Nonsuicidal Self-Injury and Pastoral Ministry:
Joining the Current Cultural Conversation on Self-Injury

by

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Abstract


Nonsuicidal self-injury is a growing practice amongst young people in Canada. Young people as young as ten years old are engaged in self-injurious behaviours such as cutting themselves, burning their skin and poisoning themselves. Oftentimes these injuries are kept hidden from family and friends. Information relating to non-suicidal self-injury (NSSI) and self-injury (SI) is widely available in current psychological literature but is underrepresented in theological sources to date. This thesis examines how the conversation can be deepened between the psychological and theological communities relating to nonsuicidal self-injury. It also considers how existing theological resources concerning mental health, disabilities and ethics can inform and strengthen this conversation.
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Chapter 1

Youth and Nonsuicidal Self-Injury: Understanding the Current Cultural Situation

I look at you, and I see you. I smile at you even as you refuse to look me in the eye. But that’s ok; you don’t have to look at me. You don’t have to say anything out loud because I can hear you. I can hear your silent screams. My heart breaks at all the things you can’t say out loud but desperately wish someone would hear.

~Brett Ullman, Your Story: The Wounding Embrace

But for reasons I don’t fully understand, God allows mere mortals like us to participate in the miraculous work [God] is able to do in the lives of students who invite us into their stories.

~Marv Penner, Hope and Healing for Kids Who Cut: Learning to Understand and Help Those Who Self-Injure

A) Introduction and Case-Study: Christians Who Cut. The Case of Emily

Emily’s mother, Barbara and I frequented the same coffee shop. A few days a week I would go and study there, sitting in the corner with my laptop and my numerous cups of coffee. We would usually smile and wave at one another, as we knew one another from church. One day, she came in and picked up her coffee. Instead of the usual smile and wave, she came to speak to me. She seemed very anxious about something, weighted down and heavy. I asked her how she was doing, and she told me that her 17-year-old daughter Emily had lost another job, and was refusing to leave the house due to her depression. She had

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3 In order to protect the identity of the family whose story this case is based on, the names and identifying places have been changed. Emily is a composite of three different young people that I have become friends with in the past few years.
recently taken up her habit again of cutting herself on her arms with razor blades and burning her skin with a lighter.

I knew Emily well, and had seen scars on her arms during the very few times when she was not wearing long sleeves. Some had been covered up with tattoos, but others could not be hidden. Barbara stood before me crying, unable to contain her emotions as she spoke of her daughter, who she loved so much and wanted desperately to help. Her husband Paul worked long hours, and did not know what to do to help Emily. I asked Barbara if Emily was getting any help through counselling or therapy, and she said that indeed she was, but she did not have much faith that this time it would do much to help her daughter. They had also been in and out of counselling and therapy as a family for many years.

Barbara knew that I was a studying pastoral theology and asked me if I had heard of any resources that she could look at about youth and cutting from a Christian perspective. At that time, I did not know of any other than a few online articles I had read. I told her that I would ask my friends who are ministers and conduct my own search to see what is available. The search turned into the paper you see before you. This thesis project exists because of Barbara’s question, and because of Emily’s pain.

B) Joining the Conversation About Nonsuicidal Self-Injury

Emily is not alone. Many young people Canada hurt themselves, beginning usually between ages ten to twelve. They poison and cut themselves, burn their skin, hit themselves, pull out their hair and pick at their scabs, interfering with the process of healing

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of their wounds, among other self-harming behaviours. Usually their self-injurious behaviours, often referred to as “self-harm”, “self-injury” (SI), or “non-suicidal self-injury” (NSSI) are hidden from their parents, teachers and friends.

Barbara’s question concerning the availability of theological resources for self-harming individuals prompted a wide-ranging search for current articles, books and online resources devoted to those who injure themselves. Her question has also provided a context for the re-examination of how it is that we are engaging the complex issues relating to self-injury and NSSI theologically. The main research question that I would like to explore in this thesis is how can we as Christian ministers, pastoral counsellors, youth workers and lay people involved in ministry become more involved in the current cultural conversation on self-injury? Some of the supplemental questions that I will also address are as follows: what helpful pastoral theological resources already exist concerning self-injury, and what new avenues need to be explored? How can pastoral theology begin to explore the direction for a more fruitful dialogue with psychology in a deeper way about the issue of self-injury? Are there any theological resources that exist in different areas of pastoral care that could bring helpful guidance and wisdom to this conversation about NSSI?

After preforming the search to obtain an overview of the quantity and type of resources that exist in the fields of psychology and theology regarding self-injury, it became evident that an opportunity exists for theology and psychology to continue its collaborative effort to study and better understand self-injurious behaviours. The thesis statement for this project reflects the need for more research to be done in this area and is as follows: a gap exists in the existing pastoral theological literature concerning self-injurious behaviours. In

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order to bridge this gap, I will argue that it is essential for psychology and pastoral theology to come into deeper conversation with one another in order to create a vibrant and helpful theological perspective on self-injury. In an effort to begin to bridge this gap, this thesis explores the phenomena of self-injury and presents the dominant themes in the psychological and theological research on NSSI. I will also endeavor to begin to construct a pastoral theological response to the tragic reality of self-injury. The hope is that this research will further the conversation on pastoral care and self-injury so that members of the Christian community will better understand how to become a part of self-injurers’ journeys towards wholeness while simultaneously offering them a place of true belonging and authentic friendship for those who engage in NSSI.

C) Methodology

The primary literature that will be surveyed for this thesis is drawn from psychological and theological sources. The methodology employed is correlational researching the fields of psychology and theology/spiritual care and engaging psychology and theology in conversation around the phenomenon of nonsuicidal self-injury. In this paper, I will correlate the findings from the literature from the two fields, summarizing the themes and suggesting areas for further theological exploration. I will then theologically engage the psychological literature in order to further the pastoral theological response to the issue of self-injury and present suggestions for further research in this area.
D) A Comparison of Resources Relating to Self-Injury in Current Psychological and Theological Databases

The terms “self harm/self-harm”, “self injury/self-injury”, “self-cutting”\textsuperscript{6}, “non-suicidal self-injury/non-suicidal self injury”, and “self-mutilation” were entered into every psychology database available through the University of Toronto library system (which is one of the largest available in Canada), the date ranges selected for articles was in the past ten years, (2006 - 2016), and the terms were entered into the databases as subjects. These terms were subsequently searched in the two main religion databases at the University of Toronto Library: the ATLA Religion Database, as well as Proquest Religion. ATLA is the primary theological database that is used by students of theology and ministers when searching for theological articles. Proquest Religion summarizes and amalgamates articles from a variety of disciplines, such as psychology, psychiatry, nursing, social work and medicine, providing an overview of issues that the Church may be dealing with at any given time.\textsuperscript{7} Finally the terms were searched online as a Google search, as well as Amazon.com and Amazon.ca as these are very common places for members of the Christian community to search for resources such as books and websites devoted to self-injury that are outside of the library.\textsuperscript{8} Originally, the terms were put into the databases without being narrowed down by article subject and the results were too numerous to imagine looking through. For example, the database Psychinfo had over 24,000 results for articles using the search term “self-harm/self harm”, while Healthstar had over 566,000 results for the same search term. Upon

\textsuperscript{6} “Self-cutting” was used instead of “cutting” as the latter produced results that were not in any way related to psychology as it is a widely used term (for example, cutting something out, cutting away etc). Even when the results were narrowed down using the subject heading of psychology there were still too many unrelated results.

\textsuperscript{7} None of the articles that were produced from searching in Proquest Religion were directly related to discussing theological issues as they relate to self-harm. The articles were pulled from a variety of disciples and had no apparent theological focus.

\textsuperscript{8} Please see Table 1.
reviewing the articles that came up under this wide search method, many had nothing at all to do with self-harm, bring brought in from different disciplines like chemistry. Narrowing the search by subject helped the databases to suggest helpful articles that were the correct topic.
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It is worth noting at this point that ATLA, the primary theological database available produced a relatively small number of articles relating to self-injury, with only 10 articles produced by the search. The psychological databases produced an enormous number of resources in comparison, (for example, Psych Info has over 1,800 articles and Pub Med over 2,500). The search performed online produced the largest amount of resources overall (Google pulled over 7,000,000 results). At this time, the primary source for theological/pastoral care resources regarding self-injury can be found online. These sources consist of personal blogs, counselling resource websites, Christian support websites and online Christian magazines, which will be discussed in detail in chapter 3.

E) The Outline of Chapters

This paper will look at the dominant themes encountered in the psychological and theological resources surveyed, followed by a theological reflection that engages existing
theological mental health literature that has much to bring to the table regarding self-injury. Chapter 2 will focus on the dominant themes within psychological sources. Within these resources, it became clear that researchers are primarily concerned with the “what and why” of self-injurious practices, its differentiation from suicide, the relationship between past experiences of trauma and self-injury, the role of caregivers, developing policies in schools and the impact that the online world has in the lives of self-injurers. Areas for further research will then be identified and explored.

Chapter 3 will provide an overview of dominant theological themes relating to self-injury. Within the theological literature surveyed, the themes shifted to a focus on the role of the minister and youth worker in the lives of self-injurers, the influence that the Church has had in self-injurious behaviours to date. We will also examine the impact that scripture, sacrament, sin, spiritual warfare and grace can have in the life of the self-injuring person. Following this we will consider the importance of storytelling in the theological literature relating to self-injury, and finally how it is that grassroots movements that are creating positive connections in the lives of self-injuring individuals. Again, areas for further research will be considered and examined.

Chapter 4 will move into theological reflection in the form of three meditations. This chapter will be in the form of a conversation with existing theological literature from three areas: mental illness, disabilities and Christian ethics. We will first consider the importance of friendship and belonging in the life of the self-injuring person. We will then explore the importance of the role of hospitality for those involved in NSSI. Finally, we will then contemplate the practice of listening and how it can function as a radical act.
As we move through this thesis we will pause to consider how the ideas discussed in each chapter could be of help the young person in our case study, Emily. My hope is that this paper will present very helpful and practical information for those in the Christian community who seek education about NSSI and would like to learn how to better support self-injurers and their caregivers within their churches, families, workplaces and neighbourhoods. I pray that this paper will be a helpful part of furthering the dialogue between the psychological community and the theological/pastoral care communities.
Chapter 2

An Overview of Themes Relating to Nonsuicidal Self-Injury in Psychological Sources

A) Self-Injury in Brief Historical Review

Patricia Adler presents a concise history of nonsuicidal self-injury in The Tender Cut: Inside the Hidden World of Self-Injury that goes back as far as the time of Herodotus in fifth century BCE when individuals in the military sliced their flesh open prior to battle. Shamans throughout history across a variety of cultures have dismembered themselves in order to attain purification. In ancient societies, individuals participated in various methods of self-injury such as body modification, tooth extraction and the removal of body parts. In the early Christian era, religious zealots and priests practiced the mortification of the flesh. Into the Middle ages, scarification, flagellation and bodily dismemberment are practiced by religious individuals. The Black Death increased the fear of guilt and sin so many flagellated themselves in order to alleviate divine judgement.  

Instances of self-injury have been documented in medical journals for over one hundred and fifty years. In “The Coming Age of Self-Mutilation”, Armando Favazza presents a helpful, concise history of self-mutilation in psychological literature. The first

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10 Steven Levenkron draws a parallel between acts of self-injury during the time of the Black Plague and today, equating the alienation people experienced from the church with the difficulties that are experienced today in families. He writes: “The scourge of the Black death increased the fear of guilt and sin, yet by the fourteenth century the moral corruption of the church made it impossible for many religiously sensitive people to turn there for relief. Flagellants sought by their own efforts to mitigate the divine judgement that was felt to be at hand, forming groups that traveled about the country on foot. In reading these accounts, one can see a parallel between failed faith or trust in the church and failure of trust in one’s own family in contemporary life. Perhaps we are talking about a universal defense mechanism to which people have always resorted in order to avoid some sense of dread – whether in terms of believing themselves literally damned or feeling emotionally tormented”. See: Steven Levenkron, Cutting: Understanding and Overcoming Self-Mutilation. (New York: W.W. Norton and Company, 1998), 20.
documented case of self-injury published in a medical journal is from 1846 that involved enucleation, based on a literal understanding of Christ’s words about plucking out your eyes if they are offensive. Genital mutilation was first documented in 1882, in which a 29 year old farmer removed both of his testicles in order to obey Christ’s words from Matthew 19 in which he describes eunuchs who castrate themselves for the sake of the kingdom of heaven. The first recorded case of skin cutting was documented in 1887 concerning a 29 year old female psychiatric patient. In 1938, American Psychiatrist Karl Menninger wrote in Man Against Himself that self-mutilation is actually a concession made by the individual in order to avoid suicide. Menninger explains that “self-mutilation is actually a compromise formation to avert total annihilation, that is to say, suicide. In this sense, it represents a victory, even though sometimes a costly one, of the life instinct over the death instinct.”

In the 1960’s psychiatric literature turned primarily to wrist cutting in young female patients, termed “wrist cutting syndrome”. Most patients not only cut their wrists, but also scratched their faces, cut other parts of their bodies, and rubbed pieces of glass into their skin. The patients primarily described feeling numb and empty before they harmed

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13 Favazza does not mention in his concise history of self-injury the interesting article written by L. E. Emerson that appeared in 1913’s The Psychoanalytic Review. This article chronicles the self-injurious behaviour of a young woman who was sexually abused by her uncle from the ages of eight to twelve and was also sexually assaulted by her cousin when she was twenty. She presented for therapy “with a self-inflicted cut on her left arm. Her arm had many other scars, and there was one on her breast: she said that she had cut herself twenty-eight to thirty times; and on the calf of her right leg was a scar forming the letter W.” (43). In therapy, she disclosed that she had cut herself so that she would find relief from headaches and had also been injuring herself in her genitals. Emerson concludes that “pain and sexual stimulation were intimately related. Another motive for her painful self-mutilation was a desire to escape mental distress. Physical pain distracted her attention and was a means of escaping such distress. She also felt disgusted with herself and wished to punish herself, in a way, for her acquiescence as a child in what she instinctively felt were serious misdeeds” (51). The
themselves, and afterwards felt relieved and happy.\textsuperscript{14} Wrist-cutting syndrome was later abandoned as the need for a clear distinction between self-mutilation and suicide became apparent. In 1976, Simpson made the distinction between suicide and self-harm very clear, calling self-harm “anti-suicide” in his article in the psychiatric journal \textit{Suicidology}. In 1983, Pattison and Khan developed the first prototype for “self-harm syndrome”, following their research into 56 published reports. The syndrome consisted of multiple repeated acts of self-harm, usually cutting or burning of the skin without suicidal intent. Finally, in 1987, Favazza himself became instrumental in solidifying the notion that self-mutilation and suicide are distinct acts, a differentiation that remains in place as of today.\textsuperscript{15}

\textbf{B) Defining Nonsuicidal Self-Injury}

Armando Favazza’s seminal work \textit{Bodies Under Siege: Self-Mutilation, Nonsuicidal Self-Injury and Body Modification in Culture and Psychiatry} was first printed in 1987 and has been revised and reprinted two additional times, in 1996 and most recently in 2011. The term “self-mutilation” was widely used in 1987 when the book was first published. In 2017, the term is used sparingly and has been replaced by the term “nonsuicidal self-injury”. Oftentimes, the term “self-mutilation” is used by clinicians when referring to “major” self-injurious acts, such as eye enucleation, gential mutilation or the removal of body parts through amputation. NSSI is the term that is now used most frequently and that focusses on

\begin{quote}
\textsuperscript{14} Favazza, “Coming”, 261
\textsuperscript{15} Favazza, “Coming”, 261.
\end{quote}
self-harming acts such as skin cutting and burning.\textsuperscript{16} \textit{Bodies Under Siege} is widely referenced in the psychological sources and has heavily influenced our current understanding NSSI in American psychological and clinical literature. \textit{Bodies Under Siege} presents an overview of self-harm that that encompasses religion, its place in history, medicine and psychiatry. Favazza’s own work with psychiatric inpatients forms the basis of his research.

Favazza’s definition of self-injury that was presented in 1987 deeply influenced the psychological literature on NSSI that was written after it. He maintains that self-injury is \textit{not} an attempt at suicide. On the contrary, self-harming actions are preformed in order to find some relief in so that the self-injurer may continue living. His definition of self-injury is as follows: \textit{Self-injury is the deliberate, direct alteration or destruction of healthy body tissue without an intent to die}.\textsuperscript{17} Favazza contends that most people self-injure not because they want to end their lives, but because they desire to find temporary relief from difficult situations. He stresses that people who really want to die go forward and actually commit suicide.

Suicide to Favazza is the ultimate act of escape, a permanent exit unto death. Self-injury on the other hand self-harm provides relief from anxiety, tension, guilt and adverse social situations.\textsuperscript{18} He stressed that it is “a morbid act of regeneration, a return to a state of normalcy, and a seeking to feel better”.\textsuperscript{19} He believes, like Mennenger, that self-harm acts as a kind of anti-suicide, which allows the self-injuring person to come back to life from a near

\begin{itemize}
\item \textsuperscript{17} Favazza, \textit{Bodies}, location 4146.
\item \textsuperscript{18} Favazza, \textit{Bodies}, location 545.
\item \textsuperscript{19} Favazza, \textit{Bodies}, location 4146.
\end{itemize}
dead state. This definition of NSSI has been adopted in the current psychological literature, and remains the most widely used definition of NSSI within an American context.  

Self-poisoning is included in the European definition of NSSI, which is also the case in most Canadian, Australian and British studies. The American definition of NSSI does not typically include self-poisoning and is limited to the intentional harm of bodily tissue with the absence of suicidal intent. Hawton et al explain that in Europe:

Self-harm [is] defined as intentional self-poisoning or self-injury, irrespective of type of motivation, including degree of suicidal intent… This definition, which differs from the binary classification nonsuicidal self-injury and attempted suicide now popular in the USA is used by most researchers in Europe and official bodies is based on the fact that motivation for self-harm is often complex.  

Ron Best points out that the mental health literature on NSSI presents the complexity of researchers and clinicians working together to define exactly what self-injury is. The terms used across Canadian, American, Australian and British studies include such terms as: “self-harm, deliberate self-harm, self-mutilation, self-injury, self-injurious behaviours, self-destructive behaviour, self-poisoning, overdosing, self-cutting, self-wounding, delicate cutting, attempted suicide and para-suicide”.  

American psychological literature typically

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uses the definition set out by Favazza above. Best presents the definition of self-harm as laid out by the *United Kingdom’s National Inquiry into Self-Harm and Young People* which states that self-harm includes such behaviours as: cutting, burning, scalding, banging or scratching one’s body, breaking bones, hair pulling, and ingesting toxic substances or objects”.23

The inclusion of self-poisoning into the definition of self-injury is significant for an understanding of self-injury within a Canadian context. In Canada, the primary method of self-injury employed by Canadians between 2001 – 2002 within 162 Ontario hospitals was self-poisoning with a medicinal ingredient.24 The Canadian Institute for Health Information reports similar data from 2009 – 2014, with self-inflicted poisoning being the primary method of self-injury among self-harm hospitalizations in girls age ten to seventeen.25

C) Nonsuicidal Self-Injury and The Diagnostic and Statistical Manual of Mental Disorders

In 2013, nonsuicidal self-injury was included in the *Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) by the *American Psychiatric Association* but is not yet considered to be an official mental disorder.26 The DSM-5 has included NSSI in the back matter of the manual in a section entitled “Conditions for

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26. Steven Levenkron sees this as a major failure of the psychological community. Writing in 1998, he states: “This failure on behalf of the *Diagnostic and Statistical Manual* to consider a severe, physically endangering, and sometimes life-threatening psychological behaviour as a disorder means that clinical efforts to understand the problem are in danger of remaining on the back burner. For victims and their families, this means that most who suffer will continue to do so.” To see self-injury included in the back matter of the most recent DSM shows that the psychological community is interested in investing more time and resources into NSSI and it may be classified as a disorder in the coming years. See: Steven Levenkron, *Cutting: Understanding and Overcoming Self-Mutilation*. (New York: W.W. Norton and Company, 1998) 25.
Further Study”. This section presents numerous conditions that have been deemed by the DSM-5 taskforce to have insufficient evidence to have the condition classified as an official mental disorder. These conditions consist of various conditions such as “Persistent Complex Bereavement Disorder” and “Suicidal Behaviour Disorder” amongst others.

These conditions are presented so that a common language can be developed for practitioners as well as to encourage future research and to produce a better understanding of the disorders by clinicians.

**D) The Functions of Nonsuicidal Self-Injury**

A functional approach to understanding nonsuicidal self-injury is prominent in the psychological literature and is the method employed by two leaders in the field of NSSI: Matthew K. Nock and E. David Klonsky. This approach to understanding self-injury is based

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27 The proposed criteria for NSSI in the DSM-5 is summarized as follows:

a) In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to his or her body of a sort likely to induce bleeding, bruising or pain (e.g.: cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will lead only to minor or moderate physical harm (i.e.: there is no suicidal intent).

b) The individual engages in the self-injurious behavior with one or more of the following expectations: 1) to obtain relief from a negative feeling or cognitive state 2) to resolve an interpersonal difficulty 3) to induce a positive feeling state.

c) The intentional self-injury is associated with at least one of the following: 1) interpersonal difficulties or negative feelings or thoughts 2) prior to engaging in the act, a period of preoccupation with the behavior that is difficult to control 3) thinking about self-injury occurs frequently, even when it is not acted upon.

d) The behavior is not socially sanctioned (i.e.: body piercing, tattooing, part of a religious or cultural ritual).

e) The behavior or its consequences cause clinically significant distress or interference in interpersonal, academic, or other areas of functioning.

f) The behavior does not occur excessively during psychotic episodes, delirium, substance intoxication, or substance withdrawal.

The section on NSSI also includes an attempt to define its diagnostic features, such as the individual’s repetitive behavior of inflicting shallow, painful injuries to their body on their forearms or thighs with a sharp object, as well as the fact that most individuals who engage in self-harm do not report the incident or seek medical care. Finally, it includes a summary of the ways NSSI differs from other disorders that share similar features, such as Skin-Picking Disorder and Suicidal Behaviour Disorder. See: American Psychiatric Association “Conditions for Further Study: Non-Suicidal Self-Injury” *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition*. Accessed February 20, 2017. [http://dsm.psychiatryonline.org.myaccess.library.utoronto.ca/doi/full/10.5555/appi.books.9780890425596.ConditionsforFurtherStudy#x56706.2818342](http://dsm.psychiatryonline.org.myaccess.library.utoronto.ca/doi/full/10.5555/appi.books.9780890425596.ConditionsforFurtherStudy#x56706.2818342), online version - section 1. Section 9.
on the concept of “functions”. A functional approach is rooted in behavioural psychology. It states that behaviours are caused by the events that immediately precede and follow them (i.e.: taking into consideration the antecedent and consequent events that influenced the self-injurious behaviour).

Nock presents a two-tier model of understanding NSSI from a functional perspective. In the first tier, he emphasises that there are four possible “reinforcement processes” for maintaining NSSI behaviours, which can be either positive or negative in origin. The processes are summarized as follows:

- **Intrapersonal negative reinforcement** – the behaviour is followed by a decrease or cessation of adverse thoughts or feelings. This usually happens immediately.
  
  Example: tension relief or angry feelings may decrease.

- **Intrapersonal positive reinforcement** – the behaviour is followed by the increase or occurrence of desired feelings and thoughts. Example: self-stimulation, feelings of satisfaction after punishing oneself.

- **Interpersonal positive reinforcement** – the behaviour is followed by the increase or occurrence of a desired social event. Example: obtaining attention from family members, or support from friends.

- **Interpersonal negative reinforcement** - the behaviour is followed by cessation or decrease in of a social event. Example: others stop bullying, family members stop fighting.²⁹

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The second tier is related to the reasons why people choose the self-injurious behaviours that they do. For instance, why do some people choose to cut themselves while others burn themselves? Nock presents different hypotheses as to why individuals choose the specific self-injurious behaviours.\(^\text{30}\) The hypotheses are summarized as follows:

- **Social learning hypothesis** – many behaviours are learned from observing those around us. Peers can greatly influence both non-pathological (i.e.: learning how to dance or play a sport) and pathological behaviours (i.e.: risky sexual behaviours and self-injury). The influence of the media is also strong.

- **Self-punishment hypothesis** – individuals use self-injury as a way of punishing oneself for a perceived wrongdoing or also for self-hatred/self-depreciation/self-criticism. Self-injury provides affect/cognitive regulation.

- **Implicit attitude/identification hypothesis** – individuals choose self-injury over other available behaviours that all serve the same function. For example, if a person wants to feel better, they could choose to self-injure or have a drink of scotch. A person’s attitude and identification with self-injury may cause them to choose self-injurious behaviour as a way to modify their cognitive/emotional/social regulation.

- **Social signaling hypothesis** – individuals choose to self-injure to communicate with others as it is a way of signalling distress that is more effective at obtaining help from

\(^{30}\) For abbreviated versions of Nock’s functional approach to NSSI, please see:


others versus yelling or crying. Words may fail the self-injurer, or words may be limited or ineffective.

- **Pain analgesia/opiate hypothesis** – Individuals report little to no pain during self-injurious episodes. Some self-injurers may have a higher pain threshold than non-self-injurers, or they may develop a lower pain sensitivity over time as they repeatedly self-injure. Endorphins are released in the body during SI episodes to reduce pain and lead to feelings of euphoria. The analgesic effect can lead to feelings of pleasure and a higher baseline for levels of endorphins.

- **Pragmatic hypothesis** – individuals may choose NSSI because it is rapid, effective and easy to implement in order to regulate cognitive/affective and social experiences. This is important to consider in adolescents as SI can be performed quickly, quietly, privately and in any setting (home, work/school restroom).³¹

Klonsky provides additional functions for NSSI behaviours in “The Functions of Deliberate Self-Injury: A Review of the Evidence”. The functions identified by Klonsky overlap with the functions that have been previously summarized by Nock, with the addition of 5 functions:

- **Affect-regulation model** – individuals who have biological dispositions for emotional instability are prone to use NSSI to manage their affect. Often these individuals come from early invalidating environments that teach poor coping strategies for emotional distress.

- **Anti-disassociation model** – individuals who self-injure experience disassociation/depersonalization when loved ones are absent and as a result of intense

emotions. NSSI may shock the system (possibly due to the sight of blood) and help to regain a sense of self and to feel real/alive again.

- **Anti-suicide model** – NSSI behaviours are a coping mechanism for resisting urges to commit suicide, to express suicidal thoughts without risking one’s own death, and as a replacement for/compromise with the desire to end one’s life.

- **Interpersonal boundaries model** – NSSI is a way to affirm the boundaries of the self, marking one’s own skin separates the individual from the environment and other people, asserting one’s own autonomy and identity.

- **Sensation-seeking model**: NSSI behaviours act as a way of generating excitement or exhilaration, such as one would get from the thrill of skydiving.\(^{32}\)

Both Nock and Klonsky’s research into the functions of NSSI assist in developing a better understanding of why individuals participate in self-injurious behaviours and are relied upon heavily in American, Canadian, Australian and European literature concerning self-injury.

Klonsky furthers his research into the affect regulation model in “The Functions of Self-Injury in Young Adults Who Cut Themselves: Clarifying the Evidence for Affect-Regulation”. This study is important because it highlights affect states before and after incidents of NSSI. In this study, 2776 undergraduates at an American university participated in an interview concerning deliberate skin cutting on various parts of their bodies. The most common affect states before episodes of self-injury were: overwhelmed 85%, sad 82%, hurt emotionally 82%, frustrated 80% and anxious 77%. Following self-injury, the most common

states were relieved 77%, angry at self 77%, calm 72%, hurt emotionally 66% and lonely/sad 64%.

Klonsky concludes that self-injury primarily serves to reduce negative affect as opposed to increasing positive affect. Also, since participants often used NSSI behaviours to produce positive affect, they may come to repeat the behaviour often as positive reinforcement is provided. Klonsky also reinforces that because high negative affect is a characteristic of many disorders, such as disorders relating to personality, mood, anxiety psychotic, eating, substance use disorders, and borderline personality disorder, it is common to see self-injury as a feature of these disorders.

E) A Discussion of Five Key Studies in the Field of Nonsuicidal Self-Injury

In order to provide the reader with an overview of key studies in the field of NSSI, a summary of articles identified by Janis Whitlock in “Self-Injurious Behaviour in Adolescents” will follow in this section. For each article, brief summary of each study will be provided, followed by a discussion of the study’s conclusions and importance within the wider field of NSSI research. These studies primarily give insights into: a) who it is who injures themselves b) the method(s) they employ c) frequency of self-injury and finally d) their reasons for self-injury.


Magnall and Yurkovich present a helpful summary of NSSI and co-morbidities. They explain that a defining criterion for borderline personality disorder is self-injury according to the Diagnostic and Statistical Manual of Mental Disorders IV. As well, they explain in a study by Saxe et al (2002), 86% of their participants with dissociative disorders engaged in NSSI behaviours. This is logical since many individuals with dissociative disorders have a history of childhood abuse. They also reference a study from Castille et al (2007) in which out of 105 self-injurers, 56% had mood disorders, 30% had anxiety disorders, 4% had post-traumatic stress disorder, and 4% had eating disorder. See: Magnall, Jacqueline and Eleanor Yukovich. “A Literature Review of Deliberate Self-Harm”. Perspectives in Psychiatric Care ” 44 (2008): 179. Accessed April 21, 2017. http://simplelink.library.utoronto.ca/url.cfm/5246162.

**Summary**: This study was the first to examine NSSI in a high school sample of adolescents. 440 students from one urban and one suburban high school were given a questionnaire concerning how they deal with stress, followed by comprehensive interviews. 16.4% of students used more than 1 method to self-harm, while 83.6% used only one method. The types of NSSI behaviours were as follows: skin cutting 41%, self-hitting 32.8%, pinching 6.5%, scratching 5%, biting 5%, burning 3.3%.

**Conclusions**: This study was the first to document the high prevalence rate of NSSI among adolescents in a non-clinical population. Ross and Heath conclude that “NSSI is a prevalent problem affecting today’s youth… and it may be becoming an increasingly widespread behaviour in adolescents”. 35 They emphasize the importance of teaching young people to learn positive coping strategies with regards to stressors.


**Summary**: This study was the first to document a functional approach to understanding NSSI. It also includes support for a multi-functional understanding of NSSI. 108 adolescents were surveyed (32 boys, 76 girls) from 12 – 17 years old who were drawn from a psychiatric inpatient program in New England. 82.4% of

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adolescents in the sample reported engaging in self-harm at least once in the past 12 months. The primary methods of NSSI were: cutting/carving skin, picking at a wound and scraping skin to draw blood. The primary reasons why NSSI behaviours were utilized were: to stop bad feelings, to feel something even if it was pain, and to punish oneself.

**Conclusions:** NSSI is prevalent, occurs via more than one method, and begins at an early age. The primary purpose of NSSI behaviours is to increase or decrease emotional or physiological experiences.

- **Key Study 3:** Janet Whitlock, John Eckenrode and Daniel Silverman “Self-Injurious Behaviours in a College Population” *Pediatrics*, 117 no 6 (June 2006), 1939-1948.\(^3\)

**Summary:** This was the first study to provide a large-scale overview of college students and to provide detailed data about the phenomenon through an epidemiological lens. 8300 students were surveyed in an internet-based questionnaire from 2 American universities and 3069 completed the survey. 17% of students reported having engaged in NSSI one time, and 75% engaged in 2 or more of various NSSI practices. Students with repeat NSSI behaviours were most likely to be female, bisexual or questioning their sexual orientation and have a history of emotional/sexual abuse and an eating disorder. The primary means of self-harm was scratching/pinching skin, banging and punching to create bruises and cutting.

**Conclusions:** the students were unlikely to seek help following incidents of self-harm and NSSI behaviours often co-exist with high levels of emotional distress and suicide-

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related behaviours. Questions concerning NSSI should be considered a routine part of all routine medical history and physical examinations by physicians in clinical settings.

• Key Study 4: Jennifer Muehlenkamp and Peter M Gutierrez “Risk for Suicide Attempts Among Adolescents Who Engage in Non-Suicidal Self-Injury” Archives of Suicide Research. 11 no 1 (January 2007) 69-82. 38

Summary: This was the first study to document the distinctions between NSSI and suicide using data from high school students and further expanding NSSI research beyond clinical settings. 540 American high school students were surveyed with a questionnaire between the years 2001-2004. 23.2% of the students reported NSSI, and 8.9% reported a suicide attempt. Females were more likely to have engaged in NSSI and also attempted suicide, and Caucasians reported more self-harm than non-Caucasians (African-American, Hispanic, Multi-Ethnic). 15% reported self-harm beginning at 13 years old, and 28.4% at 14 years old.

Conclusions: it is important for clinicians to monitor for suicidal ideation when working with adolescents who engage in NSSI as they are an at-risk group. Suicide as a possibility is often overlooked in those who self-harm because NSSI is thought to be behaviour void of any intent to die. The main ways to differentiate the adolescents who engage in NSSI and who attempt suicide is through measures of suicidal ideation, reasons for living, and depression.

• Key Study 5: Ingeborg Rossow, Mette Ystgaard, Keith Hawton, Nicola Madge, Kees van Heeringen, Erik Jan de Wilde, Diego DeLeo, Sandor Fekete and Carolyn Morey “Cross National Comparisons of the Association Between Alcohol Consumption and

Deliberate Self-Harm in Adolescents” *Suicide and Life Threatening Behaviour*, 37 no 6 (December 2007 605-615. 39

**Summary:** This was the first study to look at NSSI prevalence internationally. It also laid the foundation for future work in studying the relationship between NSSI and adolescent risk factors (such as alcohol use). 30,532 15-16 year old students completed a survey from seven countries: Australia, Belgium, England, Hungary, Ireland, Netherlands and Norway. The primary questions asked concerned whether a student had ever taken an overdose of pills or other medications and whether or not they had engaged in self-harm acts such as cutting. Questions to ascertain the correlation between alcohol use and NSSI followed. England had the highest population of adolescents engaged in NSSI within the past year at 6.7% followed by Norway and Australia at 6.6%. The students from Hungary reported the highest association between NSSI and alcohol use at 27%, followed by Norway at 25%, indicating that 1 in 4 episodes of self-injury occur under the influence of alcohol.

**Conclusions:** strategies to minimize alcohol consumption in adolescents are an important part in the prevention of NSSI in adolescents.

**F) Key Themes in the Psychological Literature**

I will now present a summary of key themes concerning NSSI encountered in the psychological literature. For each section I will present an introduction to the theme, followed by key insights into the themes and example studies. It is an understatement to say that the literature on self-injury is very extensive so I have made a concerted effort to isolate

themes that I felt to be the most prominent in the literature and also those that I feel would be
the most helpful for those who are looking to form a coherent understanding and solid
foundation concerning self-injury.

1) Nonsuicidal Self-Injury is Different from Suicide

An emphasis on the differentiation between nonsuicidal self-injury and suicide is
common in the literature that was surveyed. For many clinicians, teachers, parents, family
and friends, it is difficult to know if a young person is engaging in NSSI behaviours because
they ultimately want to die, or for other reasons relating to affect regulation or intrapersonal
reasons. Although NSSI tends to happen at high frequencies over time and suicide attempts
at low frequencies, it remains important for clinicians to constantly assess for suicidality and
not to be lulled into forgetting about suicide risks because suicidal behaviour is more rare.40

Muehlenkamp and Kerr present a helpful summary of the main differences between
NSSI and suicide in “Untangling a Complex Web: How Non-Suicidal Self-Injury and
Suicide Attempts Differ”. The authors first explain that most self-injurers never exhibit
suicidal behaviour, but there is evidence that a correlation does exist between NSSI and
suicidality. Between 28 – 55% of self-injurers experiences suicidal thoughts during NSSI
episodes. 70% of individuals who have a history of repetitive NSSI will also attempt suicide
in their lifetimes. In addition, the two behaviours have correlational risks, such as: conflicts
in interpersonal relationships, problem solving skills that are poor, a history of childhood
abuse, self-criticism that is very high, as well as other psychiatric diagnoses.

The authors also stress that although NSSI is *not* a suicide attempt, it is a clear indicator that something is not right in the life of the individual engaging in the behaviour. NSSI needs to be taken very seriously by those around the self-injurer while remembering to maintain perspective and to manage unnecessary over-reactions to NSSI behaviours. In order to simplify this complex issue they present six ways to differentiate NSSI from suicide attempts:

- The first difference concerns *intent/purpose*. The primary reason for NSSI behaviours is to provide escape from overwhelming negative emotions, while the intent of suicide is finality, an escape from consciousness. Both NSSI and suicide are attempts to escape from psychological distress, but the primary difference is the degree to which the distress is averted, whether temporarily through NSSI or permanently through the final act of suicide.

- The second difference is *severity/lethality* of methods used. Most often, suicide deaths in the United States are reported to be a result of gunshots, hanging, jumping from high heights and overdose, while NSSI acts are superficial acts such as cutting or burning of the skin. It is important to understand that as the method of NSSI severity increases, so does the risk for suicide attempts, therefore it is important to monitor changes in NSSI severity.

- The third difference is *behavioural frequency*. NSSI is viewed as being a repetitive behaviour, while suicide attempts often occur only once and are successful. Adolescents report between one to over one hundred acts of NSSI in their lifetimes, while suicide attempts often occur in singularity. If the attempt is repeated it is in very low frequency.
• The fourth difference is number of methods used. Repeated suicide attempts usually use the same method the second or third time, while individuals who engage in NSSI report using multiple methods to injure themselves depending on availability, preference and need for effect.

• The fifth difference relates to the cognitive state surrounding the behaviour. Individuals who are suicidal report high levels of hopelessness and helplessness, as well as ineffective problem-solving which results in “tunnel-vision”. They believe the only solution is to end their life as they are incapable of generating alternate solutions. In contrast, individuals who engage in NSSI report stronger hope for the future, greater reasons to continue living and fear of suicide.

• The sixth and final difference is the psychological repercussions following the behaviour. Individuals who attempt suicide are often distressed and frustrated that death did not occur which may lead to increased suicide attempts and desires to end their life. For those who engage in NSSI, the immediate psychological consequence is often feelings of relief and reduction of negative affect.41

It is important for clinicians and counsellors to understand that suicidal behaviour if often viewed sympathetically by others, while NSSI is often met with negative reactions from family, friends and care givers. Those engaging in NSSI may not be as open to seeking help for their behaviours as they are concerned they may encounter unsympathetic responses from others. This theme will be expanded upon in further detail below.

Barent Walsh also notes that clinicians and counsellors need to be alert so they will recognize when their patients say that their self-injury has “stopped working” as this can

signify that a switch may be coming to more lethal methods such as using a firearm or hanging themselves. In addition, if patients switch methods of self-injury to a way that is very different for them, this also may signal that their method of NSSI is diminishing. Those with a greater history of self-injury are more prone to suicide attempts. Self-injury should be alleviated early in its trajectory through treatment so that it does not escalate into more lethal methods.\textsuperscript{42}

Hawton et al performed a study in England regarding repetition of self-injury in young people and its association with suicide. They analyzed data from 5205 individuals who presented for NSSI to six hospitals in England from 2000 – 2007. 74% of individuals in the study were female, 26% male. Ages ranged from 7 years old to 18 years old for a total of 7150 episodes that resulted in ER visits. The primary methods of NSSI were self-poisoning and cutting. The authors attempted to follow up with the individuals until December, 2010. Out of the 5205 individuals from the study, 51 (1%) had died by the end of the study, nearly half by suicide/probably suicide (via jumping from a height, self-poisoning and hanging). Most of the deaths involved a method of self-harm that was different from the method that was used in the last episode of NSSI, with the most common method being hanging. The authors conclude that the risk of suicide was greater in males and was associated with cutting, psychiatric history and instances of previous NSSI. Also they stress that it is essential for clinicians to assess risk of repetition of self-harm and of suicide for all children and adolescents who present with self-harm at a hospital.\textsuperscript{43}

Brausch and Gutierrez studied the differences between NSSI and suicide attempts in an American study of high school students. 373 high school students from the Midwest

\textsuperscript{42} Walsh, \textit{Treating}, location 25.
\textsuperscript{43} Hawton, “Repetition”, 1212-1218.
United States were collected as a part of mental health screening. The students were assessed about a variety of issues such as: self-injury, suicide attempts, suicidal ideation, body satisfaction, disordered eating, self-esteem and social support. Out of the sample of students NSSI was reported by 21.2%, while 4% reported suicide attempts (the authors stress that this is lower that what was expected according to national survey data that found between 6.9 – 8.4% had attempted suicide within the past 12 months). The authors conclude that the group of students who had only engaged in NSSI had lower levels of suicidal ideation, greater parental support, higher self-esteem and lower levels of anhedonia (the inability to feel pleasure in normally pleasurable activities) and negative evaluation of the self. The group of students who had both NSSI behaviours and had attempted suicide had less parental support, less self-esteem, higher rates of depression and increased negative self-evaluations. There were no reported differences between the two groups with regards to disordered eating.

It is essential to understand the differences between NSSI and suicide while remaining alert to the fact that NSSI is a major risk factor in suicide attempts. Clinicians and counsellors should be vigilant and know the main warning signs of suicide that are: ideation, substance abuse, purposelessness, anxiety, feeling trapped, hopelessness, withdrawal, anger, recklessness and mood changes. It is important to assess individuals for suicidal behaviour when they begin treatment for NSSI and to take appropriate action in order to monitor and treat the behaviour.

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2) Nonsuicidal Self-Injury and Childhood Trauma and Sexual Abuse

The correlation between childhood trauma/sexual abuse and NSSI is a significant theme in the psychological literature. Smith et al explain that the foundation of trauma theory and its relationship to NSSI was laid in 1996 by Robin Connors. Connors observed children in clinical settings following such traumatic experiences as abuse, neglect, loss and abandonment. She described self-injury as a coping mechanism that “enables people struggling with overwhelming and often undifferentiated affect, intense psychological arousal, intrusive memories, and dissociative states to regulate their experiences and stay alive”. Connors proposed that NSSI served four functions:

1) a re-enactment of the original trauma in order to gain control, to tell what happened and make real the original trauma.

2) to express feelings and certain needs (guilt, shame, rage, frustration and self-punishment) and to give voice to an internal experience.

3) to reorganize the self and regain homeostasis as following NSSI trauma survivors can feel more calm and in control over intense feelings.

4) to aid in management of dissociative processes as the pain from NSSI can make the survivor feel more anchored to reality, or can work as a “switch” in which the person can disconnect from current distress. In addition, NSSI can make survivors feel more alive and help them to regulate sensation, such as managing flashbacks.

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47 Connors, “Functions”, 199.

Building on Connor’s work Smith et al contend that rates of PTSD are higher in those who self-injure compared to the general population (24% vs. 6.8%). Those with both bipolar disorder and PTSD have significantly higher frequencies of NSSI and trauma-related triggers of self-injury such as flashbacks/nightmares, and thoughts about abuse and rape. The authors also provide a theoretical model for understanding the relationship between traumatic experiences, trauma symptoms and NSSI. Relying on Nock and Prinstein’s functional model of NSSI, trauma related symptoms lead to self-injurious behaviour. NSSI serves the following functions for trauma survivors:

- **automatic negative reinforcement** – decrease or reduction in aversive feelings and negative emotions, relief, ending flashbacks, distraction from intrusive thoughts.
- **social negative reinforcement** – generates feeling, acts as self-punishment, ends dissociation/depersonalization, helps to express emotion.
- **social positive reinforcement** – establishes boundaries, stops others from hurting the individual, assists in forming social isolation.
- **social negative reinforcement** – aids in feeling connected to others, gets attention, communicates the level of pain inside.\(^ {50}\)

In addition to this helpful summary of the functions of NSSI for trauma survivors, the authors also present a comprehensive review in addition to key findings for over 40 studies relating to trauma and NSSI. This is very helpful for individuals who wish to explore the relationship between trauma and NSSI in further detail (as this goes beyond the scope of this paper).

\(^ {49}\) For a very thorough explanation of these functions, see section D above.

Glassman et al explain that sexual abuse has shown a strong association with different forms on NSSI, while physical abuse has been associated with NSSI in some studies but not others. They argue that individuals who are excessively criticized and verbally or emotionally abused as children may learn to engage in excessive self-criticism which in turn leads to using NSSI as a form of “self-abuse”. NSSI in these cases serves to act as an extreme form of self-punishment. Major depression is also a factor in individuals who have been abused as children, which may explain NSSI behaviours used as a coping mechanism with regards to their depression. Upon examining the data from 86 adolescents between the ages of 12 – 19 years in an American high school, Glassman et al determined that physical neglect, emotional abuse and sexual abuse were significantly associated with NSSI, while physical abuse and emotional abuse had smaller, non-significant relations with NSSI behaviours.51

Contrary to Glassman et al’s findings, Klonsky and Moyer analyzed data from 45 studies regarding the relationship between childhood sexual abuse and NSSI and argue that in fact there is minimal or negligible unique associations between childhood sexual abuse and NSSI behaviours. The use of NSSI in abuse survivors might be the result of other variables in the individual’s life, such as depression, anxiety and feelings of worthlessness. If the severity of the abuse is analysed in future studies (i.e.: coercion, frequency, penetration, relation to perpetrator), the association between abuse and NSSI might be larger.52

Noll et al highlight the relationship between NSSI and re-victimization. Re-victimization is defined by the authors as harm perpetrated from an outside source (either physical abuse or sexual abuse) that serves as a re-enactment of the initial childhood abuse (either physical or sexual). They also argue that self-harm is a direct re-enactment of initial childhood abuse that the survivor inflicts upon themselves, which also represents an internalization of the trauma. They studied 84 abused females aged 6 – 16 years old who had been sexually abused by a family member. The data from these 84 participants were compared to 82 girls who had not been sexually abused. The results of the study suggest that when compared to the non-abused females, the sexually abused girls were twice as likely to be sexually assaulted later in life and four times more likely to engage in NSSI. In this study, the participants used NSSI as a direct response to their dissociative experiences that resulted from the abuse they suffered. NSSI acts as a coping mechanism in this case. The authors also hypothesize that sexual abuse survivors use NSSI to communicate their level of internal pain, to claim power over their own body, to regulate affect, to end feelings of depersonalization, for self-stimulation and to enact feelings of shame/worthlessness. Finally, sexual abuse survivors may also re-enact the abuse that they suffered by putting themselves into the role of the perpetrator and harming themselves. Sexual abuse is also associated with feelings of

53 One example of a survivor of sexual abuse who turned to self-injury is recounted by gynecologist Robert Cavanaugh who presents a case study from his practice, in which a 14 year old female was seen for a physical exam. She had also been receiving psychiatric care for her worsening anxiety disorder, was under considerable stress and was not sleeping. Upon physical examination, Cavanaugh noticed that she had numerous scars on her forearms ranging from ½ inch to 1 inch in width and 3 to 4 inches in length. When asked about them, she revealed to him that she had been sexually assaulted a few months earlier and had been carving out “tattoos” on her arms in order to remove the skin where the perpetrator had touched her as he held her down during the assault. She felt that the new skin was now “clean”. Cavanaugh stresses the importance of supportive counselling and psychotherapy, as well as anti-anxiety medications and antidepressants for abuse survivors who self-injure. See: Robert M. Cavanaugh. “Self-Mutilation as a Manifestation of Sexual Abuse in Adolescent Girls”. *Journal of Pediatric and Adolescent Gynocology* 15 (2002): 97-100. Accessed February 22, 2017. http://simplelink.library.utoronto.ca/url.cfm/524624.
negativity about one’s own body so NSSI may serve to be a way to elicit painful experiences and bodily disfigurement.\textsuperscript{54}

3) \textbf{Nonsuicidal Self-Injury and the Role of Caregivers}

Help-seeking after episodes of self-injury is a common theme in the psychological literature. Unfortunately, individuals who self-injure oftentimes do not find the support they need following episodes of NSSI. In addition, many caregivers who encounter self-injurers feel underequipped to assist them. This section will focus primarily on three areas where self-injurers could go for help: their family, the emergency room and clinicians/therapists.

i) \textbf{Family Members}

Arbuthnott and Lewis report that self-injuring youth typically seek support from their friends before they will ask their family members for support. As a result, parents may not be aware that their child is self-injuring. In general, youth tend to seek help for NSSI after an episode, not before. When parents are made aware of their child’s self-injurious behaviour, they can play a key role in initiating treatment and continuing to support the child as they undergo therapy. From the perspective of a parent or guardian of a youth who self-injures, dealing with NSSI in the home is very difficult and can negatively impact the mental health of the parent and their own wellbeing. In addition, it is reported that NSSI among youth may affect family dynamics and increase financial burdens, with many parents reducing their work hours and taking sick leave to care for their children. Some parents also make the difficult decision to leave paid employment so they may tend to the needs of their self-injuring child.

The authors also stress that parents of self-injuring children often deny their own needs in order to take care of their child, so is important that parents maintain their own self-care regimens. While working with parents, clinicians and counsellors can direct them to parental education programs about NSSI, as well as helpful internet resources such as *Self-Injury Outreach Support* and *The Cornell Research Program on Self-Injury and Recovery* so that they can learn more about self-injury and how to support their child.\(^5^5\) *Self-Injury Outreach and Support* is a non-profit organization providing resources and support for those who self-injure, along with their family and friends. It is a joint project between Guelph University and McGill University. *The Cornell Research Program on Self-Injury and Recovery* is a project by Cornell University that studies NSSI and provides resources for self-injurers and their caregivers/family/friends.\(^5^6\)

McVey-Nobel et al provide a helpful guide for parents on how to approach their child if they are self-injuring. It is important for parents to recognize that they are valuable members of the youth’s care circle and it is important for parents to talk about self-injury with their children. When the parent is ready, they can speak with the child at a time when both parties are rested in a private place. It is key for the parent to succinctly state that they love the child, that they are concerned about them and that they believe the child may be self-injuring. At this point, it is acceptable for the parent(s) to acknowledge that they are uncomfortable with the conversation as it is difficult for both parties to discuss self-injury.


If the child becomes very angry or hostile about the questions, which McVey-Nobel stresses is likely to happen, it is important to validate the child’s feelings of anger and discomfort and to continue to speak with them in an non-accusatory tone. It is also the right time to try to gather some information about how long the child has been self-injuring, how often the NSSI episodes are taking place, where on their body they are self-injuring and to try to ascertain their motivations. This will help the parent to determine what type of help is necessary such as outpatient therapy or if immediate hospitalization is required. Following these questions, the parent will have successfully conveyed two important messages: that the child’s self-injury has been acknowledged and that the parent is invested in helping the child with their NSSI in a patient, caring manner. Following this conversation, parents should not attempt to rid the home of all sharp objects, as young people will find alternate means to injure themselves even if all sharp objects are taken away (such as fingernails). Additionally, parents should not perform routine body checks as this is very shameful for the young person and once the body checks stop, the child will often return to self-injurious behaviours.

ii) Emergency Room Departments and Medical Staff

When taken to the emergency room for medical attention, individuals who self-injure are not always met with the same level of compassion and attention as others whose injuries are accidental or inflicted by another person. This can make the life of a self-injuring person very difficult as they are routinely brought to the ER and may be met with less than adequate

57 Merry McVey-Nobel, Sony Khemlani-Patel and Fugen Neziroglu. When Your Child is Cutting: A Parent’s Guide to Helping Children Overcome Self-Injury. (Oakland: New Harbinger Publications, 2006. Kindle Edition) location 1251- 1309. For additional resources concerning the conversation between parents and children about NSSI, please see McVey-Nobel et al Chapter 6 “Responding to Answers: Common Obstacles to Communication About Self-Injury” from the same book. The authors provide solutions for common issues such as a child who will not talk about their NSSI, whether or not a parent should believe a child who says they will stop self-injuring and what to do if a child is finding excuses to stop self-injuring.

care. At the same time, health care providers routinely report feeling unprepared and undertrained on how they can properly assist those who engage in NSSI, further compounding the situation.

In a recent American study of family medicine physicians, pediatricians, family nurse practitioners and pediatric nurse practitioners 49% of participants said that they felt unprepared to address NSSI with adolescents and 70% of participants indicated wanting more training in this area. In addition, only 1 in 4 primary care physicians routinely asked their adolescent patients about NSSI behaviours when providing health supervision. This may be due to their lack of comfort with the topic, as well as a lack of training. With proper training programs, clinicians may become more willing to ask about NSSI and suicidality amongst their patients.59

It is important to understand that general practitioners are not usually the primary health care providers for NSSI. Instead, individuals are most often taken to the emergency room to be seen by doctors and nurses. For example, Warm et al explain that in England and Wales, on average, GP’s will see between five to seven patients per year following their self-injury, while the ER will see 140,000 presentations of NSSI within one year. The authors recently performed an international study involving 243 individuals with a history of self-injury. Their data showed that voluntary organizations and self-harm specialists received the most favourable ratings with regards to care following NSSI. Participants stated they feel less satisfied with the treatment they receive from doctors, nurses and psychiatric services. The

authors stress the need for front-line specialists to receive accurate information about NSSI and increased training and support.\textsuperscript{60}

Jennifer Harris preformed an interesting study in the United Kingdom in 2000 in which young self-injuring women were approached and asked to correspond via letter writing with Harris. The women were asked to recount the details of any visits to the emergency room relating to their NSSI. In total, six women corresponded with the researcher. When asked about their experiences in the ER, the women recounted being met very unsympathetically by medical staff along with being classified right away as suicides. One woman was told that she was wasting the doctors time and taking up the bed that another person could be using. Another young woman recounts being told by the staff that her self-injury was not a “real emergency” in the eyes of ER staff members.\textsuperscript{61}

Deb Martinson explains that due to the stigma associated with NSSI in combination with the lack of information that is readily available on the subject, often the treatment methods used by emergency room staff and mental health professionals can make the lives of self-injurers worse rather than better. The negative stories that she has heard by self-injurers regarding their experiences with healthcare professionals has lead to the creation of “The Bill of Rights for Those Who Self-Harm”. The Bill has been created to help medical practitioners better understand the emotions that are a part of NSSI and to be able to respond to self-injurers in a way that protects the patient.

The Bill is highly effective at describing the issues that self-injurers struggle with as they seek help at emergency rooms and also with counsellors and clinicians in treatment


settings and its components are summarized below. The Bill is an integral part of understanding how individuals who self-injure have been treated by medical staff in the past and what steps can be taken to improve medical treatment in the future. The Bill’s main points are as follows.\footnote{Due to space constraints, I have chosen to briefly summarize the Bill here. For a longer summary of each of the Bill’s points with explanations, please refer to the appendix.}

a) The right to caring, humane medical treatment.

b) The right to participate fully in decisions about psychiatric treatment, (as long as no one’s life is in immediate danger).

c) The right to body privacy.

d) The right to have the feelings behind the NSSI validated.

e) The right to disclose to whom they choose only what they choose.

f) The right to choose which coping mechanisms they will use.

g) The right to have care providers who do not allow their feelings about NSSI to distort the therapy.

h) The right to have the role SI has played as a coping mechanism validated.

i) The right to not be automatically considered a dangerous person simply because of self-inflicted injury.


The Bill is a very helpful resource that I encountered in numerous places throughout my research. For example, Hollander, Walsh and Penner all cite the “Bill” and refer to it as a
guide to help family members, friends, counsellors, nurses and clinicians better understand the needs of self-injuring individuals. Variations of the “Bill” also exist online, for example on self-injury.net. This site which is devoted to self-injurers and those who support them, has numerous posts relating to the “Bill”, primarily written in the users’ own words.64

In addition to the studies that present the negative experiences that individuals who self-injure have had with the staff at emergency departments, studies do exist that present positive and hopeful outlooks from medical staff regarding the treatment of self-injury. O’Connor and Glover present a helpful overview of the complex issues that medical practitioners face when treating patients who self-injure. They explain that doctors and medical staff must provide care for their patients while continuing to work within the system that has been set up for them, alongside the rules and cultural and environmental expectations that exist within the system. Doctors and nurses both express feelings of helplessness as they desperately try to prevent self-harm but not knowing how they can help the patient. As well, raw emotions often precede instinctual reactions when treating self-injuring patients which can create an overwhelming sense of responsibility in staff members. Staff members also convey their passion to work alongside the whole person who self-injures which is based on the ability of staff members to know their patients and understand, acknowledge and identify the role that self-injury has in the life of the patient. Finally, it is essential for caregivers to be able to hold hope for their patients and envision their recovery. In this way staff members

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64 The various forms of the Bill were written by and posted on self-injury.net up until October 2016 in which, unfortunately, this very helpful site that ran from 1999 – October 2016 was shut down. When I returned to gather quotations and citation data, I learned of its closure. This is very unfortunate as the self-injury.net community was a wide-reaching helpful resource for self-injurers themselves, researchers and caregivers of those who self-injure. See: Selfinjury.net. “What Happened to Self-Injury.Net?”. Accessed April 6, 2017. http://self-injury.net/self-injury-net
persevere alongside the self-injurer and hope for them when patients are unable to see their own recovery in the near future.\textsuperscript{65}

Similarly, Hadfield et al interviewed five doctors working in the ER department in the United Kingdom who highlighted the importance of understanding the self-injurer’s life story and considering the difficult circumstances they are going through when treating their physical wounds. The doctors stress that they too might turn to NSSI if they were forced to undergo very stressful or hopeless similar life circumstances. They maintain that it is important to realize how medical staff can make an enormous impact in the lives of their patients and that is imperative to discuss treatment options with these patients and give them options for care.

The authors also stress the importance of continuing to train emergency room staff on how they can better attend to the emotional needs of self-injurers. As well, they point out the value of involving psychologists in this training as they can bring much to the table regarding the moral judgements and relational decision making in health care and how these decisions relate to personal, political and cultural values that surround NSSI. Psychologists can also assist ER staff to better understand the complex relationship that individuals who self-injure have with their families and other relationships. Finally, the authors emphasize the importance of medical staff opening up to others regarding their own experiences of NSSI. This will allow doctors to explore personal understanding of self-injury which will produce

more helpful responses and will break down some of the barriers between doctors and patients.66

iii) Therapists and Counsellors

Barent Walsh explains that working with self-injuring clients can be a very complex and emotional experience for therapists and counsellors. As a case example, he presents the experience of therapist while working with her first client who self-injured. The therapist felt the young girl’s self-inflicted wounds had such an impact on her that the therapist began to feel that *she herself* had been wounded. The therapist also describes the sadness she felt as she imagined the pain the young girl had felt that brought her to self-injury, along with the frustration and discouragement she eventually felt when the girl did not stop hurting herself despite a long time in therapy.

Walsh explains that negative reactions to self-injury on behalf of clinicians are very common. He presents three main categories of negative reactions that therapists (and other professionals) often have when they see their patient’s self-inflicted wounds:

- Biological responses – increased heart and respiration rate, nausea, light headedness, agitation, insomnia.
- Psychological responses – cognitive (confusion, disorientation, indecisiveness, pejorative judgements, pessimism regarding treatment, self-doubt regarding professional competence, “saviour” fantasies), affective (anxiety, fear, shock, disgust, bitterness, rage, sadness, panic, helplessness) and behavioural (excessively sympathetic, emotionally charged/agitated

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responses, use pejorative language to refer to clients, attempt to coerce, control and extinguish the behaviour via the use of safety contracts, withdraw, avoid, terminate treatment of clients, abandon professional boundaries by becoming overly involved with clients/preoccupied with their self-injury).

- Social/environmental responses – punishing clients for their self-injuring behaviour by withdrawing privileges, suspending them from school/treatment settings, intervene inappropriately in clients’ lives outside of treatment with unnecessary psychiatric hospitalizations, violating confidentiality by contacting clients’ significant others without permission, and warn other clients to “avoid” self-injuring clients.\(^\text{67}\)

Walsh emphasizes that the way for caregivers to learn to manage negative responses to self-injury is to “unlearn” these negative reactions. This will enable them to provide proper, compassionate and therapeutic care for their clients. He provides these guidelines for managing negative reactions to self-injury:

- **Physical self-soothing**, such as employing breathing skills that allow the slowing of respiration and heart rate and ushering in a bodily calmness.\(^\text{68}\)

- **Cognitive restructuring.** Biological, affective, behavioural and social/environmental reactions begin with thought processes. A dispassionate and very patient attitude is required for therapy with those who self-injure. It is important to deal with the negative reactions to self-injury when they are still at cognitive and affective levels before they emerge in the relationship with the client.

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\(^\text{67}\) Walsh, *Treating*, 272-274.

\(^\text{68}\) For a detailed explanation of breathing skills please see Walsh, *Treating*, Chapter 11.
• **Regulating affective responses.** The therapist can recognize fear and anxiety and turn them into positive attentiveness towards the client. Anger can be transformed into a commitment to assist the client and help to fight the problem. Sadness and discouragement can be transformed into proactivity.

• **Abandon such actions** as being late for sessions, being inattentive during sessions and raising fees inappropriately. Instead, therapists should remain calm, strategic and helpful with regards to self-injury and it is important for patients to learn replacement skills that are as effective as self-injury.

• **Manage inappropriately intervening in client’s environments.** Therapists should arrange outpatient intervention and whenever a therapist wants to speak to a spouse, partner or friend written permission from the patient should be obtained.

4) **Nonsuicidal Self-Injury and Developing Policies in Schools**

The need to create policies for elementary, high school and university settings is a common theme in the psychological literature. Bergel et al summarize the primary concerns and explain that teachers the United States and in Canada have not received adequate training regarding what to do if they find their students are self-injuring. Since school staff tend to lack knowledge about NSSI, oftentimes they misinterpret self-injurious behaviours as attention-seeking and manipulative on the behalf of the student. These misconceptions can be

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69 Walsh recommends that there are three instances when this should not be the case: 1) when the patient is a minor as their parents/guardians should be notified immediately, 2) when circumstances have progressed from low-lethality NSSI to severe self-injury, such as self-injury to eyes, faces, breasts and genitals in which psychiatric evaluation/hospitalization is needed for the safety of the patient and 3) the self-injury is worsening and may shift into suicidal behaviour.

70 Walsh, *Treating*, 4749-4836.

very damaging to the students and quality of care they are provided by staff members. In a separate study, Berger at al recently interviewed 501 secondary school staff members working in United States high schools. Their findings were that the majority of staff members underestimated the prevalence of NSSI within their schools. Teachers primarily reported feeling sympathy for the self-injuring students, frustrated by the lack of services in place and confused about how to help the students.

In addition to the need for schools to begin to create self-injury policies, schools are also finding that NSSI is becoming more commonplace amongst students. Teachers and support staff have identified a need for specific protocols to be in place so they know exactly what steps they should follow to assist self-injuring students. Hasking et al provide a very helpful summary of key elements that should be considered when creating a protocol for school settings. They emphasise that it is important to offer responses that are timely, appropriate and consistent. The key elements of the school response proposed by the authors are summarized as follows:

- Establish roles and responsibilities. These roles/responsibilities should be clearly outlined for staff members so they know how to detect and respond to NSSI. As well, it is beneficial to establish a point person or team (called the self-injury team or SIT) who co-ordinate case management for students and who are responsible for staff training on NSSI.

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72 Berger, “Developing”, 629. This article also contains a helpful template for schools to use as they move towards developing their own self-injury policies for managing NSSI among students.

• **Risk assessment.** A SIT member conducts an initial risk assessment paying attention to the possibility of suicide risk. The SIT then determines the next step (a high-risk student may need referral to the hospital, a low-risk student could benefit from follow up from within the school to explore healthier coping strategies and to monitor changes to the NSSI behaviour).

• **Referral.** The SIT can refer based on the risk assessment and with the involvement of the parent/guardian where appropriate. The SIT should have a list of referral options based on risk profiles and the socio-economic levels of the family.

• **Parent/guardian notification/involvement.** Local regulations vary in different schools, parental notifications need to be created in relation to these regulations. It is beneficial for the SIT to work with the student and involve the parent/guardians so they can provide ongoing support. The SIT can also provide information/resources to parent/guardians.

• **Managing social contagion.** School communication about self-injury should focus on enhancing healthy coping and avoid materials that focus solely on self-injury. Peer communication about self-injury should not be banned but guided, and it should be made clear that others may be triggered by explicit detail. Students should be asked to cover wounds when possible as others who are struggling with recovery may be triggered. The emphasis should be on supporting others who are recovering.74

The authors also emphasise that when staff members respond to NSSI that they validate the behaviour, feelings and thoughts that are causing the NSSI. Communicating to the student

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that they understand that he or she is doing their best and that their self-injury serves a purpose is also key. It is finally important for school staff to understand and communicate to the student that NSSI can be difficult to stop so conveying a genuine interest in why the student is self-injuring is more helpful than discussions regarding stopping the self-injury. The student and their peers can also be referred to the SIT or mental health staff to help manage their reactions to NSSI. Finally, the authors emphasise that if the student expresses a risk for suicide, parents/guardians must be informed and involved.75

Best, whose work on NSSI focusses on “pastoral care”, (the term for the care that teachers provide for their students in the United Kingdom), emphasises the importance of creating environments that foster self-worth and provide a clear message of support in schools. Teachers, school counsellors and school nurses should actively listen to students and provide them with a sense of feeling valued when NSSI is disclosed. When the reason for NSSI lies outside of the pressures of school, such as parental divorce bereavement or child abuse, school staff members should work to support the students as much as possible.

Best also emphasises the value of creating school environments that work to create emotional literacy, teach positive coping skills and learning how to express feelings in a healthy way. Support should also be made available for teachers through supervision by a counsellor so that teachers can receive supervision but also so that they can share the emotional burden that they may experience while providing care for students who self-injure.76 Best also contends that it is key for chaplains working in university settings to remain very open, available and approachable to students as they too have the opportunity to offer care and support to students who self-injure. Working to develop relationships and to

provide positive interaction prior to instances of NSSI will encourage students to seek help from chaplains if they feel that their door is always open.  

5) Nonsuicidal Self-Injury and the Online World

Another theme that is very prevalent in psychological literature is the influence that the online world has on self-injurious behaviours. Whitlock et al. estimate that more than 80% of young people in the United States between the ages of 12 – 17 years old use the internet, logging on at least once per day, primarily for social reasons. For young people, the internet facilitates social interactions in a variety of forms, as well as a place to find information about socially sensitive topics such as sexuality. In a two-month long examination of over 400 self-injury message boards and 3000 individual posts, the authors determined that young people seek out online relationships so that they may “exchange support, share personal stories about daily life events and voice opinions and ideas”.

The authors point out it is important to note is that due to the anonymity of the internet, online sharing often produces more truthful dialogue and disclosures than anywhere else, especially amongst self-injurers. This may be because young people seek acceptance and

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78 Statistics Canada presents similar numbers for Canadians with 80.3% of Canadians having access to the internet in 2009, with the primary access point being from home at 77.1%. For younger users, ages 35 and under, 81.9 % of people within the age bracket have internet access at least once/day. See: Statistics Canada. “Internet Use by Individuals, by Location of Access, by Province”. Accessed April 29, 2017. http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/comm36a-eng.htm and Statistics Canada. “Internet Use by Individuals, by Selected Frequency of Use and Age”. Accessed April 29, 2017. http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/comm32a-eng.htm


belonging in social groups and desire intimacy. At the same time, young people are also exposed to the normalization and even encouragement of self-injurious practices online. It is possible that the internet may contribute to “epidemics” of self-injury amongst young people in the same way that NSSI has been shown to be socially contagious in hospitals and schools.  

An example of self-injury technique sharing and a pro-self injury discussion can be found when searching Youtube for “self-harm”. In a fourteen-minute video by a Canadian teen who has over 81,000 subscribers entitled “How to Hide Self-Harm From Your Parents”, Hannah Vancouvarr discusses how to apply make up to cover up self-injury scars, the importance of wearing long sleeves and the best time that individual should cut themselves to draw less attention from their parents. Even though this video has been identified by the Youtube community as being “potentially inappropriate”, it is still completely accessible. At the time of writing this thesis, this video has been viewed over 280,000 times. Hannah’s other videos concerning self-injury are entitled: “How to Start Cutting”, “How to Cut Deeper” (in which she explains how to produce better scars - this video has close to 300,000 views), and “How to Take Care of Self-Harm Cuts”.  

On Instagram, Moreno et al analyze different hashtags commonly associated with self-harm such as: self-injuryyy, self-injuryy, self-injury, selfharmmm, secretsociety123, secretsoociety_123, secret_society123, blithe, and myssecretfamily (which provides code

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82 For these videos, see:  
3) __________ and “How to Take Care of Self-Harm Cuts” Youtube. Accessed April 16, 2017. https://www.youtube.com/watch?v=bFsfcn7DyYQ
names for different problems that young people may be struggling with). For example, if a young person struggles with anorexia, girls would write the hashtag #ana, and boys #rex, or if they want to discuss self-harm, for girls they would use #cat and for boys #sam. This way the hashtag meanings are known only to others who know the names of the specific family members. This also creates anonymity for users as their posts would not be reported as easily since they are not posted under the obvious hashtags of #anorexia, #suicide or #self harm.\(^8\)

The purpose of this study was to see when navigating to the photos associated with these hashtags if Instagram generated a content advisory warning, or a redirect source to help an individual who may be in distress. The hashtags were often very obviously tied to self-harming behaviours in their names, such as #self-harmmm and #selfinjuryyy, but oftentimes, especially when posts were posted under the Secret Society hashtag, no content advisory warning was generated and no redirect resource was offered.\(^4\)

The authors stress that Instagram, with such a high quantity of teenaged users, should improve their content advisory resources. They do have an entire section on their blog dedicated to explaining what hashtags are banned due to their graphic content (such as #thinspiration, #probulemia and #proanorexia), and tell these users that they will have their accounts disabled if they are found to have any content that glorifies or promotes self-harm. The problem is, once users accounts are shut down, they can easily create a new one in its place by creating a different username.\(^5\) When I conducted my own simple search on

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http://journals1.scholarsportal.info.myaccess.library.utoronto.ca/pdf/1054139x/v58i0001/78_ss1utlosoi.xml

\(^4\) To view the complete chart of hashtags, please see: Moreno, *Instagram*, 83.

\(^5\) Instagram explains their policies on their blog: “Going forward, we won’t allow accounts, images, or hashtags dedicated to glorifying, promoting, or encouraging self-harm. Should users come across content of that nature, we recommend flagging the photo or flagging the user as a ‘Terms of Service’ violation for our Support team to review. It is important to note that this guideline does not extend to accounts created to constructively
Instagram for the hashtag #selfharmmm, over 1,900,000 posts became available. It is interesting to note that Instagram will also suggest similar hashtags, such as #selfhatred, #wanttodie, #worthless and #hatemyself to “broaden” a search after inputting the self-harm hashtag. At the time of this search, none of the images associated with these hashtags led to any positive redirect sources, although #selfharmmm did lead to a content advisory notice. Also, a large quantity of posts did have trigger warning messages associated with them. That being said, the images are very disturbing, and show young people with actively bleeding cuts from razors, many with bloody bandages on their wrists, and with slashes on their legs from knives and glass. I have included two examples below.

discuss, or document personal experiences that show any form of self-harm where the intention is recovery or open discussion. While we strongly encourage people to seek help for themselves or loved ones who are suffering, we understand the importance of communication as a form of support, in order to create awareness and to assist in recovery. The language we have added to our Community Guidelines can be found below: Don’t promote or glorify self-harm. While Instagram is a place where people can share their lives with others through photographs, any account found encouraging or urging users to embrace anorexia, bulimia, or other eating disorders; or to cut, harm themselves, or commit suicide will result in a disabled account without warning. We believe that communication regarding these behaviours in order to create awareness, come together for support and to facilitate recovery is important, but that Instagram is not the place for active promotion or glorification of self-harm. In addition to these Guideline changes, hashtags that actively promote self-harm, such as “thinspiration,” “probulimia,” and “proanorexia,” are no longer searchable.” For the entire policy and explanation see: Instagram “Instagram’s New Guidelines Against Self-Harm Images and Accounts” Accessed July 2, 2016. http://blog.instagram.com/post/21454597658/instagrams-new-guidelines-against-self-harm
These images are representative of less violent images that I found in my search for images associated with #selfharmmm. A large quantity of the images are more disturbing and include blood dripping from fresh wounds on the lower arms and thighs and also complete body images in which young women stand in front of the mirror and take photos of themselves covered from head to toe by self-inflicted cuts and burn marks along with scars.

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86 Instagram Image 1. Instagram. Ragazzasola_2. Accessed July 23, 2016. https://www.instagram.com/ragazzasola_2/ This user has over 3,000 followers. In her profile, she asks that those who view her image do not report her to Instagram for the graphic images that she posts.

Oftentimes users will have images associated with suicide interspersed amongst these images, such a young person sitting on top of a bridge contemplating jumping, or images of ropes to be used as nooses and images guns. Some users have happy images as well posted to their accounts amongst images of self-harm and suicide, such as photos of their pets and social groups.

Seko et al address the question of why young people are drawn to use social media such as Instagram and other online methods of communication such as forums, blogs and online multimedia websites in conjunction with their self-harming practices. The authors interviewed 17 individuals ranging in ages from 16 - 27 years old. Participants were from countries all over the world such as Canada, the United States, India, the United Kingdom, Australia and the United Arab Emirates. The main reasons why the participants went online to post NSSI content was that they felt the internet was a safe place to share their stories, express their creativity, share images, and disclose their struggles. The participants also stressed that when they created these self-harming materials, they found it was a way to distract themselves from the urge to self-injure, with the online content at times even becoming a substitute for their own NSSI.\textsuperscript{88} Participants also explained that they felt they were supporting others with their online content, as they find it difficult to obtain help outside of their online community due to their feelings of shame and isolation. Finally, the participants felt the online world provides them with a venue to show others who do not self-harm how they struggle daily, that there are real people behind the scars, and to provide a safe space to advocate for self-harming communities.

In a separate study, Seko et al analyze NSSI images shared on the social media site Tumblr.\(^8^9\) They analyzed 294 images, and 41.8% of the sample images contained images similar to what was found in my informal Instagram search: 84.5% showed images of cutting (primarily of wrists, legs and thighs), followed by 7.3% showed carving images or words into the skin, and 2% showed burning and 2% showed hitting. They also found that 171 images (58.2 of the total sample) did not show direct images of NSSI, such as cutting or wounds. These images primarily had images of young white women, images from movies and television, along with eating disorder images with extremely thin women and their associated hashtags (such as #ana and #thinspiration).\(^9^0\) The authors also found that amongst these images of self-harm, many pro-recovery images existed, symbolizing inner strength and resilience. Alongside this a re-reading of scars exists, in which the users see their scars as proof of authenticity and belonging to self-harm communities. Scars can also symbolize their ability to integrate their painful past into a present self-narrative that is more meaningful as the individual seeks to reestablish their own self worth and seek healing.\(^9^1\)

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\(^8^9\) Like Instagram, Tumblr also has a policy on self-harm images, which at the time of writing this thesis is in a state of flux. In February 2012, Tumblr staff posted that they are unsure of how to manage self-harm images posted by users on their site, so they asked their community to weigh in. As of January 2017, no definite policy has been outlined by Tumblr and interestingly the same questions posed to their online community from 2012 still remain. They explain that “Our Content Policy has not, until now, prohibited blogs that actively promote self-harm. These typically take the form of blogs that glorify or promote anorexia, bulimia, and other eating disorders; self-mutilation; or suicide. These are messages and points of view that we strongly oppose, and don’t want to be hosting. The question for us has been whether it’s better to (a) prohibit them, as a statement against the very ideas of self-harm that they are advancing, or (b) permit them to stay up, accompanied by a public service warning that directs readers to helplines run by organizations like the National Eating Disorders Association. We are planning to post a new, revised Content Policy in the very near future, and we’d like to ask for input from the Tumblr community on this issue”. See Tumblr.com “A New Policy Against Self-Harm Blogs” http://staff.tumblr.com/post/18132624829/self-harm-blogs, accessed Jan 2, 2017.


\(^9^1\) Yukari and Lewis, “Reblogged”, 13.
G) Gaps Identified in the Psychological Literature: Suggested Areas for Further Research

In the psychological literature that was surveyed for this thesis, two areas of research were underrepresented in relation to self-injury. I would like to suggest that more work needs to be done in these two areas. The first area for further study is self-injury and gender, especially relating to self-injury within the LGBTQ community. The second area for further study is self-injury in Aboriginal communities around the world.

1) Nonsuicidal Self-Injury, Gender Issues and LGBTQ Individuals

Research on gender variant individuals and transgender individuals is not well represented in most research on self-injury, nor in the majority of wider healthcare literature. In a recent study conducted in 2016, Jackman et al gathered data from articles in healthcare, psychology and social science databases. They extracted 1729 articles with a focus on NSSI. After preforming a screening process to exclude all articles that did not focus on NSSI and sexual/gender minorities, they were left with only 26 articles, with 4 studies that focussed exclusively on self-injury within LGBTQ populations, highlighting the lack of research in this area.92

In 2011, the Institute of Medicine in the United States published a report entitled The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding that highlighted the health disparities of sexual and gender minority populations, calling for increased attention and research among LGBTQ populations within healthcare research. In addition, the federal government in the United States Healthy People

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2020 goals include the mandate to revise a goal to increase the identification of LGBTQ individuals within health databases, which is a change from the current structure that does not collect data relating to gender identity and sexual orientation. This research attention will assist clinicians in better understanding the needs of their LGBTQ patients and allow them to provide better intervention and patient care.  

Roen argues that the primary way that gender is represented in most research and studies is in a binary fashion with no option for transgender identity. Such research does not represent the complexities of gender fluidity, as well as gender diversity. Since 1995, research focussing on NSSI within the LGBTQ community has increased, providing insights into the prevalence of self-injury for LGBTQ individuals. In order to demonstrate the prevalence of self-injury amongst LGBTQ individuals, Roen cites a study, conducted in 2011 by House et al. This study sampled 1126 LGBT individuals in an online questionnaire. The findings were that female and transgender participants were more likely to self-injure, with 29.9% of transgendered individuals reporting self-harm. LGBTQ and gender variant youth are very likely to be subject to abuse and negative emotional outcomes which in turn lead to NSSI as a coping strategy. In addition, Roen points out that young people who experience gender distress and who seek clinical intervention are often met with a paradox. In order to be considered a plausible transsexual subject, a young person must present in a convincing way to their clinician so they can be diagnosed within the terms of gender dysphoria. Roen argues that self-injury can become a dangerous part of the process of conveying authentic distress to clinicians. 

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Liu and Mustanski studied 246 multi-ethnic LGBT youth from 16-20 years old who self-identified as gay, lesbian, bisexual and questioning/unsure/other who were recruited from LGBT identified neighbourhoods and events. They found that self-injury was predicted by female gender, gender non-conformity and a history of suicide attempts. In addition, hopelessness and LGBT victimization (experiences over the past 6 months of property damage and verbal/physical threats or assaults because an individual is or is thought to be LGBT) were associated with greater instances of self-injury. Victimization of LGBT youth also predicated self-injury and suicide attempts. Victimization correlated to a 2.5 fold increased risk of NSSI. The authors stress the importance of increasing social supports for LGBT youth in the community, as well as focussing on increasing parental supervision of youth in order to limit opportunities to engage in NSSI.95

McDermott et al studied the responses from approximately 290 individuals in online communities between the years 2005 to 2011. The participants in the study identified as “genderqueer, trans, lesbian, bisexual, pansexual, pan-sapphic, heteroqueer, female-gay, transgender-straight, male-gay, androgenous, demisexual and polyamorous”. The study found that a large proportion of the individuals claimed they were self-injuring and considering suicide due to the distress from homophobic reactions to their identities from family members and peers at school. Individuals were also engaging in NSSI due to their feelings of self-hatred, fear and shame. They reported body dissatisfaction, discomfort with their identities and being silenced by mainstream conceptions of heteronormative sexuality. Many participants also claimed that their self-injurious behaviours were not at all related to their sexuality and gender, but instead were attributed to issues relating to self-esteem and

academic pressure at school. Respondents explain that their sexual identity is a positive part of their lives and a source of strength.96

Similar to the above findings of Hose et al, Davey et al report a relationship between transgender identity and NSSI. Davey et al surveyed 97 ethnically diverse transgender patients from the National Identity Clinic in the United Kingdom who were in the process of gender reassignment. They found that 19% of the individuals reported current NSSI behaviours, primarily by cutting (39%). The matched control group reported NSSI at 4%. 71% of the transgendered individuals reported engaging in self-injurious behaviours between 1-5 days in the past month. The trans individuals in the study had greater psychopathology, lower self-esteem, lower body satisfaction and lower social support than non-trans individuals. Davey et al highlight the importance of clinicians working with trans individuals to assess their patients for NSSI behaviours as they are undergoing treatment. They also stress the important role that the clinician plays in helping their patients develop positive coping strategies that can increase their psychological well-being, self-esteem and positive body image.97

2) Nonsuicidal Self-Injury and Indigenous Communities

Within Indigenous communities, self-injury occurs at rates that are significantly higher than non-Indigenous populations. In an analysis of Indigenous communities in rural Australia, Proctor argues that self-injurious behaviours by Indigenous individuals should be


seen as a response to very stressful life events. The meaning of self-injury within Indigenous communities is vastly different than self-injury within non-Indigenous communities, and should be interpreted differently. For example, NSSI within this context is not primarily about managing affect, but addresses larger structures of power, injustice, tyranny, socioeconomic conditions, cruelty and hurt experienced by Indigenous peoples over many years. Proctor argues that the disintegration of community structures within the Australian Indigenous community has lead to a loss of future orientation for young people. Positive role models, especially for males, have diminished due to alcohol and substance use, depression and loss of kinship networks. Young people as a result turn to NSSI and suicide as coping strategies.

In New Zealand, data was collected between 2006 – 2007 at various emergency departments around the country with a focus on understanding the presentations of NSSI in the Indigenous population. In this study, individuals identified themselves with the following ethnicities: New Zealand/Eurpoe/Pakeha, Maori, Pacific Island, Asian or other. The highest rates of self-injury were from female Maori individuals. At one rural hospital, 39.9% of individuals who presented for self-injury were female and Maori. This area that this hospital is in has a very high Indigenous population at 29% with a disproportionately elevated level of socioeconomic deprivation.

Within Canada, a national study conducted by Oliver et al from 2004 to 2010 looked at communities with high populations of Inuit, Mètis and First Nations individuals and

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compared them with areas with a low population of Indigenous peoples. They analyzed emergency department presentations for NSSI and found that the areas with high populations of Indigenous peoples had 2.5 times more presentations to the ER for self-injury than non-Indigenous areas. Females had higher rates of self-injury within the Indigenous peoples who presented for NSSI. The primary methods of self-injury were self-poisoning, cutting/piercing, drowning and suffocation. Fantus et al provide similar data concerning Indigenous individuals living in Ontario. Their study looked at individuals living on Indian reserves and settlements with First Nations identities in Ontario. They report that these individuals were 5 times more likely to present to the ER for self-injury than individuals with non-Indigenous identities living in nearby northern areas in Ontario, such as Sudbury, Thunder Bay and Manitoulin.

Within the United States, two studies exist concerning the White Mountain Apache Tribe, located on a reservation in Central Arizona. These studies present data collected by their “tribal surveillance system”, which is managed by the Celebrating Life team of Apache professional case managers and Johns Hopkins University. The System mandates that all suicidal ideation, suicide attempts, deaths by suicide, NSSI and severe use of alcohol and drugs are reported to Johns Hopkins Centre for American Indian Health so that proper intervention by mental health experts can take place. The suicide rate amongst youth in this tribe is 13 times the rate reported in the United States and 8 times the rate of other American Indians. Study participants were recruited from reports received by the surveillance system.

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from 2007 – 2008. The findings were that rates of NSSI for Apaches is higher than the general population in the United States, especially amongst youth ages 10 – 14 years whose NSSI occurs at the rate of 3000 in 100,000. The primary method of NSSI was reported as cutting, with many individuals under the influence of alcohol and drugs at the time of self-injury. The primary function reported was to manage affect. Additional data from 2007-2010 shows a high frequency of substance abuse co-occurring with NSSI, with Apache males being drunk or high 50-60% of the time during episodes of NSSI and youth aged 15-24 drunk or high 49.4% during NSSI. The high prevalence of NSSI in Indigenous communities across the world points to a need for further research with regards to self-injury in this area.

H) A Return to Emily: Implications for Our Case Study

Now that we have surveyed the main themes in the psychological literature, what do these insights and research have to bring to our case study concerning Emily? There are four key insights that I would like to suggest are important for Emily and her family. I have chosen these issues as they provide multi-tier support for Emily and her family members at home, school and church and are very practical.

- **Referral to counselling and therapy.** At the time that I had spoken to Barbara, Emily’s family had already made the wise and (difficult decision) to seek professional therapy for both their daughter and for their family. This is very important so that Emily can

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receive both therapy and pharmacological support if needed. Supportive therapy is also very important for Emily’s family members so that they can receive the help and guidance they need during this difficult time.

• *A “spiritual” self-injury support team.* I would like to suggest that the family could also benefit from pastoral counselling and a support team from the church (comprised of a formal self-injury team, youth workers or trained volunteers) who could walk beside them through this time. This team could help with prayer support, providing a listening ear when needed, and with more practical matters such as driving Emily to doctor’s appointments or making meals for the family. We will discuss what a self-injury support team could look like at church in chapter 3.

• *Parental education on NSSI (psycho-education).* Whether through Emily’s school, through the therapist who is working with the family or through community support groups, Emily’s parents need to be directed to resources such as *The Cornell University Self-Injury and Recovery Research and Resources* website that has excellent resources for caregivers so they can better understand self-injury and how to provide positive communication, proper parenting strategies as well as work through misconceptions about self-injury.104

• *Policies for school and church.* Emily’s high school should have a proper self-injury policy in place so that she will know who she can turn to when she needs medical attention, a listening ear and for counselling and referral assistance. In the next

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104 Please see Chapter 3 for more information about Cornell’s program. It is my opinion that Cornell’s website is hands down the most comprehensive and helpful resource on self-injury that I encountered throughout my research. Resources can be found at: *Cornell University Self-Injury and Recovery Research and Resources* “Resources” [http://www.selfinjury.bctr.cornell.edu/resources.html](http://www.selfinjury.bctr.cornell.edu/resources.html) Accessed May 1, 2017.
chapter we will discuss how having a self-injury policy in church could have helped
Emily along the way, and what this policy could potentially look like.

We will now begin an overview of the themes regarding self-injury in the theological and
pastoral care resources surveyed. The themes overlap slightly but do have very different
tones and I would suggest, different purposes and within the theological literature, tend to see
self-injurers as a “whole person” with physical, emotional and spiritual needs. We will return
to Emily’s case at the end of chapter 3 to consider how the theological and spiritual care
themes can be practically applied to her situation.
Chapter 3
An Overview of Themes Relating to Nonsuicidal Self-Injury in Theological Literature

While searching for theological sources I found, as mentioned in Chapter 1, that it was much more difficult to obtain resources relating to self-injury and theology, pastoral care and pastoral counselling than it was to find psychological, psychiatric, nursing and social science resources on NSSI. As a result, I was forced to broaden my search for resources relating to self-injury and theology/pastoral care and to be much more creative about where I looked. This turned out to be a blessing in disguise. My search took me away from traditionally academic sources such as journal articles and academic texts and brought me towards Christian counselling websites, youth ministry websites, narrative books and pastoral care booklets as this is where the conversation about self-injury in theological circles is currently taking place. While academic resources such as journal articles concerning self-injury and theology do exist, they are very few and far between.

I would ask the reader to remain open minded as they consider the sources that I have assembled here. I ask this as I am unaware of another resource that has made an effort to compile an extensive list of theological/pastoral care resources regarding self-injury to date. As well, I hope to encourage the reader so they will not be disheartened, (as I initially was), thinking that resources on self-injury from a Christian perspective simply do not exist.

A) The Church Community and Mental Health

It is difficult to find resources concerning how all members of the wider Christian community can come together to support self-injurers. Most of the resources I encountered in my research focused on the specific responsibilities of ministers, youth workers and Christian
counsellors as they work with self-injuring individuals. I would like to suggest that although self-injury has not yet been defined as a mental illness in the DSM-V, (as was discussed in the previous chapter), existing theological mental health literature has a lot to bring to the table concerning the conversation about self-injury.

Existing theological mental health literature provides a wealth of guidance for members of the wider Christian community who desire to come together and support those with mental illnesses. It is not surprising to read in Brett Ullman’s work that at a recent talk with Canadian Christian high school students he asked the audience to raise their hands if they knew someone who struggles with cutting, bulimia, anorexia, suicide or self-injury. He recounts that over ninety percent of those one thousand people in attendance raised their hands. As previously mentioned, although self-injury has not yet been classified as a mental illness according to the DSM-V, what I discovered in my research is that self-injurers have been treated much the same way as other individuals have with mental illnesses by the Christian community. They recount stories of being misunderstood, alienated, silenced and afraid to reveal their wounds to others.

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105 For the interested reader, Donald Capps presents a helpful summary of all publications regarding mental illnesses in pastoral care journals in The Journal of Pastoral Care and Counselling, Pastoral Psychology and Journal of Religion and Health from 1950 – 2003. He concludes that mental illness articles have always been present in the publications since their beginnings, but the volume of articles being published more recently may not necessarily reflect the fact that mental illness is increasing in the United States. The main topics covered by the journals during the time span were: depression, suicide, alcoholism, anxiety and mental illnesses such as borderline personality disorder and bipolar disorder. See: Donald Capps. “Mental Illness Publications in Major Pastoral Care Journals from 1950 to 2003”, Pastoral Psychology 55 (2007): 597. Accessed April 16, 2017. doi: 10.1007/s11089-007-0070-5

106 Ullman, Your Story, location 136-151.

107 It is interesting to consider that ministers who have a mental illness, or by extension, may have struggled with self-injury throughout their lifetimes, are more likely to recognize and prioritize ministry towards these areas within their churches. Amy Simpson conducted a survey of 500 churches within the United States and found that “church leaders who have suffered from mental illness, such as depression or an anxiety disorder, are more likely to indicate that they are aware of mental illness within their congregations…. Among church leaders who have suffered from any type of mental illness, 100 percent indicated that they have seen some type of mental illness within their congregation… In general, church leaders who have suffered from some type of mental illness feel more competent to minister to those who are suffering”. It is worth contemplating how ministers can become more open about their own struggles in order to minster to others. Also, how can the
In *Mental Health: The Inclusive Church Resource*, Jean Vanier and John Swinton offer suggestions concerning how the whole church can come together to welcome and support those with mental illnesses. Their ideas are very helpful as well for self-injurers. They offer three helpful insights, which we will now examine, and we will return to their writings in Chapter 4 as they have much to offer from a theological perspective to the conversation about self-injury.

The first way that individuals in the wider church community can help those with mental illnesses and by extension, self-injurers, is by realizing that as disciples of Jesus, it is not enough to preach and to tell others that God loves them. Disciples of Jesus must say to those in need that they are fully committed to them and assist them in finding appropriate help. The authors stress the importance of disciples offering their understanding and loving hearts to those suffering from mental illnesses. Both those with mental illness and self-injurers “need to be able to find and interact with other disciples within our churches; people who seek to *meet* with them; to *understand* them, to *appreciate* them, to *love* them and to reveal to them that they are loved by God”.

Vanier and Swinton also stress that it is key for churches to learn to accept these same gifts *from* people who self-injure and others with mental illnesses.

The second way that members of the wider Christian community can support those with mental illnesses and self-injurers is by listening to them. The authors present the story of a young woman who is struggling with mental illness and decides to stop taking her medications due to the side-effects with negative consequences of paranoia and delusions.
She stands in the street as she is very frightened by imaginary people, she screams and is taken away by the police. Instead of passing her off to the “specialists”, the authors stress the importance of coming close to her and listening to her so that we can better understand how she is feeling. They write:

If we were to take time and listen to what she is going through, perhaps we could understand her? Instead of passing her on to the ‘specialists’, perhaps our job is to learn how to come close and listen to her; to learn how to value her experience and love and understand her?... The real problem may be that we have not yet learned the practice of listening properly; of slowing down, being patient and opening our souls to the confusion of the other...Taking time to listen and understand is not complicated: a look of respect, a gesture of love and tenderness, a thoughtful word that will reveal to people that they are not forgotten by God (or humans); that they are loved. It is in the small things of this world that the Kingdom of God is revealed. 109

It is very important that members of the wider Christian community feel they do have something to offer self-injurers: the small things. It is through these looks, gestures and thoughtful words that self-injurers will find love and acceptance. The small things will also counter effects of loneliness and isolation and reveal God’s kingdom.

The third way that members of the Christian community can support those suffering with mental illness and self-injurers is by resisting the urge to move away from them out of confusion and fear. By making a conscious effort to come closer to them, true friendship can be offered. 110 The authors explain that many individuals are concerned they will become

109 Vanier and Swinton, Inclusive, location 550 – 568.
110 Stanford and McAlister studied 85 Christians who self-identified as having a mental illness through an online survey in 2008 In the United States. The results of the survey illustrate Vanier and Swinton’s point that oftentimes Christians “move away” from persons with mental illness out of fear and confusion. When asked what help or services the participants would like most from their churches, the most common responses were: guidance, counseling, support and understanding. When asked how much involvement their churches had with providing the support they felt they needed, 57.6% of respondents felt that they had not been helped in the way that they needed most. 50.6% of respondents felt that their family and friends outside of the church were more supportive to them with regards to their mental illness. What is hopeful is that 36.5% of respondents said they wanted their church to become a great deal more lot more involved in providing supportive care. See: Matthew S. Stanford and Kandace R. McAlister. “Perceptions of Serious Mental Illness in the Local Church”, Journal of
engulfed by the pain of the mentally ill and as a result pull away, removing the chance for a friendship to be created.

There is a temptation, for some of us, to move away from people with mental illnesses for fear of being engulfed by their pain… Instead of moving forward in love we retreat backwards in fear. However, ‘There is no fear in love. Indeed, perfect love drives out fear’ (1 John 4:18). The call of Jesus is to hear the cries for love and to move forwards in friendship and in perseverant love; a mode of friendship which destroys stigma and opens up space for all of us together to be fully human even in the midst of our wildest storms.  

By becoming a genuine friend to individuals with mental illness and self-injurers, the stigma that often surrounds them is removed. This friendship allows others in the community to see that the self-injurer is not only their struggle with NSSI, but is also a human being loved by God. As a result, the person is not known only by their self-injury, but by their true name.

We will return to these concepts and additional writings of Vanier and Swinton in Chapter 4.

**B) Nonsuicidal Self-Injury and the Role of the Minister and Youth Worker**

**1) Practical Ways to Minister to Self-Injurers**

A dominant theme in pastoral care resources on self-injury is practical ways that pastors and youth workers can minister to self-injurers. Many of the concepts in these resources mirror Walsh’s suggestions regarding managing reactions to NSSI when working with self-injuring clients.\(^{112}\) It is important that ministers and youth workers have a list of available resources in their community for referral to psychological, psychiatric and pharmacological assistance as needed. Ministers can come alongside self-injurers and offer a combination of

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\(^{111}\) Vanier and Swinton, Inclusive, Kindle location 586.

\(^{112}\) For more details on Walsh’s suggestions, please see Chapter 2 section iii.
assistance through prayer, pastoral counselling as well as offering emotional and spiritual support.

Jerusha Clark’s *Inside a Cutter’s Mind: Understanding and Helping Those Who Self-Injure* is a valuable resource for ministers, counsellors, church leaders and youth workers. It details the reasons why self-injurious behaviours begin, different methods of treatment for NSSI as well as an exploration of some of the spiritual implications of self-injury. What is particularly noteworthy is Clark’s detailed suggestions of what ministers and youth workers can do to support self-injurers. Clark emphasizes the importance of compassionate responses to learning that self-injury is taking place as well as modeling a strong faith commitment. Her suggestions are briefly summarized below:

- **Getting comfortable with uncomfortable emotions.** Intense emotions are not “bad, “forbidden” or “unacceptable”. Learning to process and express emotions relating to the anger, fear, shock and frustration that a person will feel regarding another person’s self-injury is key.

- **Allowing others to experience uncomfortable emotions.** Self-injurers often report that their feelings are trivialized or discounted. Validating their emotions is very important.

- **Avoiding oversimplification and trivialization.** There are no easy answers for self-injurious behaviours. Oversimplifying or trivializing a self-injurer’s pain creates a false reality and does a disservice to the self-injurer.

- **Rejecting shame-ridden and guilt-tripping messages.** Shame and guilt do not help self-injurers learn more positive coping strategies. Parents should not punish their
self-injuring children and therapists should not threaten to terminate therapy if NSSI behaviours continue during the course of therapy.

- **Steering clear of threatening, demanding and trying to convince self-injurers that their behaviour is unreasonable.** Take time to listen to the meaning the self-injurer assigns to their NSSI. Threats do not provide the motivation needed to end self-injurious practices.

- **Watching out for hypocrisy.** It is important to model authenticity for self-injurers who have grown up with inconsistent, hypocritical and confusing messages from others.

- **Learning to empathize rather than sympathize.** Empathy invites a person to experience the emotional world of another person while sympathy makes others objects of pity. Condescension will alienate self-injurers as they seek help and cause them to turn away.

- **Using faith as a blessing.** Overscripturalizing and spiritualizing self-injurious behaviours and paths to recovery can do more harm than good. Rigid systems of judgement create environments where wounded people feel unsafe to feel and express their sorrows.¹¹³

¹¹³ It is also important to point out that the opposite effect can be equally damaging to self-injurers. “Underspiritualizing” or completely discounting a person’s faith in therapy can be very harmful and confusing. For example, a recent study of church leaders who run mental health support groups in their churches in the United States found that at times when individuals with mental illnesses seek help from psychiatrists and psychologists, questions regarding spirituality are diminished and transcendent experiences may even be seen as psychotic in nature. Stetz et al explain the results of their study: “Pathologizing spirituality was also evident when interviewers described the tendency among some mental health professionals to assume that religion or spirituality was itself indicative of a mental disorder. Language about one’s faith was viewed with suspicion, limiting the ability of persons with severe and persistent mental illness to speak openly about their religious or spiritual values, concerns and experiences. This type of estrangement was reflected in approximately one fifth of the responses (19%).” See: Kathleen M. Stetz, Marcia Webb, Amelia Holder & David Zucker “Mental Health Ministry: Creating Healing Communities for Sojourners” *Journal of Religion, Disability & Health*, 15 (2011): 66. Accessed April 19, 2017. doi: 10/1080/15228967.2011.565590
• **Showing your faith commitment.** Many self-injurers live with fears of abandonment as they have been rejected by others throughout their lives. It is crucial for care givers to show they will stay with the self-injurer even when it is difficult and exhausting to do so.¹¹⁴  

Clark’s emphasis on looking for ways to offer very practical help to the self-injurer, such as offering to drive them to a doctor’s appointment and remaining present for the self-injurer when it is difficult is key. Remaining patient with self-injuring individuals is needed as their recovery process may be lengthy.¹¹⁵ They also may relapse so it is important to model a steadfast and understanding attitude.¹¹⁶

Drews writes a similar list of helpful ways for youth ministers and youth workers to respond when self-injury is disclosed to them. Her suggestions pair very well with Clark’s actions for ministers with the addition of some interesting insights regarding the development of positive coping strategies and becoming aware of additional mental health issues that may

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¹¹⁵ Marion Carson summarizes the importance of patience when ministering to self-injurers, pointing out how essential it is to continue to offer support to self-injurers even when they are not currently injuring themselves, and not to giving up on them especially when those in the medical community have. She explains: “These recommendations are good to bear in mind when someone seems to be caught in a pattern of self-injury which goes on for a long time. It can be very difficult to remain patient with someone who, despite long hours of medical therapy and help, continues repeatedly to cut herself”. Patient care givers show self-injurers that they will not be abandoned and show them God’s steadfastness faithfulness. See: Marion Carson. *The Pastoral Care of People with Mental Health Problems.* (Great Britain: Society for Promoting Christian Knowledge, 2008) 118–119.
¹¹⁶ Helen Ruth Thorne adds to Carson’s thoughts on the importance of patience when ministering to self-injurers by reminding us about the endless patience of God. “Human beings have a tendency to think that there are only a certain number of times they can be forgiven for messing up in the same way. ‘People are bound to give up on me if I keep doing the same wrong thing time after time,’ we muse. The apostle Peter thought that it would be generous to give people seven strikes, then they are out. Jesus has a rather more generous approach: limitless forgiveness (Matthew 18:21-22). That is an important message to embody to people whose recovery often consists of relapse as well as progress”. See: Helen Ruth Thorne. *Understanding Self-Harm: A Biblical Model for Encouraging Recovery.* (Cambridge: Grove Books, 2011). 25.
occur alongside self-injurious behaviours. She emphasises the importance of proper response when self-injury is disclosed or discovered which is summarized here:

- **Acknowledging the severity of the person’s distress and pain.** Let self-injurers know that you take them seriously and see their pain.

- **Encouraging the self-injurer to verbalize their feelings.** Be an active listener, provide a safe space for youth to talk about their emotions.

- **Making yourself available.** Ask the young person how they feel leadership can be helpful. Work with the student to set up a network of caring adults who are available to them when they need help.\(^{117}\)

- **Never trying to control a self-injurer’s behaviour.** Taking away sharp objects, strip searches and threats can make self-injury worse. Work with them to seek out professional referrals instead of forcing them against their will.\(^{118}\)

- **Work together to form more positive coping strategies** such as calling a trusted adult.

- **Being aware of other issues.** Self-injury often occurs alongside other mental health issues such as anxiety, depression and eating disorders so it is important to be watchful for other issues that may affecting the young person.

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\(^{117}\) In addition to being available for self-injurers, Jeremy Lelek stresses the importance of establishing healthy boundaries with self-injurers, being careful not to offer to be available to them all hours of the day as at times this is impossible and may be seen in the eyes of the self-injurer as a broken promise. Instead, it is more helpful to establish times when the young person youth can call and to ensure to return their call or text them back as soon as possible. Lelek, Jeremy. *Cutting a Healing Response: The Gospel for Real Life Series*. Kindle Edition. (New Jersey: P&R Publishing Company, 2012. Kindle Edition). location 569 – 597.

\(^{118}\) The severity of the self-injury will also dictate whether or not the young person should be taken to the ER and should also be seen for immediate psychiatric evaluation. If the youth’s method of self-injury is increasing and they are claiming that the method they used to use is “no longer working” caution should be taken as more lethal methods of NSSI and suicide attempts may follow. For a more detailed explanation, see Walsh’s insights in chapter 2 section F “How Self-Harm is Different from Suicide”.
• *Work with family members and friends.* Youth often turn to their friends first following self-injury. It is important to ensure that their friends are not overwhelmed and have adult support and guidance.

In addition to this helpful list, Drews highlights the importance of teaching theology that values the body. Self-injurers can believe that their bodies are sinful so they use self-injurious behaviours to punish themselves or to provide penance for sin in their lives. It is important to help the young person understand that they are made in God’s image, their body is a part of God’s good creation.¹¹⁹

Jennifer Watts details the importance of developing new skills for ministering to self-injurers. She presents the story of a self-injuring woman named Denise who longed to a part of a Christian community. Denise felt she had not been accepted by numerous churches that she had attended in the past due to her depression, sexual orientation and self-injurious behaviours. Denise shares that she had only felt true acceptance from the network of friends she had made through Alcoholics Anonymous. Tragically, Watts argues, many self-injurers stand outside of the doors of churches, too ashamed and afraid to enter. I would like to suggest that within this article, Watts writes from a position of “righteous anger” and disappointment with the church brought about by hearing Denise’s story and many others like it. Self-injurers like Denise had tried very hard to connect with Christian communities and have felt either completely ignored or uninvited to stay.

What is hopeful is that since this article was written in 2000, doors have begun to open for NSSI to become better understood by the Christian community. The theological and pastoral care resources that are available to dialogue with for this thesis are proof that the

conversation on self-injury is growing in Christian circles, albeit slowly. This being said, the suggestions for change that Watts highlights are still very relevant for today. She emphasizes that ministers and youth workers have much to offer those who self-injure, particularly in relation to healing their woundedness and offering a sense of renewed connection to their own sense of self-worth, to God and to others. Watts helpful insights concerning what is required to meet the needs of self-injurers are summarized below. We need to have:

• *Eyes that can see* – seeing through eyes of understanding of self-injurers wounds and being a witness to the suffering that motivates the wounds counters the self-injurer’s feelings of invisibility.

• *Ears that can hear* – it is important to notice silences, gaps in participation and to observe what self-injurers are not saying. This points to the fact that many self-injurers use their self-harming behaviours to say what they cannot speak in words, therefore Watts emphasises themes of muteness, voicelessness and silence. It is key to embrace silence and to create a safe space where not-speaking is valued.

• *Re-membering and remembering* – the minster can become trusted to carry some of the memories that the self-injurer has marked on her body through wounds and scars. As well they can become part of the process to create alternative methods to record memories.

• *Story-telling, participation in the Christian story* – ministers can help self-injurers to see and claim their ability to create their own story instead of continuing to re-enact past traumas. Self-injurers have the need to better understand their own stories and how they fit into the larger narrative of God’s story.
• **Liturgy, ritual and sacrament** – James 5:14 details the calling of the elders of the church to pray for the sick and to anoint them with oil. This can be done for self-injurers in an anointing ceremony or a healing service.

• **Develop other ways of binding than rending** – using the Christian tradition of prayer and contemplation self-injurers can create a space to open themselves up to God’s presence. Centering prayers can be used, Ignatian Spiritual Exercises, icon/scripture meditation etc.

• **Counter isolation through a caring network** – ministers cannot provide everything that self-injurers need for their healing journey, so a “pit crew” can be formed consisting of a therapist, doctor, pastoral counsellor and spiritual director.  

Watts also includes further examples of anger and disappointment concerning the experiences of self-injurers within churches and the wider Christian community. She points to the silence from religious institutions concerning NSSI and the “ignorance” on the part of ministers who are biased, fearful and uncomfortable, arguing that silence is an inadequate response to the pain and suffering experienced by self-injurers.  

Again, it is my position that since this article was published awareness about self-injury is steadily growing in Christian communities and the response of ministers and church leaders is improving regarding ministering to self-injurers.

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121 Watts, Developing, 48.  
122 Lucy Tatman presents a theological analysis of self-injury from a similar standpoint to Watts, writing about self-injury at about the same time (in 1998). She desires to change the elements of the system that she sees as broken with regards to assisting self-injurers. Tatman shares stories of self-injuring women who the church and Christian counselling system has failed. She recounts stories of mental health professionals and Christian women’s shelter staff who mean well but ultimately do not provide the women with what they need. She shares the personal stories of two women. One was physically abused and began to use cutting as a coping mechanism during her repeated dissociative events. The other woman was sexually assaulted repeatedly by her mother’s boyfriend and uses cutting to manage affect. Tatman’s theological response to the pain and suffering
2) Becoming a Part of Cultural Change

Three authors provide helpful insights into how ministers and youth workers can become a part of positive cultural change in the Christian community with regards to embracing and accepting self-injurers. Brett Ullman suggests that self-injury needs to be discussed more openly in Christian communities. Ullman’s background is in teaching in the Toronto area and he has now has moved into speaking with high school students and young adults across Canada about self-injury and mental illness. He advocates for starting a much-needed dialogue concerning: 1) self-injury (primarily cutting) in churches and Christian schools and 2) the value of ministers feeling empowered to refer self-injurers to trusted Christian psychotherapists, counsellors and psychologists. His main argument is that within Christian communities, the discussion surrounding self-injury is happening within small circles and needs to be widened out to incorporate more people and resources.

His book, *Your Story: The Wounding Embrace* has chapters devoted to self-injury in which he pulls from a wide variety of sources regarding the prevalence of self-injury in a contemporary North American context, such as incorporating the lyrics from various songs and films. He also includes recent articles from local newspapers, news magazines, psychological studies and books concerning self-injury. The main concepts of the book are also summarized in a *Youtube* presentation that would be beneficial for church leaders,

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experienced by these women is a re-working of her own understanding of what atonement means. She contends that atonement does not refer to the one-time action of Christ in history involving his crucifixion. Instead, she proposes a model of atonement that is relevant to today, to the women who suffer here and now. Atonement becomes the refusal of annihilation on behalf of the self-injurer, the site of suffering and struggle remembered, the yearning for wholeness. See: Lucy Tatman. “The Yearning to Be Whole Enough or to Feel Something, Not Nothing: A Feminist Theological Consideration of Self-Mutilation as an Act of Atonement” (*Feminist Theology* (1998) accessed March 27, 2017. http://search.ebscohost.com.myaccess.library.utoronto.ca/login.aspx?direct=true&db=rfh&AN=ATLA0001006836&site=ehost-live) 26-35.
volunteers and small groups to watch to better understand self-injurious practices within a North American context.\textsuperscript{123}

What is compelling about Ullman’s approach to discussing self-injury is that he presents a series of twelve fictional therapy sessions with Dr. Lin, (a real-life psychologist), to help the reader to better understand the structure of therapy. The sessions are told from the perspective of the reader undergoing the sessions. Ullmann explains that the beginning of therapy is integral to the therapeutic process as is trust and safety is established. Following this, Dr. Lin will present psycho-educational sessions in order to enable the client to better understand the physiological and psychological reasons why self-injury occurs. The next phase will concentrate on learning positive coping strategies. Finally, the patient will undergo a variety of trauma recovery therapies such a creative ways to express their pain and tell their stories and also the development of mechanisms to regulate emotions and better tolerate distress.\textsuperscript{124} This resource is also helpful for ministers to recommend to self-injurers who may be hesitant to attend therapy for fear of negative myths and judgement from others.

Hank Spaulding presents a theologically complex and very insightful discussion on self-injury and cultural change as he considers the practical theology of Andrew Root and Chap Clark. Root’s theology of “place sharing” in youth ministry advocates for the presence of caring, accepting adults in the lives of young self-injuring youth. The youth minister and youth worker become the living embodiment of the incarnation, suffering with and for youth involved in NSSI behaviors. Youth ministers fully participate in the lives of young people, sharing their questions, fears, and abuses. They are also able to share their burdens and

\textsuperscript{123} See: Brett Ullman. \textit{Your Story: The Wounding Embrace. Youtube}. Accessed April 10, 2017. https://www.youtube.com/watch?v=OAOoDSK5a70. The video is one hour long and incorporates the main themes from Ullman’s book. It also addresses the self-injurer directly, encouraging them to consider the issues raised in the video and most importantly to get in touch with Ullman through various online methods.

\textsuperscript{124} Ullman. \textit{Your Story}, location 183-201.
suffering, just as Christ does. Spaulding emphasizes that the ultimate purpose of place sharing is that the youth minister to be able to look at the wounds and the worst pain of the self-injurer and to not turn away. This action is a sign of faithfulness and is an act of place-sharing.\(^{125}\)

Spaulding’s analysis of Clark’s theology of youth ministry highlights the importance of community. Clark argues that adults have rejected and abandoned youth in contemporary North American society due to their need to fight for their own emotional and relational survival. The result is that abandonment becomes a “defining reality of adolescent life”\(^{126}\) and adolescents experience loneliness, stress and marginalization. In order to counteract what Clark terms the resulting “systemic abandonment” experienced by youth, he maintains that adults need to make a great effort to re-integrate youth into their lives. This means that adults need to spend more time with youth and become very intentional about welcoming them into the adult community. Spaulding highlights the importance of welcoming youth into the adult community as it is in fact an incarnational and counter-cultural act, allowing leaders to act as agents of the kingdom of God as the Holy Spirit does its ongoing work in the lives of young people. For the self-injurer, the presence of caring ministers and youth workers can have a large impact in their journey towards healing and recovery.\(^{127}\)


\(^{127}\) Similar to Spaulding, Baxter advocates for the importance of Christian leadership offering support and being present in the lives of self-injurers. She explains that when self-injurers are living in residence at Christian therapeutic communities, leaders and community members become the incarnation of Christ to the self-injurer. The community around the self-injurer is called to gather around the self-injuring person and accept her as she dis-members her body and help her to re-member. They are called to create a safe place where they can “witness the pain and to heal the broken hearted, by re-establishing real presence, the *I am*” and to help her to realize that she belongs to the body of Christ and when one person suffers they all suffer with her. See Elizabeth Baxter. “The Cutting Edge: Rites of Passage in Therapeutic Community” (*Controversies in Body Theology.* Marcella Althaus-Reid and Lisa Isherwood Eds. London: SCP Press, 2008) 55.
C) Key Themes in the Theological Literature

1) Nonsuicidal Self-Injury and the History of the Church

Turning now to resources that wrestle with the connection between self-injurious behaviours and the history of the Church, we will look at the writings of two authors who argue that the historically the Church has encouraged, (or perhaps has not discouraged), acts of self-injury. Both authors argue that this encouragement can be seen through the writings of Pope Benedict XIV, through the self-injurious actions of numerous saints and finally in the self-injury seen in the lives of holy stigmatics of the Middle Ages. The first author is Heather Pinks who presents an analysis of self-injury that is heavily influenced by Favazza’s writing in *Bodies Under Siege*. Favazza argues that self-injurious practices on behalf of mentally ill persons have absolutely no transendency and their blood does not open any special channels to God. He also maintains that their self-injurious acts have little meaning for the world but affect only themselves and at times other members of their small social networks. Using this as her primary counter argument, Pinks presents a critique of the statements made by Pope Benedict XIV who wrote that the Church supports and sanctions actions that are related to the mortification of the flesh, calling for individuals to add to Christ’s atonement through painful acts of self-injury. St. Teresa of Lisieux and St. Teresa both endured spiritual darkness and physical suffering that they considered to be gifts from God. Pinks concludes that acts of suicide and self-injury are not acceptable ways to serve

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God, explaining that self-injury functions as a way to communicate the pain they are feeling that cannot be said with words.\textsuperscript{129}

Robert Mullen examines the similarities between the holy stigmatics of the Middle Ages and contemporary self-injurers, focussing on individuals who use cutting as their primary method of self-injury. He concludes that numerous similarities exist between the self-injurers of today and the stigmatics, primarily that they both experience dissociative episodes and are motivated by a desire for transcendence through the use of self-inflicted wounds. The analysis that he presents is not helpful nor is it clear as he makes numerous generalizations about self-injurers such as their “propensity” to be anorexic and to have dissociative episodes. He also examines co-morbidities that he argues often exist with self-injurers, (but more importantly, also may not), such as borderline personality disorder and anxiety disorders and bases a portion of his analysis of these co-morbidities on a medical journal article published in 1973. While Mullen is successful at identifying some of the reasons why individuals may cut that go beyond the psychological and medical models, such as a yearning for a new body that has been healed by God and using cutting to bring about a form of healing, he does not present a helpful discussion about self-injury that includes contemporary research from clinicians in the field, distorting his analysis of self-injury for the reader.\textsuperscript{130}


2) Nonsuicidal Self-Injury, Scripture and Sacrament

Christian counselling websites offer resources for self-injuring individuals, mainly designed to encourage the self-injuring person as they seek help and support from a Christian community and to direct them towards counselling and referral to therapy. These resources outline the pain and sadness typically experienced by the self-injurer and share the hope and healing that can be found in Christ. These resources typically address the self-injurer with the use of stories of others who have found hope through Christ on their journey to healing and with scriptures that offer images of God as comforter and healer.

*Focus on the Family* out of the United States has an online series on self-injury that is a helpful resource for the self-injuring person. This series encourages seeking out a compassionate Christian counsellor and a professional therapist. Shute presents a series of truths from the scriptures for self-injurers that reveal God’s love for them. These truths are presented as counter-statements to negative feelings that may be experienced by self-injurers, such as the feeling that God has abandoned them, or that they are unacceptable to God. For example, the feeling that God has abandoned the self-injurer is countered with the Biblical truth that nothing can separate the self-injurer from God’s love for them (Hebrews 13:5, Jeremiah 31:3, Romans 8:35-39 and Hebrews 4:16). The feeling that the self-injurer is unlovable is countered with the Biblical truth that Christ demonstrated his love for them by dying on the cross, the ultimate act of love (Romans 5:6-11 an Colossians 3:12). What makes this series compelling is that the author of the final article, Rachel Zoller shares that self-injured for ten years. She explains that after four years of cutting herself she confided in a friend and with the support she found she began the process of recovery through counselling.

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and therapy. She also shares scriptures that were helpful to her as she began to learn that she is valued by God and stresses that the healing process will take time but with the support of her community she was able to find hope.132

The Biblical Counselling Coalition also has online resources for self-injurers. Baker writes with compassion for self-injurers, in this case individuals who cut themselves. She identifies God as being close to the broken-hearted and who binds up their wounds and whose son Christ bled so that all who look to him will find love and acceptance. She also identifies a scripture from Psalm 72:12-14 in which God is described as the one who will deliver the needy when they cry out and will rescue them from violence and oppression. Most importantly, God sees the needy person’s blood as being very precious. Baker then suggests to the self-injurer that they have been using their own blood as a tool to alleviate their pain, self-loathing and guilt and explains to the cutter that their blood can never permanently provide relief or atonement for sin; only Christ’s blood has the power to do so.133

Concerning the healing place that sacrament can have in the life of the self-injuring individual, Kristin Russell presents very helpful insights into the Sacrament of Anointing which she uses in her pastoral ministry, especially with young self-injuring women. The sacrament of anointing focusses on the scripture found in James 5:13-14 (this scripture was also used by Watts above) in which sick people and are instructed to call the leaders of the church to anoint them with oil and pray for them. Their prayers offered in faith to God will raise the sick person up and make them well again. The sacrament of anointing is important

as it helps to reorient the sick person’s life back to God. The anointing of the sick should not only take place when a person is close to death, but also when they are suffering from illnesses that affect them physically, psychologically, culturally, socially and spiritually.

Russell advocates for a holistic approach to healing in which the self-injurer is recognized as being connected to a larger system of relationships, first with themselves (their body, psychological condition, their own life history), their family, friends, church, society and the rest of the natural and cosmic world. This Sacrament of Anointing stands alongside the sacrament of the Eucharist and Reconciliation as it fosters and sustains right relationships with God, self and others and function as symbols of unity for those who partake in them. The sacrament should be performed with a small number of friends and family, outside of the larger body of the church who gather for Mass due to the shame that can often accompany self-injury. The sacrament can be the first step in making relationships right in the life of the self-injurer, allowing the individual to experience a loving community as friends and family gather around them. Russell stresses that the sacrament is one of the steps that will help self-injurers in their journey to healing and should be offered alongside professional counselling and therapy.

3) Nonsuicidal Self-Injury, Sin and Spiritual Warfare

Online pastoral care resources from Christian counselling websites provide varying viewpoints on the concept of sin as it relates to self-injury. Both the Biblical Counselling Coalition and the Association of Biblical Counsellors have articles about self-injury and sin which for the most part are unhelpful. Julie Ganschow, a counsellor for the Biblical Counselling Coalition encourages parents to seek help from the bible and biblical counsellors.

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instead of allowing their child to receive treatment through psychotherapy and non-Christian counselling. She sets secular and biblical methodologies against one another and claims that self-injurers do not have an illness that can be diagnosed medically. Instead, self-injurers have developed a coping mechanism that is a “sinful” habit.

Using a case example of a young girl who cuts and burns herself repeatedly, Ganschow argues that the young girl needed to learn how to properly repent of the sin of self-injury and to comprehend that her self-injury had become an idolatrous behaviour. NSSI in this article is also relegated to the realm of fleshly desires and self-injurers are encouraged to continue to read their bible, especially the Psalms, in order to find comfort in their distress. Depak Reju, in an article on cutting from the same website, argues that cutting is an individual’s “worthless” attempt at self-atonement and primarily an act of rebellion against God. Similarly, Gaultiere writes on the Soul Shepherding Christian Counselling website that self-injurers are seeking comfort in their own wounds rather than the wounds of Christ, converting their emotional pain into physical pain that will heal instead of bringing their pain to Christ.

Mark Shaw writing on behalf of Truth In Love Ministries has also designed a short book for self-injurers, predominantly written for those who cut themselves. Shaw uses a case example throughout of a young woman named Pam who is taken to the ER due to a self-


inflicted cut on her inner thigh. Pam’s parents meet her at the hospital after her husband alerts them that they are on their way to the ER. The ER doctor explains that Pam needs their support and therapy so they find a biblical based counsellor. In counselling Pam reveals she injured herself due to the emotions she had following a disagreement with her husband. The scripture that is used to show Pam she should not cut is Leviticus 21:5 which states that priests should not cut their bodies like pagans do during their funeral rituals and Deuteronomy 14:1-2 which also states that God forbids cutting as the pagans did as they mourned their dead. Shaw then proceeds to equate Pam’s cutting with the pagan practices and classifies it as a “sin against God…who commands you to live differently in the world than those who are lost… cutting is a sin because the Lord strictly forbids his people from acting like unbelieving pagans”.

From here, Shaw states that self-injurers lack faith in God, calls self-injurious behaviours selfish and methodically plan their self-injury so that they can get what they want from others. He goes on to argue that self-injurers should “stop cutting because it is a sin and offends a Holy God who commands His children to obey Him” and that “a Christian cutter is often unknowingly partaking in a private pagan ritual of idolatry” and that God hates their sinful actions. He also maintains that “covering up” self-injury means that the self-injurer is trying to hide their sins from God who will not show them mercy unless they admit they are doing something that God hates. I would like to suggest that these kinds of statements are very unhelpful for self-injurers and can be potentially damaging. Shaw advocates for the intervention of a biblical counsellor, prayer partner and trusted friend in order that the “self-injurer become less self-centered, and enable the self-injurer to become more focussed on

pleasing God and others in a positive manner”.\textsuperscript{141} What would be more helpful is to emphasize the hope that Christ can bring, God’s grace and the healing that can be found in Christian community – through loving relationships with friends, ministers, counsellors and therapists.\textsuperscript{142}

During my research, I encountered a few resources that caused me to pause as they were very difficult to read. I understand that when researching any topic, there will be varying viewpoints and theological positions. Instead of choosing to ignore or overlook these resources, I have chosen to include Nancy Alcorn’s book \textit{Cut: Mercy for Self-Harm} as a part of the dialogue along with supplemental sources that also discuss Alcorn’s ministry. This is not to validate Alcorn’s theological position, but instead to raise concerns about her methodology and her use of scripture. Most importantly, these resources are included in order to highlight the potential they have to cause damaging effects in the lives of self-injurers.

The Nancy Alcorn’s book \textit{Cut: Mercy for Self-Harm} comes out of her leadership and ministry at \textit{Mercy Ministries} (now called \textit{Mercy Multiplied}), which was founded in 1983. \textit{Mercy} offers Christian live-in treatment programs for young women who suffer from depression, physical and sexual abuse, eating disorders, sex trafficking and self-injury that

\textsuperscript{141} Shaw, \textit{Hope}, 25.
\textsuperscript{142} An additional online resource that focusses on the “sin” of self-injury is an article published by the \textit{Association of Biblical Counsellors}. The author contends that self-injury is an outward manifestation of the relational hurt experienced by individuals who have broken relationships with God. Cutting is an attempt at self-healing relationships with both God and others that have ultimately failed. They also argue that the counsellor needs to see that the sin of self-injury is the self-injurier’s act of turning inward for relief rather than to God. The self-injurier’s sinful perspective is that they are alone and that there is no one to help with their pain. The article does take a more helpful turn as it then goes through each line of Psalm 23 as an illustration showing that God is near the self-injurier and to encourage the counsellor to show the self-injuring individual a new worldview through the reading of this scripture. While some of the insights in this article may be theologically true, it is difficult to read as the author presents a bleak picture for the self-injurier instead of focussing on the mercy, grace and hope that God can bring. See: Association of Biblical Counsellors “Self-Injury and Psalm 23”. \textit{Association of Biblical Counsellors}. Accessed March 14, 2017.http://www.biblestudytools.com/blogs/association-of-biblical-counselors/self-injury-and-psalm-23.html
has homes across the world, such as in Canada, New Zealand, the United Kingdom and the United States. The ministry encourages women ages 19 – 28 to stay on average six to nine months in their residential programs which are free of charge. The programs offer biblically based counselling, life skills and education development programs, nutrition and wellness planning and daily exercise and physical recreation.  

Alcorn’s book contains stories of various young women who recount their reasons for self-harm, such as experiences with abusive parents and bullying at school. These personal stories are insightful and assist the reader to better understand why some young women may injure themselves. What is unhelpful is Alcorn’s insistence that in order to become free from self-injurious practices, a person must be freed from demons (literally), “demonic oppression” and “strongholds” that are placed in a person’s life when they willfully sin by cutting themselves. The self-injurer is encouraged to pray a prayer that against Satan and demons and she will then become free from her sinful actions and future temptation to harm herself. At no point in the book does Alcorn recommend professional therapy or counselling, or consultations with a family doctor regarding self-injurious practices. Instead, she encourages the reader to change their mindset and embrace “Godly beliefs” in order that they may “walk in freedom”.

Mercy Ministries has come under scrutiny in recent years for preforming exorcisms on young women who were enrolled in their treatment centres and discouraging them to see outside professional, accredited therapists and counsellors. Their residences have been closed down in Australia due to misrepresentation of the credentials of staff who were found to lack

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145 Alcorn, Cut, 77-81.
licences for counselling and therapy. Numerous young women who were enrolled in treatment programs in the past with this ministry have come forward and shared their stories of psychological abuse while staying in residence, afraid to come out of their rooms as they were told that demons were going to harm them. There is also an online support network for women who are survivors of the treatment centres that detail the abuse they suffered there, such as being denied their medications for panic attacks and instead being told to pray their fears away. It is a sobering reminder to self-injurers and also to family members and guardians of self-injurers that adequate research should be done concerning any kind of treatment before commencing counselling or therapy, especially when it is a residential treatment program where a self-injurer will be staying away from both home and loved ones. A network of trusted therapists and counsellors should be accessible by ministers and doctors so they can make appropriate referrals for self-injuring individuals.

146 That being said, the current website for the ministry in Canada does state that the director of counselling must hold a master’s degree from an accredited university in counselling, social work or psychology and must provide proof of licensure with an external certification body. See Mercy Ministries “Frequently Asked Questions” http://mercycanada.ca/frequently-asked-questions/ accessed April 4, 2017.
149 Another similar resource for self-injurers is by Lynda Irons who presents an analysis of self-injury, primarily cutting, that is based on fear of demons. She argues that self-injury is a sinful act and the self-injurer must realize that they are in a “spiritual battle” in which demons can torment and oppress them. She writes: “Cutters are in a spiritual battle and they may not know it. When they sin by cutting, they are creating that spiritual stronghold from which a demonic oppressor can torment them. This is why the urge to cut becomes stronger. It becomes ‘demon fueled’. I am NOT saying that cutters are demon possessed. I am saying that they have opened a door that can allow a demon to ‘legally oppress’ them. The demons have been given an opportunity, a place, and a stronghold from which to operate. I would like to suggest that this theological analysis of self-injury is very unhelpful and potentially damaging for the self-injuring individual. Neither Alcorn or Irons focus on the healing that God can bring for self-injurers, on God’s grace on God’s acceptance of them as they continue to move along on their journey of healing, instead advocating for prayer as a substitute for therapy and psychiatric care. They also do not advocate for a team of accredited individuals such as therapists, ministers, counsellors and doctors who can come alongside the self-injurer and provide support and guidance. Again, caution must always be taken when considering any kind of therapy, residential treatment
4) Nonsuicidal Self-Injury and Grace

The presence of God’s grace in the lives of self-injurers is an important theme in the theological literature. Many self-injurers feel deep shame and guilt about their self-injurious behaviours and believe that they are worthy of punishment by God. Emphasis in these resources is that self-injurers need to trust God that God has already forgiven them for any sins they have committed. Also, they highlight that Christ has suffered and died for them so that they do not have to try to offer their own contrition to God through acts of self-injury.

*Christianity Today* published an online article in 2011 for women who self-injure which highlights the grace that God shows them. Karen Swallow-Prior reviews a study published in the journal *Pediatrics* which analyzed *Youtube* videos about self-injury. The study concludes that the videos have a hopeless message and reinforce normalization of self-injury through regular viewing of such content. Swallow-Prior also comments on the glamorization of self-injury in the videos with the use of music and the incorporation of artistic images of self-injury. She remarks in conclusion that the self-injurer’s desire to control elements of their own lives “directly opposes the gospel of grace”\(^{150}\) and point at the human desire to be our own God. Emphasis is put on the need for self-injurers to trust God and the work that Christ has done for them through his own body so they do not need to punish themselves.

Jeremy Lelek writes on behalf of the *Association of Biblical Counsellors* regarding grace for self-injurers. Using scriptures from Galatians chapter 5:1-4 and 2 Corinthians 5:21,
he explains that it is only thorough the completed work of Christ that we can have true freedom, not through any law. There is no need to add anything to what Christ did. Instead, Christ’s work is to be seen as a free gift. Lelek uses the example of a self-injuring youth named Justine who views herself before God based on how successful she has been at resisting injuring herself. This mentality can be damaging as she has fallen away from the free gift of grace that was given to her by God. Because Christ’s righteousness has been imputed to Justine, she does not need to do any work for it (Romans 4:2-5). Freedom is found in Jesus’ own perfection being accounted to Justine so that she does not have to be perfect herself.¹⁵¹

Writing on behalf of The Christian Counseling and Educational Foundation, Edward Welch provides information for self-injurers who are looking to break what he refers to as “the cycle of self-abuse”. The cycle of self-abuse is never ending according to Welch as once the experience of inner peace fades, the same difficult emotions return and self-injurer again repeats their acts of NSSI. He explains that the self-injurer’s feelings of guilt actually point to misconceptions they have God: that God is never pleased and is waiting to punish them when the make a mistake. Instead, Welch invites to self-injurer to find forgiveness in what Christ has done for them instead of trying to offer contrition or our own self-loathing as payment for the gifts God freely give to us. He explains that:

A great gift calls attention to the generosity of the giver. It reminds us that we could not obtain the gift on our own. This means that any response to God’s gift, other than thankfulness and praise, demeans the generosity of the giver and exaggerates our moral ability to contribute to the gift’s cost. It means that we are looking for what we do rather than what God has done. God tells us to come to [God] with empty hands but we want to wait until we feel more worthy. All the while, our Father… keeps telling

us that Jesus was worthy for us – we just need to trust him… if you hear the story as a tale of condemnation and a life of trying hard to measure up, you are putting your own twist on it. Your story is about your failure. God’s story is about how, when you trust in Jesus, his story becomes your own.\footnote{Edward T. Welch. \textit{Self-Injury: When Pain Feels Good}. (New Jersey: P&R Publishing, 2004) 13-14.}

God is the God of love who loves to show mercy and forgiveness to the self-injurer, giving gifts to them that do not require repayment. The self-injurer does not need to wait until they are worthy to come to God or pay for God’s gift through injuring themselves. Using the example of the Hebrew people, (Ps. 107:9 and 94:14) Welch encourages the self-injurer to come to God and to trust God’s faithfulness and character.

5) \textbf{Nonsuicidal Self-injury and the Importance of Storytelling}

Storytelling is a dominant theme in the theological and pastoral care literature on self-injury. Both non-fictional and fictional accounts of self-injury assist the reader - whether it be a minister, caregiver, friend or self-injuring person – to better understand the motivations for self-injury and how caregivers can better support self-injurers. Telling these stories of self-injury provides a connection point for other self-injurers and their caregivers as they seek healing and wholeness. The stories also provide hope for those who desire to end their self-injurious practices as others have been able to learn positive coping strategies and in turn have been successful at stopping their self-injurious behaviours.

In the online magazine \textit{XOJane}, Jennifer Martin writes about her struggle with self-injurious behaviours - primarily cutting - that has been a part of her life since she was sixteen years old. Her experience is that she has encountered a “don’t ask don’t tell” policy in the churches that she has attended with regards to mental illness and self-injury, often relegating those suffering with anxiety disorder and depression, like Martin, to the background where
they sit in silence. She recounts feeling very isolated and ashamed while at church, unable to discuss with her pastors what is truly going on in fear of their reactions. She has now become an advocate for discussing issues relating to mental illness and self-injury openly in the Christian community. She argues that “the church has an obligation to talk openly about mental illness and become a place that is welcoming of those who struggle. Support groups lead by the church counsellor are a good start. Sermons by people who have to deal with mental illness are even better”. To Martin, this would be a welcome change. She also desires to become a part of a change in culture at her church and she now wears short sleeves so that her scars are visible and when asked, openly discusses her struggles with anxiety and depression in an effort to share her story and reduce stigma associated with NSSI.

Jess Wilson writes about her history of self-injury in her book *The Cutting Edge: Clinging to God in the Face of Self-Harm* so that others may find encouragement. She turned to self-injury due to academic pressure. What is unique about this resource is it functions as both an analysis of self-injurious practices, (such as focussing on why individuals engage in NSSI and the influence of the media), and as a work-book for self-injurers who desire to connect with God. She includes ideas for having quiet time with God such as meditative practices, visualizing Christ, suggestions for scripture readings and going for a quiet walk. Her ideas for prayer time are also creative and helpful as she suggests the use of candles to signify a situation or person that the self-injurer would like to bring to God in prayer. Also, stones can be used as symbols of letting go of a burden as they are dropped into a bucket of

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water symbolizing that the request has been submitted to God. Wilson also advocates for professional therapy, explaining that her own experience was that much progress can be made through prayer, supportive friends and family and counselling, but trained therapists will assist the self-injurer in a professional capacity and may choose to offer pharmacological assistance as well.

Christian Educators Journal has an online article about self-injury that is intended for parents of young people involved in NSSI behaviours. DeBoer shares the case study of a young girl named Jessica who was sexually assaulted at a party and as a result began cutting her arms to deal with her emotions. Her mother was cleaning the washroom at home one day and found a smear of blood behind the faucet. After some deliberation, she confronts her daughter in love and finds out that she was assaulted and as a way to deal with the pain has been cutting herself. They agree to see their family doctor the next day. DeBoer presents a realistic picture of Jessica’s feelings; ashamed of both the assault and her self-injury combined with a great amount of fear concerning what God would think about her assault and cutting. Emphasis is put upon the hope that comes through her mother’s loving reaction to discovering Jessica’s self-injurious behaviours and the help that a community of caregivers can bring such as a compassionate therapist, family members and friends.

An article published online in Today’s Christian Woman Suzanne Eller stresses that within the past ten years, self-injury has become more openly practiced and discussed among the youth she ministers to, (interestingly this article was written in 2004). She details the pain and confusion often experienced by parents she meets at youth ministry conferences who

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155 Wilson, Cutting Edge, 42-46.

disclose to her that their child is self-injuring. The key insights from this article are contained in the detailed stories from young people who recount their stories of self-injury and healing. One young girl explains that she found hope in understanding that God was not repulsed by her self-injurious behaviour, that God accepts her, is compassionate and sees her great worth. Another young girl shares her insights that God does not want her to harm herself; Christ is with her even in the darkest of times and deepest of pits and that he is her healer.  

In my research I encountered two helpful theological resources self-injurers that come from a fictional narrative perspective. They are both aimed at young adults who self-harm and can potentially be used for small groups who want to learn more about helping their friends who self-injure, or for parents of youth who self-injure would desire insight into their child’s behaviours from a theological perspective. The first is a book by Jan Kearn that is written in stream of consciousness style based on the experiences of a fictional 14 year old girl named Jackie. Jackie burns herself with a lighter and cuts her arms constantly due to her overwhelming emotions caused by her parent’s unsteady marriage and the heavily family responsibilities placed upon her due to her father’s drug and alcohol abuse. The book details Jackie’s discovery that God loves her, her acceptance into a church community that cares for her, the disclosure of her self-injury to her parents and subsequent counselling and therapy. At the end of each chapter the reader is invited to reflect upon Jackie’s story and upon their own life, to engage with scripture and spend time in prayer. There is also the invitation to participate in numerous creative activities following each chapter, such as painting or

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sculpting an artistic representation of how the reader sees their life at this time and then to considering how God can become a part of it.¹⁵⁸

The second fictional narrative resource is a novel, *The Merciful Scar*, which is about a young girl named Kirsten who is living away from home while doing her masters degree in architecture. Kirsten had been cutting herself for many years, most of the time to manage her emotions due to her parent’s divorce. Upon the discovery that her long time boyfriend had been unfaithful to her, she cuts herself very deeply and is taken to the ER. Kirsten’s experience in the ER is that she is classified as a suicide even though she maintains it was an accident that she cut herself so deeply and is sent to a psychiatric facility for evaluation.

What makes this novel compelling is the presence of strong Christian mentors in Kirsten’s life. The minister from Kirsten’s church meets with her numerous times while she is an inpatient and is very compassionate, understanding and encouraging. He makes the recommendation that she should go and participate in a treatment program lead by a nun named Frankie who specializes in helping young girls who self-injure. Kirsten accepts and stays at Frankie’s ranch. While there she learns to take care of various animals and most importantly how to accept and care for herself. Frankie teaches Kirsten how to “stop going for the razor for release and to come to [Christ]”¹⁵⁹ with her fears and pain. St James is particularly good at conveying the motivations behind Kirsten’s cutting, namely academic pressures, depression, relationship issues and family stressors. This resource also provides excellent examples of how Christian leaders can be a positive, helpful part of a self-injurer’s

recovery and journey towards healing and wholeness and would be an excellent addition to Bible studies and small group settings who want to learn more about self-injury.

6) Nonsuicidal Self-Injury and Grassroots Movements

The term “grassroots movements” was chosen for this section as it is full of resources run by individuals who have either known self-injurers, or who have a history of self-injury themselves. These individuals have come together online to provide help and assistance to those struggling with NSSI. This group of theological and pastoral care resources is the most creative and inspiring as each resource pushes the boundaries of what kinds of support can be offered to self-injurers and their caregivers. It will be very interesting to see as time goes on and the online world continues to evolve, what types of new creative and innovative resources will become available for self-injurers.

The first example of a creative resource is for those who suffer from depression, anxiety and self-injury and is an iPhone app called *Abide: Prayer and Meditation on Depression and Insomnia*. This app is very helpful as it has a wealth of prayer guides organized by topics such as worry, hope, forgiveness, addiction recovery, anger and cutting. One might think an app might not be very helpful, but since most self-injury happens at night when the person is alone, the prayers and meditations available on this app are readily available when another person may not be. A prayer guide specifically for self-injury and cutting that has meditative music and a prayer spoken by a pastor named Katrina AuCoin, whose background is in ministering to survivors of child sex trafficking. She uses Psalm 147:3 during her prayer that states that God “heals the broken hearted, binding up their wounds”.[160] She speaks encouragement over the self-injurer and then prays that they will

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receive healing from God and experience joy. She also reminds the listener that they are not alone and that God has plans for their life. Finally, she encourages the listener to speak with a friend or loved one if they are feeling the urge to cut and to meditate on scriptures that focus on peace and joy. Prayer guides can also be chosen that span multiple days and can be integrated into a self-injurer’s daily life as the app sends reminder emails and notifications.

The second example of a creative resource for self-injurers is a video found on Youtube that features a teen named Adria Panda entitled “God Saved My Life: A Self-Harm Story”. In this video she presents an account of her depression, anxiety, cutting and subsequent hospitalization. Panda shares the story of her hospitalization due to self-harm and depression and explains to her viewers that with the help of her family, counsellors at the hospital and with God, she was able to come home and begin the healing process. She still struggles with self-injurious behaviours but encourages her viewers that with the help of her community and God, she has been able to make substantial steps towards healing and recovery.

A similar resource for self-injurers that offers encouragement is a Tumblr that contains the work of The Butterfly Project. This project encourages young people to come together in solidarity regarding their experiences of self-injury and support one another’s healing and includes prayers for self-injurers. This project encourages young people to draw a picture of a butterfly on their bodies with marker or pen in areas where they would normally cut themselves. They are encouraged to then name the butterfly after a loved one.

161 This app is available through the Apple App Store for iPhone, iPad and iPod and is an excellent resource. Please go to the Apple App Store and search for “Abide: Prayer and Meditation on Depression and Insomnia”. Abide: Prayer and Meditation on Depression and Insomnia “Prayer for Self-Harm and Cutting: Psalm 147:3”. Apple App Store for iPhone. Downloaded March 1, 2017.
and to leave it on their bodies, imagining that the butterflies will die if they cut and will live if they do not. Others are encouraged to draw butterflies on themselves in solidarity with those who self-injure. Photos of hand-drawn butterflies are posted on the Tumblr along with stories of hope and healing for others to read.\textsuperscript{163}

The work of Amy Bluel at \textit{Project Semicolon} is a valuable resource for individuals who self-injure, their caregivers and friends. Bluel herself is a survivor of sexual assault and has struggled with depression throughout her life. The Project is a Christian, non-profit organization founded in 2013. The movement’s primary function is to “present hope and love for those who are struggling with mental illness, suicide and self-injury.”\textsuperscript{164} Those who are a part of the movement are encouraged to tattoo or draw a semi colon on their body to send a message of solidarity with others who are struggling with mental illness, self-harm, or from the death of a loved one from suicide. The semicolon represents the idea that the individual’s story is not over yet, they could have chosen to use a period, (signaling the end of hope or suicide), but instead they chose to use a semicolon to signify that they want to keep going. Tragically, Amy Bluel passed away in March 2017 due to suicide, but the work she has done with \textit{Project Semicolon} will undoubtedly continue to help those affected by self-injury and their loved ones.\textsuperscript{165}

Finally, the movement \textit{To Write Love on Her Arms}, based in the United States is a non-profit organization dedicated to connecting those struggling with depression, anxiety, suicidal ideation and self-injury to networks of individuals who can assist them. They are a


\textsuperscript{165} For example, in the recent and very popular Netflix series \textit{13 Reasons Why} that is based on the story of a 17 year old girl named Hannah who dies by suicide, one of the main characters has a semicolon tattoo that signifies that he stands in solidarity with Hannah and her parents and also with others who are also struggling with self-harm and suicidal behaviours. See \textit{Netflix “13 Reasons Why”}. Accessed April 5, 2017. www.netflix.com
Christian-based organization who fundraise to support mental health initiatives, provide mental health resources online and work to promote to destigmatize mental illness. The founder, Jamie Tworkowsi began with assisting one young woman who he had met at his church who struggled with self-injury, depression and substance abuse issues. He recounts his moment of realization that God often calls us to participate in God’s healing work in the world. He writes: “We often ask God to show up. We pray prayers of rescue. Perhaps God would ask us to be that rescue, to be [God’s] body, to move for things that matter. [God] is not invisible when we come alive.” The organization promotes professional treatment and beyond that, connecting to a loving community so that “community, hope and help would replace secrets and silence.”

D) Gaps Identified in the Theological Literature: Areas for Further Research

1) Preaching About Nonsuicidal Self-Injury

Preaching is an effective way to communicate about mental illness and self-injury to the wider church body. How can ministers incorporate preaching about self-injury into the life of their church? What recommendations and guidance is there for ministers who would like to preach about this topic? Donald Capps writes in Pastoral Counselling and Preaching: A Quest for an Integrated Ministry that preaching is fundamentally an act of pastoral counselling. He maintains that preaching involves the proclamation of the good news of Christ, instruction, prophetic witness and very importantly, wise counsel. Counselling sermons, according to Capps, can be considered an extension of the pastor’s counselling ministry. These sermons meet the church community members where they are at in life and

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answer their difficult questions about daily struggles with sympathy, understanding and patience. In addition, ministers who preach counselling sermons do not have to under intense pressure to feel that they are required to know everything about a topic that members of the congregation may be struggling with, such as self-injury. Instead, the pastor is called to know how issues like NSSI affect individuals and families within their congregation. Capps explains:

Unlike the topical sermon, the counselling sermon does not require the preacher to be an expert on the major political and social issues of the day, but instead requires sensitivity to the way that modern life creates a multitude of personal problems for the parishioner. The minister may not have detailed knowledge about a social problem and may not know how it may be solved. But one can know how the problems of this nature can impinge on parishioners’ lives. This knowledge comes from familiarity with parishioners’ daily struggles.168

It is important for ministers to understand that they are not expected to be experts about the history, functions and treatment protocols concerning self-injury. This would be overwhelming and place too much of a burden on ministers and may even prevent them from preaching about this topic. Instead, I would like to propose that using Capp’s model of the counselling sermon invites ministers to consider the “daily struggles” of those within their community such as self-injurious practices and raise awareness about self-injury through preaching. These sermons can also function as an invitation for the wider members of the church community to become better educated about self-injury, to break down the stigma associated with it and learn how to support self-injurers and their family members.169

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169 Although ministers should never be placed in the situation where they become overwhelmed or burdened by feeling that they have to “know everything” about self-injury and mental illness, it is also very important that these topics are discussed openly and taught in seminary so that ministers can be properly informed and educated about these issues. Donald Capps presents a helpful article summarizing a course on mental illness that he has taught at Princeton Theological Seminary. It gives an outline of topics to discuss with students, as well as making a compelling case for why students who are going into ministry should be interested
Unfortunately, I was unable to find any resources concerning preaching about self-injury exclusively. That said, I did locate a very practical resource regarding preaching about mental illness that provides guidelines for sermon writing that can also serve as a guide for preaching about NSSI. This online resource was published by The Mental Health America of Kentucky organization. This organization was founded in 1951 to promote mental health in Kentucky and to improve the treatment and care of individuals with mental illnesses who live there.\textsuperscript{170}

The authors, Bonnie L. Cook and O. Wesley Allen Jr., stress that in the United States, one in four individuals struggle with mental illness explain that “we are in denial if we imagine the statistics in the general population are not represented as well in our congregations. If preaching is to be relevant to the full depth of the human condition as experienced in our day, sermons must deal with mental illness and mental health”.\textsuperscript{171} Their suggestions of what to include in a sermon about mental illness and homiletical goals are summarized below:

a) \textit{Offer pastoral care}. Pastors can care for many members of the congregation at the same time while preaching. It is key that church members offer pastoral care to one another instead of putting all of the weight on the pastor. People struggling

\textsuperscript{170} Mental Health America of Kentucky. “About” Mental Health America of Kentucky. Accessed April 15, 2017. http://mhaky.org/about/

with mental illnesses and their family members need communities that will love them and assist with bearing their burdens.

b) *Raise awareness.* An educational component is key to preaching about mental illness as many are unaware of the prevalence of mental illnesses and how they affect individuals, families and co-workers. This observation can also be applied to self-injurious practices.

c) *Normalize mental illness.* Ministers can help to break the stigma of mental illness that is often stronger in religious communities due to views in the past that mental illness was linked to moral/spiritual failings and demon possession. Talking about mental illnesses should be the same as talking about other illnesses.

d) *A place of help.* Sermons on mental illness should help congregants know they can turn to church leaders and staff for direction regarding referrals to professionals. Letting church members know the church can help them make much needed connections with psychiatrists/psychologists will reduce fear of having to do it on their own. Sermons should also address self-injurious behaviours in the same manner.

e) *Call for action.* The community of faith should come together to create ministries for those suffering with mental illness and their caregivers. The congregation should also see the treatment of individuals with mental illness in society as an issue relating to social justice and advocate for the marginalized. This call to action should also include creation of ministries for self-injuring people.

The homiletical strategies identified by the authors are also key. They stress that pastors cannot expect to preach one time on mental illness (or self-injury) and expect to see an
enormous change in the church community. Instead, repetition should be used over a period of time in order to elicit slow change. They also emphasize the importance of using respectful and proper vocabulary when discussing mental illnesses and avoid using any terms that may be seen as derogatory.

In the same vein, any illustrations that are used in the sermons should emphasise those who have mental illnesses as sometimes being in need of care and other times as positive role models. It is important to respect confidentiality when using the story of someone with a mental illness and obtain permission from them before doing so. Also, pastors have the opportunity to emphasise that God does not judge or condemn individuals for being mentally ill (or struggling with self-injurious practices) and neither should their faith community. Finally, they can speak to the spiritual drought that often accompanies mental illness and reject notions that becoming closer to God or more spiritual and holy will eradicate their mental illness.

The biblical texts that are recommended by the authors that can be used when preaching about mental illness are also helpful to consider. First, lament scriptures, especially psalms of lament are key as they model and give permission to individuals who are suffering to cry out to God and ask why? and how long? Second, the metaphor of exile can be very powerful with those suffering from mental illnesses as they feel marginalized and like foreigners in a strange land. Emphasizing God’s continued care for those in exile is key. Third, preaching about healing stories, especially those found in the gospels can be very helpful. The authors stress that care must be taken not to emphasize that healing is dependant on the sick person’s faith as this can be damaging to those struggling with mental illness as they may feel that their illness is their own fault and if they just believed enough God would
make them better. Healing stories invite a view of God caring for those who are sick. Fourth, scriptures relating to the community’s call by God to care for the widow, orphan, sick and poor also includes those struggling with mental illness. Fifth, using wisdom literature that shows that scripture includes practical wisdom on life’s hardships is important. An example would be focussing on Proverbs 18:14 which says “The human spirit will endure sickness; but a broken spirit – who can bear?” This particular scripture could point to the fact that the Bible recognizes the depth of pain that individuals can suffer. Sixth, paying attention to the characters in scripture who exhibit signs of mental illness with empathy instead of judgement, ministers will be able to model a helpful approach to how mental illness should be approached today. The authors provide the examples of: Hannah’s depression due to being barren, King Saul’s depression later in his life, Elijah’s desire to die when he was persecuted and Jesus praying in fear and anxiety in the garden.

An additional source for creative resources can be found on the website hope4mentalhealth.com. This site is managed by Saddleback Church out of the United States. The pastor of the church Rick Warren’s son died tragically by suicide in 2013 after struggling with mental illness and since that time the church has prioritized mental health outreach and support within their community. There are mental kits available from the site for churches to use who want to start their own mental health ministries and a large quantity of videos about mental health issues that can be shown during sermons, small group meetings and bible studies. The video offered by the site entitled “There is Hope” video presents a dramatic illustration of the pain and isolation that is felt by those who suffer from mental

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172 Cook and Allen Jr. Preaching, 2-5.
illness and is highly recommended. This video can also be helpful to illustrate the suffering of the self-injuring individual.\footnote{Please see list of resources below:}

There are very helpful suggestions for churches who would like to begin their own mental health ministries on the site. These ministries would also be of great help to self-injurers and should welcome and include them. Their strategy for creating a mental health ministry is outlined in three steps: crawl, walk and run. “Crawl” outlines steps that do not require money, training or paid staff such as referring to mental illness in sermons, praying for families who are living with mental illness and inviting people living with mental illness to share their stories in services and calling/emailing individuals who are living with mental illness and offering encouragement and support.\footnote{An excellent example of a ministry that trains individuals with mental illness to speak to diverse communities about their stories is called In Our Own Voice that operates out of the United States’ mental health advocacy program \textit{The National Alliance on Mental Illness} (nami.org). This program is highlighted by Jason C. Whitehead in his theological reflection on offering a place of belonging to those with mental illness. He explains that this program “trains persons with mental illness to go into different communities and share their story. Communities of faith and support can create these sacred spaces where different and complex stories are told, honoured and experienced with gratitude”. See: Jason C. Whitehead “Ghosts and Guests: A Pastoral Theology of Belonging For Ministry With Persons With Mental Illness”, \textit{Journal of Pastoral Care and Counselling.} 70 (2016): 263. Accesses April 1, 2017. doi: 10.1177/15422305016680627.}

“Walk” includes preaching sermons specifically about mental illness, starting support groups for mental health specific issues and building a mental health library. Finally, “Run” includes such steps as developing a lay counselling ministry, hosting mental health conferences and partnering with a mental health organization in the community to provide services such as therapeutic support groups.\footnote{Sarah Griffith-Lund presents a helpful list of mental health and faith resources in \textit{Blessed Are the Crazy: Breaking the Silence About Mental Illness, Family and Church}. This resource is excellent as the author tells the story of her family in which multiple members (her father and brother) suffer from bipolar disorder. Griffith-Lund is now a minister draws attention to the intersection between faith and mental illness and the role that secrets and shame can play in harming families and communities. She shares her story in order that others may learn from her experiences and also to open up a dialogue about mental illness in Christian communities. She}
I would like to add a few practical ideas to supplement the ideas brought forth by Cook and Allen Jr. and the *Hope for Mental Health* team regarding preaching about mental illness and self-injury. First, it is important to have resources available to those struggling with mental illness following the sermons for self-injurers, their families and friends. Counsellors, prayer team members, pamphlets, books, lists of helpful websites and most importantly, lists of professionals for referrals in the community such as psychiatrists, psychologists and psychotherapists should be readily available.\(^{177}\)

Secondly, ministers, youth workers and church staff should be ready implement the church’s self-injury policy, which can be modeled after existing policies for schools.\(^{178}\) This self-injury policy can be discussed from the pulpit in order for church members to be aware that the policy exists and the practical ways that it functions. It is also important as key members of the church can serve on the Self-Injury Team (as outlined by Hasking et. al in chapter 2) and assist with referring to the hospital and to psychiatric/psychological care as

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\(^{177}\) In *Darkness is My Only Companion: A Christian Response to Mental Illness*, Kathryn Greene-McCreight cautions against bombarding individuals with mental illness with studies that say that religion and spirituality can provide healing from mental illnesses. She writes: ‘These studies… also indicate that religious people ‘are less stressed and happier than non-believers’ and that ‘religious people and less depressed, less anxious and less suicidal than nonreligious people’. This only plays into the caricature for those Christians who are indeed depressed or experiencing other symptoms of mental illness. Often they feel guilty on top of being depressed, because they understand their depression, their lack of thankfulness, their desperation, to be a betrayal of God’. When it comes to the type of materials, they should be referred to (or handed out) with discretion to those with mental illness and also to self-injurers. See: Kathryn Greene-McCreight. *Darkness is My Only Companion: A Christian Response to Mental Illness. Revised and Expanded Edition*. (Michigan: Brazos Press, 2015. Kindle Edition), location 192-225.

\(^{178}\) For a detailed summary of developing policies in schools including examples of existing policies, please see Chapter 2 section F: “Developing Policies in Schools”.
needed. It is important that the Self-Injury Team members are identified to the congregation so that self-injurers and their caregivers will know to whom they can go for help besides the pastor.

Thirdly, my final suggestion for preaching about self-injury is to seek out creative elements that can be added to the sermon. One example is a short dramatic play written by Dave Tippett who encourages pastors and youth workers to use the play as a conversation starter regarding self-injury. The play is simply entitled *Cut* and has a running time of five to six minutes. It is based on Isaiah 53:5 and focuses on four teenaged girls who tell the stories of their self-injury. The girls each take turns speaking of their cutting and their realization that Jesus had wounds too. They discuss that they cut in order to feel better and to have control. They finally realize that their self-injury is no longer offering them relief and with the help of a friend, obtain the help they need. During their healing process, they feel as though Christ’s scars have sealed their wounds.\(^\text{179}\) This play is very powerful and a highly recommended resource for pastors to use in sermons for the wider congregation and in youth ministry.\(^\text{180}\) Another recommended example is showing Stephen P. Lewis’ *TED Talk* on self-injury in which he shares his life story that includes bullying, shame and depression. Lewis is a leading Canadian researcher in the field of self-injury and oversees the website *Self-Injury Outreach and Support* (sios.org).\(^\text{181}\)

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E) A Return to Emily: Implications for Our Case Study

Now that we have completed an overview of themes relating to NSSI in the theological literature, let us once again return to our case study about Emily. I have chosen to highlight these three concepts as they are, again, very practical and I believe comprise key issues when considering theological and pastoral care issues regarding self-injury. I would like to suggest that it is important to focus on:

- **Mental health education.** It is key for Christian communities to continue to deepen their conversation about self-injury. This can be done through preaching, offering support groups, having a self-injury team at the church and through education of church staff, ministers, volunteers and Christian counsellors. If Emily’s church had embraced education about mental health and self-injury sooner, perhaps she would have felt more accepted at church and would have found some of the support that she needed.

- **The minister and youth worker as advocates.** The suggestions by various authors of the ways that ministers, Christian counsellors and youth workers can do some self-reflection and consider how they can better support self-injurers is paramount. In the next chapter we will contemplate theological meditations on ways that members of the Christian community can better walk alongside those struggling with mental illness and self-injury.

- **Living a better theology.** It is important that the negative and harmful theological positions associated with self-injury such as seeing self-injurious behaviours as sinful, or using self-injury as a way to punish oneself for mistakes and offer penance to God be made obsolete. Instead, a theological focus on such concepts
as grace, hope, acceptance and belonging should take their place. Emily and her family could truly benefit from a life-giving theology that focusses on God’s love and the assurance of healing and wholeness along their journey out of self-injury.

It is interesting to note that a lot can be done by the Christian community to support Emily and her family. With self-injurious behaviours increasing among young people, it is key that churches begin to prioritize the integration of ministries that target self-injurers like Emily. Now that we have considered our case study in relation to key theological themes, we will begin a theological reflection on self-injury. We will return to our case study on Emily one final time at the end of chapter 4.
In this chapter, we will engage theologically with three key concepts and consider how it is that members of the Christian community can come together to serve and love those who self-injure. Each section is presented as a “meditation” on the topic and will include practical ideas for action, an engagement with scripture and theological questions that will invite reflection. As previously mentioned in Chapter 3, the texts that we will dialogue with in this chapter will integrate resources from existing theological literature concerning a) mental health b) disability studies and c) Christian ethics. Finally, this chapter will conclude with a return to our case study.

A) Meditation One: Belonging and Friendship

1) Healthy Belonging

In *Becoming Human*, Jean Vanier writes about the importance of belonging in the life of every human being. Belonging is an integral part of everyone’s journey to freedom. For the individual who self-injurers, it is very important that they are offered a place to belong within the Christian community so that they are accepted for who they are, appreciated and loved. Vanier stresses that there is a “healthy belonging” that groups can aspire to emulate. He emphasises the importance of all members of the group respecting one another and functioning as one body so that all are listened to. He writes:

In healthy belonging, we have respect for one another. We work together, cooperate in a healthy way, listen to each other. We learn how to resolve conflicts that arise when one person seeks to dominate another. In a true state of belonging, those who have less conventional knowledge, who are seemingly powerless, who have different capacities, are respected and listened to. In such a
place of belonging, if it is a good place, power is not imposed form on high, but all members seek to work together as a body.\textsuperscript{182}

For self-injurers, it is important that their voices are listened to by other members of the community and that they are respected for who they are. Vanier’s focus on the Christian community operating as one body is also interesting to note as it relates to self-injurers. How does the pain of one member of the body affect others who belong to the body? How can Christians better bear each other’s pain and help one another in the healing process? Vanier provides some ideas as he offers up four signs of healthy belonging for communities.

The first sign of healthy belonging according to Vanier is that \textit{we have respect for one another. We work together, cooperate in a healthy way, listen to each other.} For the self-injuring individual, feeling as they are valued, understood and listened to is vital. This will, as previously mentioned, allow them to feel truly accepted for both what they are saying and “not” saying regarding their self-injurious practices. Vanier also explains that this also includes the importance of forgiving one another if we have been rejected or hurt, and accepting and supporting those who challenge us by humbly pointing out our errors. In addition, we can learn to accept our own personal weaknesses and limits so that we will discover that we truly need others when we are sick, going through crises or grieving.

The second sign of healthy belonging in a community is \textit{the way a group humbly lives its mission of service to others.} This points to the openness of a community where true dialogue can take place and its members are not afraid to speak as each member is respected. The community also “does not impose its vision on others but instead prefers to listen to what [its members] are saying and living, to see them in all that is positive”.\textsuperscript{183} When the community listens to self-injurers and better understands their needs, community members

\textsuperscript{183} Vanier, \textit{Becoming}, 60.
can respond in helpful ways. For example, this can be in simple ways such as driving self-injurers to counselling appointments, or in more complex ways that require the help of more community members such as starting a support group for self-injurers at church.

The third sign of healthy belonging is that as we begin to see each other’s gifts, we move out from behind the walls of certitude that have closed us up. Vanier explains that in the past, churches fought one another due to differing theologies. He believes that this time has passed, and instead of focussing on what separates them, churches are now seeing what unites them. Vanier also believes that focus has shifted in a similar way among members of the Christian community as we are realizing the beauty found in one another’s gifts and we are learning how to give of ourselves to one another. For the individual who self-injures, to have other community members give of themselves, whether it be through loving conversations, an invitation to join them for a meal, or through pastoral counselling, can form key steps on their journey towards healing and wholeness. To be recognized not just as a person who self-injurers, but also as an individual with gifts to be appreciated by the wider community is very important as well.

The fourth and final sign of healthy belonging is when a group seeks to evolve and to recognize the errors of the past, to recognize its own flaws, and to seek the help of experienced people from outside the group. This is so that the group may become more loving and true, more respectful to other’s differences, more listening and open to authority. Vanier explains that the group that will not admit its own errors runs the dangerous risk of closing itself off from others behind a wall of superiority. “Rather than opening up to others, such groups close in on themselves. This lead to the death of the spirit”. 184 This final sign is key when considering the call to ministry for the Christian community to those who self-

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184 Vanier, Becoming, 55
injure. If members of churches, ministers, counsellors and youth workers have contributed in any way to the alienation, silence and suffering of self-injurers, it is key that the group acknowledges these errors and seeks to evolve and change in order to provide a safe place for self-injurers within the community. It is key to ask for advice from individuals from outside the community, such as psychologists and therapists. Beyond this, members of other churches can be consulted who have successfully created support groups for self-injurers or work alongside mental health groups in the community. Finally, caregivers of self-injurers and self-injurers themselves can be consulted concerning how it is that their own needs can be better met within the community.  

2) True Friendship

John Swinton presents a helpful discussion about the difference between what it means for individuals with disabilities to be merely included in a community versus what it means to truly belong to a community in “From Inclusion to Belonging: A Practical Theology of Community, Disability and Humanness”. The main difference is that when one is included in a community, a person merely needs to be present. To belong to a community means a moving past simply being in the same place as others to a more meaningful and rich concept of being missed. Swinton explains:

To belong you need to be missed. People need to be concerned when you are not there; your communities need to feel empty when you are not there… Only when your absence stimulates feelings of emptiness will you know that you truly belong… When we belong people long for our presence in the same way as the prodigal son’s father longed for the presence of his wayward son (Luke 15:11-32) and in the same way that God longs for us to be present with God. 

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185 Vanier, Becoming, 57-61.

Swinton maintains that this longing for another person to the point where they are missed is a manifestation of God’s love towards human beings that is realized within communities who have come to know and love God. This is a key point when considering the place that self-injurers have had in many Christian communities in the past as they were made to feel invisible, ashamed and misunderstood. What could it mean for self-injurers to move from a place of invisibility to belonging? What would it look like for them to be missed within Christian communities? It is helpful for those to consider the difference between being included and truly belonging as they examine how they can better support self-injurers.

In *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems*, Swinton maintains that hope can be brought to the person who has mental illness through friendships with other Christians. His insights are equally helpful for bringing hope to individuals who self-injure. How then can a person that is part of a Christian community become a friend to someone who has a mental illness, or to an individual who self-injures? Swinton proposes that the friendships of Jesus are extremely helpful to reflect upon. Jesus’ friendships were always very personal and he desired to give the dignity and personhood back to those who were outcasts in society, were rejected and who had lost their sense of identity. Jesus helped people to see their own intrinsic value given to them by God rather than basing their value on personal achievement or their own behaviour. As an example, Swinton uses the story of Zacchaeus the hated tax collector, who Jesus invited to come and eat with him (Luke 19:2). Jesus stayed with Zacchaeus at his house, going beyond social expectations and treating him like a friend.

Swinton maintains that Christ followers can follow the example of Jesus and offer friendship to individuals with a mental illness and by extension to those who self-injure. The
friendship is primarily based on being with the person which enables rehumanization. The friendship does not need to be modeled after the relationships found in therapy or counseling which set out to “do something” for the patient, instead, the friend simply needs to “be there” for the person with mental illness or the self-injurer. Swinton explains:

Unlike many agents with whom people with mental health problems may come into contact, the task of the Christ like friend is not to do anything for them, but rather to be someone for them – someone who understands and accepts them as persons; someone who is with and for them in the way that God is also with and for them; someone who reveals the nature of God and the transforming power of the spirit of Christ in a form that is tangible, accessible and deeply powerful.\footnote{187}

It is through this act of friendship that individuals with mental illnesses, and I would like to suggest also individuals who self-injure, can find hope. Swinton goes on to explain that the Christian community must take seriously their ministry of friendships as this is truly how a person can be resurrected because “relational isolation, social marginalization and exclusion are not compulsory parts of the experience of mental health problems”\footnote{188}. Instead, by offering friendship and the willingness to struggle alongside those with mental illness and also with self-injurers, hope and healing can be brought into their lives.

\textbf{B) Meditation Two: Hospitality}

In this section, we will explore the concept of hospitality in the writings of Henri Nouwen, Christine D. Pohl and Thomas E. Reynolds. The primary theological questions that will be asked in this meditation are: what is hospitality? What are a few examples of hospitality in the Bible? What are some very practical and simple ways for Christians to

\footnote{187 John Swinton. \textit{Resurrecting the Person: Friendship and Care of People With Mental Health Problems}. (Nashville: Abington Press, 2000) 143.}

\footnote{188 Swinton. \textit{Resurrecting}, 144.}
integrate the practice of hospitality into their lives? By extension, how can Christians show hospitality to individuals who self-injure?

1) Poverty of the Mind and Heart

In *Reaching Out: Three Movements of the Spiritual Life* Henri Nouwen maintains that the practice of hospitality should have a prominent place in the lives of Christians. Hospitality, Nouwen argues, is not only limited to an opening up of Christians’ homes and offering food and a place to stay to strangers, but is also an attitude that Christians can have of openness towards another person, the creation of a space that enables a stranger to become a friend. When introducing the concept of hospitality, he writes:

> At first the word ‘hospitality’ might evoke the image of soft sweet kindness, tea parties, bland conversations and a general atmosphere of coziness. Probably this has its good reasons since in our culture the concept of hospitality has lost much of its power and is often used in circles where we are more prone to expect a watered down piety than a serious search for an authentic Christian spirituality. But still, if there is any concept worth restoring to its original depth and evocative potential, it is the concept of hospitality. It is one of the richest biblical terms that can deepen and broaden our insight in our relationships with our fellow human beings.¹⁸⁹

Nouwen points the scriptures to illustrate the seriousness of the obligation that we have to show hospitality to strangers with three examples. First, when Abraham received the three strangers at Mamre and offered them fresh water and a choice calf to eat, it was revealed to him that they were the Lord and the promise of Sarah’s son was announced (Gen. 18:1–15). Second, when Elijah was offered food and water by the widow of Zarephath he raised her son from the dead (1 Kings 17: 9–24), and third, when the two travellers on the road to Emmaus invited the stranger they had met on the road to stay with them for the night, Christ made himself known in the breaking of bread (Luke 24:13–35).

How then can the host prepare themselves to offer hospitality to strangers? Nouwen highlights the importance of two key concepts for hosts that require the painful process self-emptying as Christ emptied himself (Philippians 2:6-8). The first concept is the *poverty of the mind* which refers to a host who has a spiritual attitude that embraces the mystery of life. This host does not “know everything” but instead is open to not knowing everything about God so they can hear God’s voice speak to them in the words of the stranger that they have invited into their space. Poverty of the mind also allows the guest to feel welcome as the host listens to them attentively so that the gifts of the guest may be discovered.

The second concept is the *poverty of the heart* which refers to the host having an openness of heart that enables them to realize that their own limited experiences of both God and life are not the only way to understand the world. Having poverty of heart allows the host to become detached from their own experiences and as a result, open to a greater understanding of existence, history and God. This opens up the way for mutual revelation.

I would like to suggest that these concepts are key when considering how a host can offer hospitality to a person who self-injures. By maintaining poverty of the mind, a host can listen intently to the self-injurer’s story while simultaneously listening for God’s voice to speak to them through the words of the self-injuring person. The gifts of the self-injurer can be discovered as the host listens to them with humility. Poverty of the heart allows the host to better understand why the self-injurer engages in NSSI and how it relates to the self-injurer’s life experiences and current stressful or painful situation. This is important as the host themselves may not have any experience with self-injury.

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2) **Hospitality as Countercultural Act**

Christine D. Pohl writes about the countercultural aspects of hospitality and its ability to restore dignity and offer recognition to the stranger. Small acts of hospitality are life-giving and can create meaningful connections. Pohl explains that small acts of respect towards those who society disregards and dishonours point to an alternative relationship model. For Pohl, recognition means “respecting the dignity and equal worth of every person and valuing their contributions, or at least potential contributions to the larger community”.

In addition, recognition involves questions about the value of cultural traditions, exclusion, identity and basic human rights. She argues that hospitality can become very subversive when socially undervalued individuals are welcomed by a group as this can function as a challenge to the expectations and beliefs of the wider community. She writes:

> People view hospitality as quaint and tame partly because they do not understand the power of recognition. When a person who is not valued by society is received by a socially respected person or group as a human being with dignity and worth, small transformations occur. The person’s self-assessment is enhanced. Because such actions are countercultural, they are a witness to the larger community, which is then challenged to reassess its standards and methods of valuing. Many persons who are not valued by the larger community are essentially invisible to it. When people are socially invisible, their needs and concerns are not acknowledged and no one even notices the injustices they suffer. Hospitality can begin a journey towards visibility and respect.

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192 In “Hospitality and the Mental Health of Children and Families” Pohl explains that when social networks are strong, people are more likely to flourish. She writes, “Each person flourishes best within a web of relationships that can be nurtured through shared projects, common meals, comfortable gathering places, and celebrations. Insights from the tradition suggest that we should look loosely at our congregations, organizations and agencies – or at least the parts for which we have responsibility. We may not be able to change them totally, but we can ask what small acts or shifts in orientation might create space and interactions that are more life-giving? With what organizations and individuals can we partner to create settings that allow for initial connections to be built among strangers?” See: Christine D Pohl. “Hospitality and the Mental Health of Children and Families” American Journal of Orthopsychiatry 81 (2011): 488. Accessed March 15, 2017. doi: 10.111/j.1939-0025.2011.01111.x


How then, can Christians be a part of the counter cultural, transformational kind of hospitality of which Pohl writes? How can hospitality aid in recognition and the restoration of dignity in the life of the person who self-injures? In what way can this help the self-injuring person? Pohl offers insights into practical ways that Christians can show hospitality to the stranger that are helpful for ministering to self-injurers. Besides opening up our homes and offering food and drink (which can be very important as well), three concepts are key:

- First, offering a *focussed response*. At times, a host can offer a mixed welcome as the door to their home is open but they show in small ways that they are very busy and have other things to do. Rethinking how hosts respond to unexpected or inconvenient guests is important. At times, the way unexpected guests are welcomed by their hosts mirror how God loves and welcomes them.

- The second way to offer hospitality is by *taking time and making space for people*. The time hosts take for people shows them that they are valued. Enjoying guests and creating a way of being with them that shows genuine love for their presence in the space of the host is key.

- The third and final way is through offering *small acts of hospitality*. Pohl emphasizes that hosts cannot do it all and instead of becoming discouraged by this thought, they should focus on their small contributions that function in partnership with God’s work in the world. Their small acts of hospitality are located within the context of larger social transformation.\(^{195}\)

For self-injurers, it is key that their hosts take time for them and offer a welcome that is genuine. Even if the self-injuring person does not discuss their NSSI openly while visiting,

\(^{195}\) Pohl, *Recovering*, 1989 -2068
knowing that their host loves and welcomes them will help them to experience God’s love.

Hosts can also be encouraged when ministering to self-injuring individuals that very small
gestures of hospitality may not stop the individual from engaging in NSSI, but will contribute
to the larger healing that God is doing in their life.196

3) The Hospitality of Jesus

What can we learn about hospitality from the example set by Jesus? In Vulnerable
Communion: A Theology of Disability and Hospitality Thomas E. Reynolds considers the
hospitality that is shown by Jesus to the sick and disabled. Reynolds focusses on Jesus’
healing ministry that does not function primarily to “cure” a person, but instead to “heal”
them. To heal a person according to Reynolds is a much deeper than to cure them. To cure a
sick person is to restore them to health medically, to fix what is broken. To heal them on the
other hand, is to move towards wholeness, to restore the image of God in a person. Reynolds
explains that Jesus does not take pity on the sick and disabled, instead he draws them to
himself so that he can bring about wholeness and restoration into their lives. He writes:

Jesus does not stigmatize persons with illnesses, diseases and impairments. Rather, he invites people considered defiled or unclean into his presence, deliberately unconcerned with the purity codes governing temple practices. Wherever Jesus goes the destitute, sick impaired, and vulnerable in society come to the fore and gather around him. Why? Not simply because they seek Jesus. Rather, because Jesus seeks them. He esteems vulnerability and

196 A very helpful resource concerning practical, everyday ways that Christians can offer hospitality to others is in The Simplest Way to Change the World: Biblical Hospitality as a Way of Life by Dustin Willis and Brandon Clements. This resource is helpful for Christians who would like to invite self-injurers over to their living space but are unsure of where to start. The authors stress that Christians can offer much needed hospitality to others from their homes, whether they live in a house, a dorm, an apartment or in one small room. These ideas are helpful to consider for Christians who want to reach out to and connect with families of self-injurers, or to self-injurers themselves. In addition to inviting the reader to reimagine their possibly tiny living spaces as places of hospitality, they encourage the reader to consider how some new life rhythms can incorporate acts of hospitality into their weekly, monthly and yearly routines. Some examples of weekly routines are: hosting a weekly meal night or a weekly game night. Monthly idea examples are: hosting movie nights and book clubs. Yearly example ideas are: hosting holiday parties. For additional practical ideas, see Willis, Dustin and Brandon Clements. “Practical Rhythms of Hospitality” The Simplest Way to Change the World: Biblical Hospitality as a Way of Life. (Chicago: Moody Publishers, 2017) 180.
weakness, not power and ability, as the criteria for genuine personhood in relation to God… this practice is part of his overall intent to pull the margins to the centre.\textsuperscript{197}

Jesus’ ministry is concerned with liberating the sick and bringing them into the social life of the community, directly opposing any social exclusion imposed by the more powerful. Jesus’ primary focus is not on the illness or disability of the individuals that he heals; instead, it is on the whole person who God loves and accepts just as they are. Jesus brings humanization into the lives of those that he heals by welcoming them to the table. Reynolds emphasizes that Jesus does not require a sick or disabled person to be “cured” or made “normal” before they can be acceptable to God. Jesus goes in the exact opposite direction in his ministry by affirming a person’s humanity and personhood first. This is all that is needed to be invited into the kingdom of God and have abundant life (John 10:10).

How might hospitality be extended to people with disabilities and by extension to individuals who self-injure based on Jesus’ example? Reynolds offers three directions for Christian communities. First, hospitality can be shown by recognizing the presence of persons with disabilities. For Reynolds, hospitality stands in direct opposition to conformity. Churches should let go of their need to control and know exactly what to do in advance. Instead, an attitude of availability, listening and learning to those with disabilities is key. With regards to the individual who self-injures, it is imperative that churches continue to widen their vision to include self-injurers and to become more aware of their presence.

Second, hospitality means accommodation to others as uniquely precious persons, acting for their benefit. A person is more than their disability and disabilities themselves should not be seen as shortcomings. Reynolds emphasizes that the Christian community

should see individuals with disabilities as people who are capable of contributing in positive ways to the community. In addition, accommodation regarding the kind of language that is used in the community is key. Referring to metaphors concerning blindness and deafness can negatively impact people with disabilities and build up negative attitudes in those who are non-disabled. The church building should also become accessible for the different needs of individuals with disabilities.\(^\text{198}\) Regarding the self-injuring individual, they too should be known as more than just a “cutter” or “self-harmer” and as people who are an integral part of the community and have a lot to bring to it. Regarding accommodation of language and the church building for individuals who self-injure, any language surrounding self-injury should avoid stigmatization, using derogatory statements and generalizations. It is also worth considering how churches approach communion as well as Good Friday services due to the blood and violence represented at each service. Each should be re-examined so that self-injurers feel welcome and perhaps have a mentor or minister available to speak with them if they need a listening ear, guidance or prayer.\(^\text{199}\)

\(^{198}\) In addition to making accommodations to church buildings, hospitality also means being generous with all of the facilities that God has given to Christian communities. In *Slow Church: Cultivating Community in the Patient Way of Jesus*, Smith and Pattison stress that “the homes that we own, as individuals or as the church, are not just private residences but are God-given resources to be shared.” An example given by the authors is that their church has a house next door that belongs to the church community. Individuals and families are welcome to stay there when room is available for days and weeks. This enables the church community to get to know their guests and to offer them safety, security and support. See: C. Christopher Smith and John Pattison. “Hospitality: Generously sharing God’s Abundance” *Slow Church: Cultivating Community in the Patient Way of Jesus*. (Illinois: Intervarsity Press, 2014. Kindle Edition) location 2925.

\(^{199}\) In “A Lord’s Supper Liturgy for Survivors of Trauma: On Sacramental Healing”, Julie Prey-Harbaugh presents helpful guidance for self-injuring individuals who would like to take communion. She explains that for abuse survivors, the Lord’s Supper provides the chance for people to come to more fully understand Christ’s own bodily pain and subsequent healing. She explains, “The Lord’s Supper reflects the importance of embodied experience. Jesus’ suffering involved a very real physical and emotional pain. As such, it stands to reason that it is indelibly marked on the Spirit of God. Jesus’ suffering displayed God’s unwillingness to separate Godself from bodily pain, and emphasizes the importance God places on journeying through pain to move toward healing. The knowledge that God feels and understands pain experienced in the body, as well as the effects of trauma carried painfully in the heart, can be powerfully healing to the trauma survivor”. I would like to suggest that this insight, written about here in the context of the trauma survivor, has profound insights for those involved in NSSI. The communion table provides the opportunity for self-injurers to come to understand the pain that Christ felt in his body, and likewise, to realize that God understands the physical pain that is associated
Third, hospitality means advocacy... a reaching out with and not only for people with disabilities. The Holy Spirit is our advocate (John 14:16) and in the same way, the Christian community should be advocates for strangers who are on the margins. Reynolds emphasizes the role of the advocate in hospitality as one who promotes the well-being of the stranger and understands their world. The advocate shares the burdens and weaknesses of the stranger and comforts them. It also means welcoming the vulnerable so that Christ himself is welcomed. For the self-injuring person, it is key that they are welcomed and comforted by advocates as they are invited in from the margins. It is also key that those in the Christian community become educated about NSSI so that they will better understand the world and by extension the needs of those who self-injure.

C) Meditation Three: Listening as Radical Act

1) Listening to the Walking Wounded – Beyond Simply Hearing

Marilee Strong writes in *A Bright Red Scream: Self-Mutilation and the Language of Pain* that after completing the five years of research for her book she came to the realization that acts of self-injury are deeply connected to silence. She explains that after reviewing all of


In addition in *Trauma and Grace: Theology in a Ruptured World*, Serene Jones provides an example of a young abuse survivor named Leah who attended a communion service, and had to leave the service out of deep distress for the frank discussion of the blood of Christ and his broken body. Jones writes that speaking with Leah following the service changed her mind permanently about how to approach the Lord’s Supper, liturgy and prayer so that all people who attend can feel comfortable and welcome around the table. She stresses: “If the church’s message about God’s love for the world is to be offered to those who suffer these wounds, then we must think anew about how we use language and how we put bodies into motion and employ imagery and sound. With fresh openness we must grapple with the meaning of beliefs not only about grace, but also about such matters as sin, redemption, hope, community, violence, death, crucifixion and resurrection.” It is essential that we think about the way that we come to the communion table so that self-injuring individuals will feel comfortable attending. See: Serene Jones. *Trauma and Grace: Theology in a Ruptured World.* (Westminster John Knox Press, Kentucky: 2009) 11

Reynolds, *Vulnerable*, 6213.
her research she “was convinced that people cut and burned and bashed their bodies precisely because they could not put into words the pain and confusion they were feeling inside themselves. Instead of discharging negative emotions verbally, they had to do so physically”.

This meditation on listening begins by asking the reader to contemplate the silence in which many self-injuring individuals live. This silence causes many self-injuring people to feel as though they are the “walking wounded… who suffer in silence”, with some self-injurers going so far as to call themselves the “walking dead”.

If self-injurers are not able to verbalize their pain how can members of the Christian community learn to hear what is not being said? How can Christians become more sensitive to their unspoken words? In *Hearing Beyond the Words: How to Become a Listening Pastor*, Emma J. Justes presents helpful ideas for how to listen for what is not being said; to listen beyond words. She explains that “One who truly listens must be able to tune into, to be aware of, the be willing to approach, acknowledge and sometimes inquire about the meanings of that which is communicated but unspoken”.

Justes presents the concept of “thoughtful availability” that guides the reader through the process of listening for what is not being said. Thoughtful availability involves attentiveness, readiness, focus, and mindfulness on behalf of the listener. It also functions like a gesture of the listener’s hand being outstretched, palm facing upwards with their hand open, willing to receive what the other has to offer. Thoughtful availability is particularly helpful with regards to ministering to self-injuring individuals as often they are silent about

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202 Strong, *Bright*, location 100.
203 Strong, *Bright*, 3826.
their self-injurious practices. According to Justes, thoughtful availability has these key elements:

- **Consciously working against our socialization not to hear.** Society teaches us to ignore things that can be right in front of us so that we remain polite. It takes courage to hear what is being communicated without words and when words are used, to listen for what is being said underneath the surface of what is being spoken.

- **Making an effort to see feelings that are not spoken verbally, to say, “I see you”.** We can notice a facial gesture or an expression that shows how a person truly feels. Again, courage is needed to draw attention to a gesture or a sign (such as tears in a person’s eyes as they are talking). In this example, naming a person’s tears can violate social rules, but it also can function to assist the person to speak more freely about their feelings. This will also enable the speaker to feel less invisible, to be seen by the listener.

- **Going beyond the nonverbal as we know it.** Justes presents the example of a young woman named Judy who comes to see her pastor for counselling with facial bruising. The pastor is uncomfortable asking her about the bruises, so he continues to talk about other things until Judy says that her husband hurt her. Instead of asking her outright if her husband hit her, the pastor could have called attention to the bruise by

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205 Thorne also writes of the danger that politeness can bring to Christian communities and its ability to destroy authentic communities. Encouraging the expression of emotion and moving past shallow politeness is very important. “One very real danger that churches face is they become ‘nice’ superficial places when it comes to personal problems; places where everyone is pleasant to one another, where people automatically say, ‘Fine thank you’ when asked how they are… Churches need to cultivate an authentic sense of being a hospital for sinners and those struggling with the pain of being sinned against. Of course, Sunday services do not need to descend into a chaotic outpouring of past hurts and present struggles, but there does need to be an ethos in church that encourages people to answer the ‘How are you’ question with honesty”. Thorne explains that self-injuring individuals will need to express their emotions many times over a course of months or years if they have a safe environment to do so and this will certainly help in the recovery process. See: Thorne, *Biblical Model*, 19-21.
saying “I see you have a black eye” or “What happened to you?” so that Judy is given
the opportunity to respond. This is particularly important for individuals who self-
injure as their wounds might be visible to others but out of discomfort no one may ask
about them in a kind and respectful way. An observational remark about self-
injurious wounds may be all that is needed to open the door for communication.

- Finally, thoughtful availability is about recognizing the value of silence. Instead of
  using silence as an opportunity to think of what we will say next or to interject our
  own ideas, silence can be an opportunity for much more. It can become a safe space
  for the speaker to do their nonverbal work, for listening to God’s voice, for reflection,
  for contemplation of new insights and for considering what has been revealed. Instead
  of breaking the silence with questions or jumping right in to speak, both the listener
  and the speaker can trust that the Holy Spirit is working steadily in the silence.  

For the self-injurer, thoughtful availability transforms what we would normally consider
listening into a radical act of hospitality. With an outstretched, open palm, the listener can
serve the self-injurer by providing genuine attentiveness, availability and readiness to hear
beyond their words, to have courage to see their wounds and to listen for what is not being
said.

D) A Final Return to Emily: Implications for our Case Study

Let us now consider how the three meditations can guide us as we look for ways to
support Emily and her family during this difficult time. I have chosen to include Emily’s

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parents as they should not be forgotten as they too need support. Here are a few ideas for practical application:

- **Belonging and Friendship.** How can Emily’s church community offer her real belonging and true friendship? Vanier’s suggestions of offering her respect and listening to her are key. The church community can come alongside her and find ways to support her as Emily reveals her true needs to them. The church community can operate with open minds as they seek to learn how it is they can help self-injuring individuals. Emily herself and her parents can also work to forgive any members of the church community who have hurt them in the past by stigmatizing or “overspiritualizing” self-injury, as well as contributing to their feelings of isolation and anger. The church community can also take steps to offer a type of belonging to Emily so that she, in Swinton’s words, is genuinely missed when she is not there. By befriending Emily and her parents, rehumanization and inclusion are made possible.

- **Hospitality.** How can Emily’s community offer her hospitality? Nouwen’s poverty of the mind and poverty of the heart offer ways of being that show true hospitality. Opening oneself up to mystery and God’s revelation allows for the host to truly connect with Emily. I would also like to suggest that it can be a countercultural act for members of the church community ask Emily and her parents to join them for a meal. Pohl’s concept of recognition urges hosts to show those who are overlooked and invisible hospitality so that they are given dignity, worth and respect. Preparing meals and dropping them off for the family, helping Emily get to therapists appointments and even going for a walk with Emily or her parents show small acts of
hospitality that partner with God’s work in the world. Advocating for Emily and sharing her burdens brings comfort to her and her parents.

- **Listening.** Finally, how can her community learn to listen to what is not being said? How can we become more sensitive to Emily’s silence? Justes’ suggests that “thoughtful availability” urges us to make a conscious effort to work against our socialization not to hear, in order that we may truly “see” Emily and her pain. We can have the courage to ask questions and to see her wounds. We can also learn to value her silence and see it as an opportunity for reflection, contemplation and the creation of a safe space for Emily to be in so that the Holy Spirit can work.

It is my prayer at the conclusion of this paper that Emily and her family will continue to be offered a place of true belonging and friendship through the members of their Christian community. It is my belief that the Christian community can work to come alongside Emily and her family in a more authentic way and learn to support her more fully through a combination of proper education about self-injury, a creation of a safe space for self-injurers, and small gestures of love and kindness by those around Emily. As we seek together to find a way to bring psychology and theology into deeper conversation concerning self-injury, it is key that work continues to be done in this area from a theological and pastoral care perspective in order to help and support those like Emily, their caregivers and friends. It is my hope and prayer that this conversation is only beginning.
Appendix

The Bill of Rights for Those Who Self-Harm (this is a summary):

a) *The right to caring, humane medical treatment.* Self-injurers should receive the same level and quality of care as a person who presents with an identical but accidental injury would receive. Local anesthesia should be used for stitches. Procedures should be done gently, as they would be for others.

b) *The right to participate fully in decisions about psychiatric treatment (as long as no one’s life is in immediate danger).* The opinion of the self-injurer should be considered when considering the need for a psychological assessment. If the person is not in obvious distress/suicidal, they should not be subjected to an arduous psych evaluation. Doctors should be trained to assess suicidality. Hospitalization for NSSI alone is rarely warranted, although referral for outpatient follow up may be advisable.

c) *The right to body privacy.* Visual examinations to determine the extent and frequency of the NSSI should be preformed only when absolutely necessary and done in a way that maintains the patient’s dignity. Many individuals who self-injure have been abused and the humiliation of a strip search is likely to increase the intensity and amount of future NSSI. It may also cause them to look for better ways to hide the injuries next time.
d) *The right to have the feelings behind the NSSI validated.* NSSI often occurs as a result of distressing feelings and those feelings should be recognized and validated. Although a health care provider may not understand why self-injury has occurred, she or he can at least try to understand that a situation is distressing.

e) *The right to disclose to whom they choose only what they choose.* No care provider should disclose with others that injuries are self-inflicted without obtaining permission from the self-injurer, with the exception of team-based hospital treatment or other medical care providers when the information is essential in order to provide proper medical care. Patients should be notified when others are told about their NSSI.

f) *The right to choose which coping mechanisms they will use.* No patients should ever have to choose between self-injury and treatment. Self-harm contracts should never be created for self-injurers by therapists. Instead, a plan should be developed by the client and provider for dealing with self-injurious impulses. No client should feel that they must lie about NSSI, or be removed from outpatient therapy. Exceptions may be made in hospital ER treatment when a contract may be required for hospital legal policies.

g) *The right to have care providers who do not allow their feelings about NSSI to distort the therapy.* Those who work with NSSI clients should keep their personal feelings of fear, revulsion, anger and anxiety out of the therapeutic/medical settings.
h) *The right to have the role SI has played as a coping mechanism validated.* No one should be shamed, admonished or chastised for using NSSI as a coping mechanism. NSSI may be used to avoid suicide. Self-injurers should be taught to recognise that the negatives of SI outweigh the positives and learn new methods of coping that are not as destructive.

i) *The right to not be automatically considered a dangerous person simply because of self-inflicted injury.* No one should be put into restraints or locked up in a treatment room or involuntarily committed due to NSSI. Physicians should commit based on psychosis, suicidality and homicidality.

j) *The right to have self-injury regarded as an attempt to communicate, not manipulate.* Most individuals who self-injure are trying to express things they cannot say in any other way. Although the actions sometimes seem manipulative, care providers should respect the communicative function of NSSI and assume it is not manipulative behaviour until there is clear evidence to the contrary.\(^{207}\)


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