



Advocacy with Young People Who Engage in Nonsuicidal Self-Harm

Like suicidality, talking about self-harm directly with young people who have been engaged in this coping mechanism can be hard. However, because such a vital part of our work as advocates is to discuss coping strategies and help survivors discover what mechanisms work best for them, discussions that involve self-injury, self-medication, eating disorders, engaging in risky sex, and other self-harming behaviors are integral.

Advocates are often the only people in a survivor's life that are there to provide non-judgmental support and we can further foster this by fearlessly engaging in conversations about behaviors that many might find squeamish.

Understanding Self-Harm

Self-harm is defined as the deliberate and voluntary physical self-injury that is not life threatening and is without conscious suicidal intent. There is no consensus regarding what self-harm is or is not (Laye-Gindhu & Schoert-Reichl). It can involve a complex set of motives, behaviors, and strategies. More importantly, it is not a mental health diagnosis but rather a reflection of distress (Butler).

Nonsuicidal self-injury is most common among adolescents and young adults, and the age of onset is reported to occur between 12 and 14 years (Cipriano, Cella, & Cotrufo), however; individuals across demographics and lifespan participate in self-harming behaviors. Additionally, those in treatment who have a diagnosis of PTSD are more likely to engage in self-harm than those without PTSD (Gibson & Crenshaw).

Self-Harm and Sexual Abuse

Many of those who experience sexual abuse can develop a sense of disconnection from their body; they may create different physical sensations to combat numbness or give feeling to the emotional pain. Not only does a scar or

injury make tangible emotional pain, it also can effectively communicate that pain to others.

Some who self-harm may desire to change the container of pain and memories (their body) through scarring or eating habits. Some may hold the perception that their body attracted the abuse and seek self-harming behavior or changes to their body as not only a coping skills but as a way to create a sense of safety from further abuse.

Self-injury can also be an act of self-medication. The endorphins released from physical self-injury interact with the opiate receptors in the brain to reduce our perception of pain and act similarly to drugs such as morphine and codeine (Levenkron).

Emotion regulation is considered the most frequent function of nonsuicidal self-injury. Survivors are trying to function at the level needed in the world, despite the emotional turmoil.

Cultural Factors

Cultural factors can also play into self-harming behavior. A certain amount of pain-- "pushing through" related to athletics, exercise, and dieting, as well as cultural idioms like "no pain, no gain" can further the propensity for eating disorders and other self-harming behavior (Levenkron). It can foster a conflation of pain endurance with achievement.

Sometimes we miss self-harming behavior because they can be linked to expectations around masculinity or femininity. Boys hitting their head against the wall, burning themselves with lighters, bloody knuckles, or even binge drinking, can be self-injurious behavior. These self-harming behaviors can be situated within a social pressure moment and can get lost in what we've determined normal or adolescent boy behavior. Because these are things that we've decided are allowable and actually somewhat valued in masculinity, an opportunity for intervention might be lost (Broadhead).

Conflation of Self-Injury and Suicidality

Self-injury and suicidality are commonly, yet incorrectly coupled. Sometimes we see in a list of common reactions to rape a list that might include "self-harm / suicide". These are distinct, sometimes linked, concerns. In our program materials and advocacy practice, it is important that we avoid lumping these together.

According to Psychology Today, “generally people who self-harm do not wish to kill themselves; whereas suicide is a way of ending life...many people who self-harm view hurting themselves as a way of coping with life. In fact, for some, the self-infliction of pain reassures them they are still alive.”

Mental Health American agrees: “Self-injury is their way to cope with or relieve painful or hard-to-express feelings, and is generally not a suicide attempt.”

Self-harm doesn’t exclude suicidality but we cannot presume it is correlated. Suicide assessments can be used in advocacy and crisis intervention to determine suicidality and tools for these are located at the end of this paper.

Common Forms of Self-Harm Linked with Sexual Violence

Eating Disorders

“Traumatic experiences, especially those involving interpersonal violence [such as sexual assault], have been found to be a significant risk factor for the development of a variety of psychiatric disorders, including eating disorders, particularly those characterized by bulimic symptoms, such as binge eating and purging,” says Dr. Timothy Brewerton, an expert in the field of trauma and eating disorders (NEDA).

Dr. Brewerton points out that among those who have experienced trauma, binge eating and purging can develop as a kind of coping mechanism. “In much the same way as substances of abuse are used to self-medicate, binge eating and purging appear to be behaviors that facilitate 1) decreasing the anxiety associated with trauma, as well as 2) the numbing, avoidance and even forgetting of traumatic experiences. Though eating disorders have complex roots and triggers, we often hear that sexual assault acts as a catalyst for developing an eating disorder” (NEDA).

Most prevalent are eating disorder behaviors which do not meet the official criteria of any specific condition where an individual struggle with a combination of food restriction, bingeing, purging, over-exercising, negative body image and self-esteem, and an unhealthy obsession with otherwise healthy eating (NSVRC).

Cutting

Cutting is frequently linked to childhood abuse (especially sexual abuse), depression, anxiety, eating disorders, post-traumatic stress disorder, borderline personality disorder, and substance abuse problems. An estimated one-half to two-thirds of people who cut also have an eating disorder (ULifeline).

Cutters are usually secretive, and will hurt themselves in places that are easy to hide with clothing. While cutting may occur on any part of the body, it is most common on the hands, wrists, stomach, and thighs. Over one-third of the respondents in a college study who reported cutting indicated that no one knew about the behavior (ULifeline).

The conflation with suicide is perhaps one of the most harmful misconceptions surrounding cutting behavior. Dr. David Shaffer, chief of the division of child and adolescent psychiatry at Columbia University Medical Center says, "We know that cutting accounts for far fewer than 1 percent of all suicides... and one of the characteristics of this disorder is that it's repeated very, very frequently, so presumably a young person knows it's not going to kill them" (NPR).

Advocacy Strategies for Survivors Who Engage in Self-Harm

Survivors who use self-injury as a coping mechanism are whole people with complex lives. Self-harming behavior is just one aspect of the healing process for a young person who is also dealing with the daily stresses life: school, friends, relationships, family, and sometimes work, money, homelessness, addiction, or other types of violence and trauma.

True to a strength-based approach, we want to validate that they have been able cope and survive thus far, celebrate their resilience, and engage the survivor in exploring new coping skills. Advocates recognize that the person we are serving is likely to have solutions to their own challenges but may need support and prompting to locate them.

Active Listening

Being a listener to someone who needs to talk about how they hurt themselves can be hard. It is important to hear about the reasons for self-harm and to explore how it helps. By exploring the relief a survivor might get from self-injury, we can help them explore options that may not have tried that might create a similar sensation with less harm.

Everyone has different styles and ways of relating with their clients, but here are some things to explore:

- Be direct and compassionate
 - “Are there triggers to self-harm that you can identify? / How do you feel before you choose to self-harm?”
 - “How often are you _____?” (Insert their self-harming behavior mirroring the language the survivor uses to describe it.)
- Don’t avoid talking about it; share your observations. “It doesn’t make something happen by asking it. We have this big fear that we are jinxing things. They don’t have permission socially or a mechanism internally to express those things and somebody needs to be a witness and say
 - “I see that you are hurting yourself or I’m noticing that when you get distressed that you dig your nails into your skin. Can we talk about that because I am concerned?” (Broadhead)
- Ask open ended questions.
- Validate the person, not the behavior.

Planning for Safety

Harm Reduction

Simply put, harm reduction means figuring out how to reduce the danger in one’s life one piece at a time, without necessarily changing their whole life at once. As advocates we meet people where they are at, which means our work is around what a survivor feels ready for and what they identify as a priority.

- Explore the self-harming behavior
 - Include asking about suicide. (Two suicide assessments are located in the Resources section of this paper.)
- Again, validate the person, not the behavior.
 - “It makes sense that you are doing _____ because I hear that you’re experiencing a lot of distress and this is one thing you’ve found that seems to help you regulate that. I believe you and I want your distress to stop and this can be dangerous behavior that

can go wrong so how do you feel about finding one that still meets your needs but is not harmful or less harmful to you?" (Broadhead).

- "It is understandable why people make the choice to self-harm and have you considered other choices?"
- Avoid contracts.
 - Even if you are not explicitly saying that self-harming is bad and wrong, engaging in a contract or filling out a form that is signed can feel punitive and show a survivor that they or their behavior is bad or wrong, even if that is not your intention. It also doesn't help stop the behavior; it can create a punitive or hierarchical situation setting up the survivor to lie / avoid the topic in future, not return to advocacy, create barriers to other kinds of intervention, and shifts you from a collaborative advocacy relationship to another authority in a young person's life.
- Exploring available options and planning for safety with someone who is self-harming can be an aspect of harm reduction. For example:
 - Offering resources for clean needles as well as a sharps disposal box in your office.
 - Discuss the decreased chances of infection when using new blades or a process of sterilization when cutting.
 - Dress wounds and keep them clean.
 - No depth is safe, but less deep cuts are less risky.
 - A safety plan is only a plan, not a contract.
 - Be proactive and honest about the potential of reporting.
- Work with the survivor to find resources that might discuss ways for them to be safer if their coping mechanism is not something they are ready to give up. Sit down together and do some internet research. Some common, more initial replacement methods might be:
 - Temperature control- hold ice cubes, run hands under hot water, cold shower

- Wear elastic bands and snap them.
- Professional tattooing or piercing.
- Writing on oneself with pens vs. carving.
- Explore options for additional therapeutic and medical interventions
 - Mental health treatment can be an integral part of healing for those who self-harm and for those who experience sexual abuse; however, it is important to acknowledge that some survivors may not be ready to go.
 - Medical referrals are important. Identify places where the young person can get free medical attention for wounds or infections.

Triggers

Triggers are a common part of recovery from trauma. In the case of a survivor who is self-harming, it is helpful for harm reduction and safety planning for a survivor to discover the particular triggers that initiate the self-injuring actions. They may be obviously related to the sexual abuse or not.

A helpful place to start is to work with a survivor on figuring out what kinds of situations, scents, interactions, tones of voice, etc. might cause them to be triggered. It may help to provide prompting, examples, or help remembering triggering situations they may have described to you in prior meetings.

When survivors are more aware of what triggers them, it makes it easier to plan for how to respond more intentionally instead of falling back into habits. This knowledge can help a survivor avoid triggers or establish strategies to cope when triggers are a surprise or are unavoidable.

New Coping Skills

Replacement methods for self-injury can be a helpful step in moving away from injurious behavior to harmless coping strategies. It may be useful for a survivor to use new coping strategies in conjunction with harm reduction and replacement strategies as they try to transition away from harmful behavior.

- Help find positive ways to find relief, self-soothing, or positive feelings for coping.
 - “In the past, what are things that you’ve done that feel good?”

- “What are some places you’ve been that have felt good, what are things you’ve noticed about those places?”
- What activities make you feel happy, alive, or present in your body?”
- Consider impacts of oppression and resulting barriers.
 - Recognize, based on a person’s race, class, cultural background, that certain things people situate under self-care are not accessible to everyone (Broadhead).

Grounding

Grounding is a practice that helps survivors get rooted in their physical body. Grounding practices can be an alternative to harmful coping skills when the need relief is to feel more “in your body.” There are several simple ways to practice feeling in your body or connected to the earth / ground.

- Cover your crown: Place one hand on the top of your head. If it helps, close your eyes.
- Feel your feet: Place both feet on the ground, sitting or standing. This can sometimes be more effective barefoot or outside. Tap your feet. Notice where you are.
- Stand Like a tree: Stand with feet parallel and shoulder’s width apart, spine straight. Sink all weight and tension into your feet. Imagine roots growing out of the bottom of your feet.
- Lie on the ground: flat on your back, legs straight out or with knees bent and feet flat on the floor.
- Body scan.
- Meditation.
- Movement like walking, running, lifting weights.
- Explore holistic healing options like yoga, acupuncture, massage.
- Playing musical instruments; drums, guitar, etc.

- Ask the survivors about any of their cultural practices for healing, mindfulness, or cleansing.
- Essential oils that have soothing quality (lavender) or that make you feel more alert (peppermint).
- Work with the survivor to find the solution that works for them.
 - “You know best what will work for you and what won’t. I can provide options, ideas, and work with you to find even more ideas. Let’s work toward finding another way of coping. You have another solution for coping within you.”

Working with Parents

A lot of people feel very alarmed by self-injurious behavior, particularly parents. Parents can tend to approach self-harm in a punitive way; the initial response is often to stop the harm and protect their child from physical injury. Parents can do this to a varying degree:

They can make choices that are totally appropriate, like taking away the types of tools that their children might use to injure themselves, increasing supervision, and reaching out for support. However, often parents can fall back on what tends to be punitive or at least it feels punitive to the child, like grounding or restriction.

As advocates, we can support the parent to shift the focus from only stopping the self-harm to acknowledging or discovering why the self-harm is happening.

- Self-harm is a signal of greater distress (trauma, depression, etc.)
- The person who is self-harming is not manipulating (parents, authority figures, etc.); this is what they have found in terms of coping.

We can also help by talking about why self-harm is used by many as a coping strategy and validate the child and parent’s actions and reactions.

- Self-injury is used as a tool for emotional regulation.
- Help the parent move from guilt and toward problem-solving for healing and recovery.

- Validate the person and feelings, not the behavior.
- People who self-harm are often, ironically, trying to take care of themselves.

Stopping the self-harm is not going to stop the underlying issue. It has to be acknowledged as a coping mechanism and then replaced with a coping mechanism that is more functional.

- Model coping skills.
- Acknowledge it. Don't avoid talking about it.
- Help locate additional coping skills and therapeutic interventions as needed.
- Use "I" statements (except "I understand." "I understand how you feel" can trivialize their experience and, by and large, we may be able to relate but we don't understand how someone feels.) "I" statements show that you are taking responsibility for how you feel and think. For example, "I am worried about you. Why don't we make an appointment with a doctor just to make sure that you are medically safe?" This sounds far less attacking and judgmental than: "You're too thin! What are you trying to do to yourself!?" (Pandora's Project).
- Explore replacement strategies.

Considerations for Reporting

In general, don't wait for a minor client who is engaging in self-injurious behavior to figure out what is reportable.

- Have proactive agency or advocacy team dialogue on what might be reportable in these cases.
- Meet with someone in a supervisory capacity at your local CPS office to come for an in-service and engage in a conversation about what happens in these types of cases when they are reported, what services or resources are offered the family, what is the process the family goes through?

Advocates have varied boundaries, values, and biases. Because of this, supervisors will want to help clarify, through policy and practice, all places where confidentiality might be compromised or an agency compelled to disclose personally identifying information.

- Create a triage structure that involves a supervisory or other advocates can help avoid the pressure on an individual, to guard against potential unconscious bias, and to safeguard advocate-survivor privilege.

And finally, it is important to have proactive conversations with young people you work where self-harming behavior might be coming up. As with any conversation about mandatory reporting with a young person, be direct and try to foster as much self-determination for the survivor as possible. For example:

- “What are some ways we can discuss what we will do if you show up and need medical care? We need to make a plan because I don’t want to take power away from you but I want you to know that I may have certain obligations to your safety because you are under 18. Sometimes that looks like me calling in people who know how to take care of your injuries (medical professionals) because I don’t. So I want you to know that that might be something I have to do, how can I make that less scary?” (Broadhead).

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References

Broadhead, T. MSW, Director at the Center for Gender Equity at Pacific Lutheran University. (2018, April 5). Personal interview.

Butler, J. (2016). *Self-Harm*. Psychiatric Aspects of General Medicine.

Cella, S., Cipriano, A., & Cotrufo, P. (2017) Nonsuicidal Self-injury: A Systematic Review. Retrieved from <https://www.frontiersin.org/articles/10.3389/fpsyg.2017.01946/full>

Crenshaw, T. & Gibson, L. (2015). *Self-Harm and Trauma: Research Findings*. Retrieved from <https://www.ptsd.va.gov/professional/pages/self-harm-trauma.asp>

Laye-Gindhu, A & Schonert-Reichl, K. (2004). *Nonsuicidal Self-Harm Among Community Adolescents: Understanding the "Whats" and "Whys" of Self-Harm*.

Levenkron, S. (1998). *Cutting: Understanding and Overcoming Self-Mutilation*.

Mental Health America. *Self-injury (Cutting, Self-Harm or Self-Mutilation)*. Retrieved from <http://www.mentalhealthamerica.net/self-injury>

National Eating Disorder Association (NEDA). *Trauma, Sexual Assault and Eating Disorders*. Retrieved from <https://www.nationaleatingdisorders.org/blog/trauma-sexual-assault-and-eating-disorders>

National Sexual Violence Resource Center (NSVRC). *The Connection Between Eating Disorders and Sexual Violence*. Retrieved from <https://www.nsvrc.org/blogs/connection-between-eating-disorders-and-sexual-violence>

Pandora's Project. (1997). *Eating Disorders: A Guide for Loved Ones & Parents*. Retrieved from <http://www.pandys.org/articles/edlovedones.html>

Psychology Today. (2012). *Understanding Suicide and Self-harm*. Retrieved from <https://www.psychologytoday.com/blog/teen-angst/201210/understanding-suicide-and-self-harm>

Shaffer, D. (2010). Interview, NPR. Retrieved from <https://www.npr.org/templates/story/story.php?storyId=123529829>

ULifeline. *Cutting*. Retrieved from <http://www.ulifeline.org/topics/135-cutting>

Reading, Resources & Tools

- Confidentiality Considerations with Minors, WCSAP <http://www.wcsap.org/confidentiality-considerations-when-providing-sexual-assault-advocacy-services-minors>
- Girls Do What They Have to Do To Survive: Illuminating Methods Used in the Sex Trade and Street Economy to Fight Back and Heal, Young Women's Empowerment Project <https://ywepchicago.files.wordpress.com/2011/06/girls-do-what-they-have-to-do-to-survive-a-study-of-resilience-and-resistance.pdf>
- The Connection Between Eating Disorders and Sexual Violence, NSVRC <https://www.nsvrc.org/blogs/connection-between-eating-disorders-and-sexual-violence>

- Coping with Self-Harming Urges, Students Against Depression
<http://studentsagainstdepression.org/get-support/check-suicide-and-self-harm/coping-with-self-harming-urges/>
- Reducing Self-Harm Worksheet, Students Against Depression
http://studentsagainstdepression.org/downloads/workbook/module1/reducing_self-harm_worksheet.pdf
- Impulse Control Log, S.A.F.E. Alternatives
<http://store.selfinjury.com/products/The-Impulse-Control-Log/3A-by-S.A.F.E.-ALTERNATIVES-.html>
- Pandora's Project, Collection on Self-Injury
<http://www.pandys.org/articles/index.html#selfinjury>
- Columbia-Suicide Severity Rating Scale
https://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf
- SAFE-T Suicide Assessment Five-step Evaluation and Triage
https://www.integration.samhsa.gov/images/res/SAFE_T.pdf