noticed her shrink down in her body, bow her head and break eye contact. I felt as if she didn't want to know that I was in the room. I felt my own cheeks blush and thought I realised her deep shame around her self-harming and my own embarrassment at how invasive I felt my presence to be at that painful moment in Belinda's experience.

In Gestalt therapy theory, phenomenological enquiry underpins much of the work. That is, staying with the actuality at that moment and not making my own interpretations. I aim to recognise my own preconceptions, bracket these, and then support exploration where my client can observe what they *themselves* experience. In Gestalt theory, this is the Paradoxical Theory of Change. Change through growth occurs when a person identifies with their own state.

At this moment with Belinda, I felt that I was witness to her deep belief and sense of being unlovable, and that her shame showed me that she would not want to be seen in this and so might prefer to remain alone and unsupported. I responded to her tentatively, gently but also firmly. I said that I could see how she had physically shrunk in the chair and that I felt I wanted to be gentle around her but that I was also interested in how she had seemed to move away, physically, from being in contact with me. In telling her about my interest, I wanted to offer my presence as a support. I also realised that my offer might be too much for her in her shame state and I stayed present by grounding myself physically and sat with her in her silence. I noticed how embodied her feelings of shame were.

After some time, she began to sob. Her body was heaving with jerking movements and she shed streams of tears. She reached out for tissues and then looked up at me and I felt her seeing me. We looked at each other and she said that she felt guilty and ashamed about herself and to punish herself for her guilt she would cut herself. She said that the worst thing was the cycle of this. She would feel 'bad' about herself and to cope would punish herself by cutting, and then she would feel bad again because no one knew and so she was alone with how bad she felt and with what she had done.

I asked how she was feeling now that she was telling me and letting me see her as she was. She said that she was beginning to feel some relief and also had 'tiny flashes of hope' that there could be another way for her. She said that in sharing her 'secret' she felt she had 'more space' in herself and in the world. She had just sat up straighter in her chair at that point. I told her that I noticed this and she said she felt pleasingly stronger by sitting up.

Her way of self-regulating and coping with her guilt was to punish herself by self-injuring. After more work together, she realised that this function of self-injuring also perpetuated her sense of being unlovable, and she also realised that she was actually angry with her parents and how she felt their neglect of her. She realised that she had turned her anger in on herself. When she began to share how she was with me, she said she realised that she wouldn't have to work at surviving relationships alone by self-harming.

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