

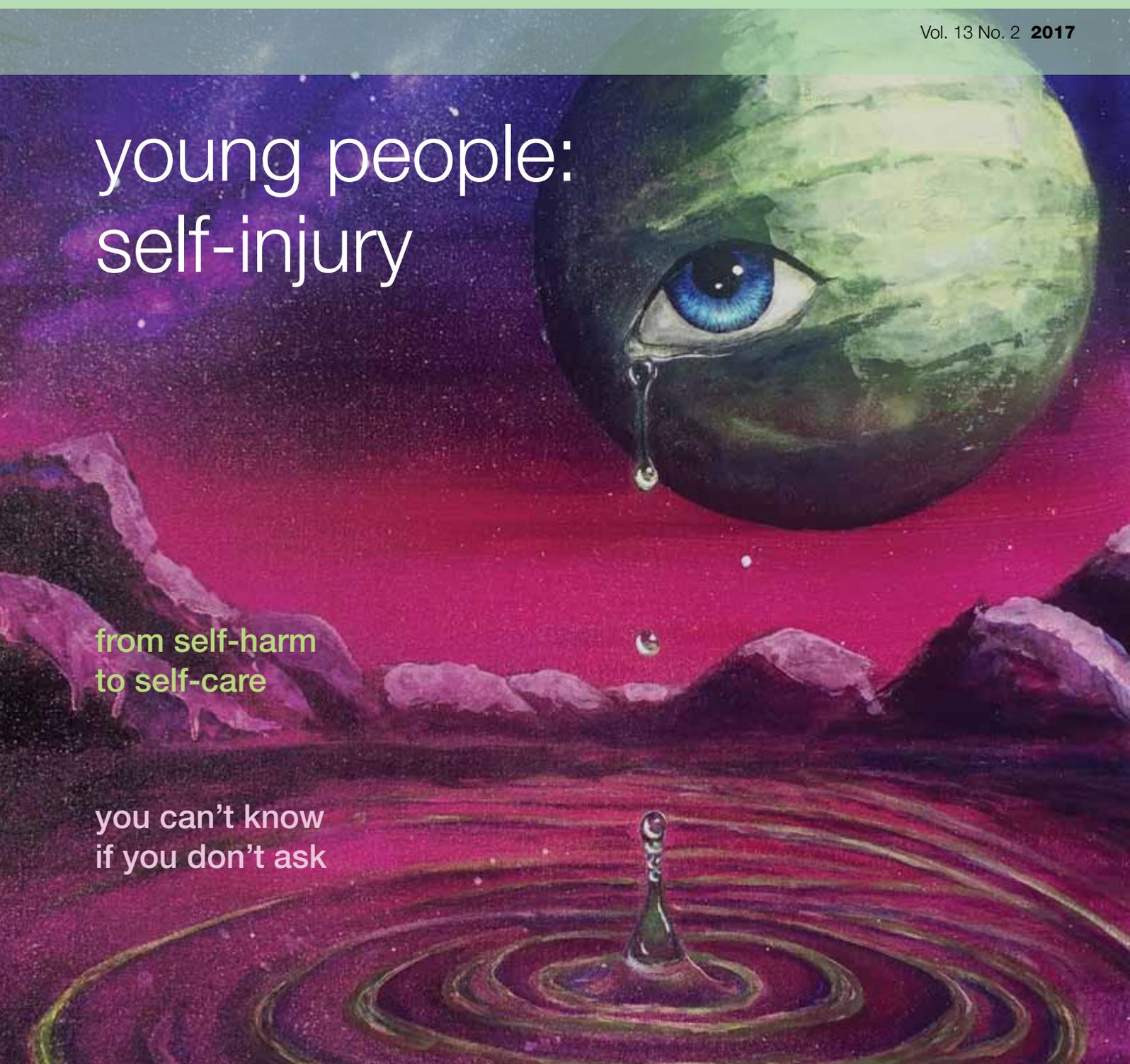
visions

Vol. 13 No. 2 2017

young people:
self-injury

from self-harm
to self-care

you can't know
if you don't ask



we're in full colour now!

We've made changes to how *Visions* is printed so that it's both more engaging and costs us less money to print. We were able to do both and hope you enjoy the new look. We welcome your feedback.

footnotes reminder

If you see a superscripted number in an article, that means there is a footnote attached to that point. In most cases, this is a bibliographic reference. For complete footnotes, see the online version of each article at www.heretohelp.bc.ca/visions.

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bc partners and heretohelp

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letter to the editor

I was encouraged by and thankful for the *Visions* issue on Stigma. The injustice of stigma deeply angers me. It's so wrong when those with mental illness are not seen as the real people they are—people not unlike themselves. All of us have the need to be accepted and loved. Everyone does.

The borderline personality disorder (BPD) I struggle with is an example of a blatantly stigmatized disorder. Yet we who suffer from it are not at fault. Often it's caused by poor parenting. At times, I've had trouble controlling my emotions. Because of this, I came to be rejected by people I least expected. They seemed to think my behaviour indicated bad character, not understanding it to be an illness. Forgiveness for my unfortunate behaviour was not given.

The pain caused by the rejection was worse than the illness itself. I wonder if this was because it reminded me of childhood experiences? Counselling has taught me that could very well be the case. With the help of therapy, I'm overcoming.

—Marja Bergen, Burnaby

from the artist of the painting on the cover

I am a Grade 10 student from School District 43. This piece exemplifies the true contrast between things we can and cannot see. We cannot see planets in our daily lives unless we really take a deep closer look. This is similar to pain in the people around us, unnoticed until looked further into. The symbolism behind the painting is that pain is everywhere even if it is not visible. (Dasha Pogrebinsky)

editor's message

I don't remember self-injury (the preferred term, less vague than 'self-harm') being a thing when I was in high school in the early 90s. Maybe it's always been there but was just well hidden; maybe it *is* actually more common now. When 15–20% of young people report at least one episode of nonsuicidal self-injury,¹ it's something we all need to understand better. Even though youth popular culture references self-injury more than it ever used to, our service system hasn't entirely caught up, especially the medial system. Too often, self-injury, like suicidal behaviours or substance use problems are treated as entirely rational decisions—and so the person can easily be blamed and then dismissed—and the underlying distress or motivation is overlooked. There is ageism, too. Troubling changes in younger people are still routinely minimized as 'a phase,' or 'teen angst' or 'drama.' Young people may internalize this view and delay seeking help.

The personal stories in this issue are profound. I am struck by how many difficult experiences many youth have had to navigate, and who have coped as best as they could. When youth tried to tell someone, sometimes they were met with ignorance as in "Can't you just stop?" Other times, they were met with nonjudgemental support and compassion and it was a major turning point in recovery. Someone else who notices this is Carol Todd, mother of Amanda Todd who took her own life five years ago in a story that involved Youtube, cyberbullying, sexual exploitation...and self-injury. Carol recently told radio listeners who might be parents or other adults to a young person to have more conversations about mental health and to ask about self-injury, to ask about suicide in a caring way. She urged adult supporters to listen more, judge less, to not be afraid and to keep having conversations.

This *Visions* supports those same themes. If you want to extend your learning beyond this issue, join some of our contributors for a "tweet chat" Q&A in November. Follow us on Twitter (@HeretoHelpBC) to get the details.



Sarah Hamid-Balma

Sarah is Visions Editor and Director of Mental Health Promotion at the Canadian Mental Health Association's BC Division



Note: We have tried to take great care in our editing and photo choices not to glamorize or normalize self-injury. Our focus is on recovery, but you cannot appreciate the recovery until you read about some of the pain. Please call the BC Mental Health Support Line at 310-6789 at any time if you need immediate support.

Understanding Self-Injury in Young People

A CLINICIAN-RESEARCHER'S APPROACH

Mary K. Nixon, MD, FRCPC

My journey to better understanding self-injury in young people began after I completed my residency in psychiatry in the early 90s. I became the director of a new partial-hospitalization program for adolescents at the Children's Hospital of Eastern Ontario (CHEO).



Dr. Nixon is a clinical associate professor in the Department of Psychiatry, UBC, and practises child and adolescent psychiatry in Victoria, BC. She has published clinical and population-based research on nonsuicidal self-injury in youth and established a network of Canadian researchers. Dr. Nixon has provided numerous seminars and workshops for parents, schools and community and mental health agencies who are interested in better understanding and supporting self-injuring youth

By the late 90s, nearly 40% of the program's youth were presenting with nonsuicidal self-injury (NSSI).

We offered a range of therapies to treat emotional and behavioural issues, including early-onset mental health disorders. Our approach took a developmental perspective and considered the interaction of biological, individual and social factors. When a youth arrived having recently self-injured, we would discuss with the youth, or the youth and the family, what might be triggers or contributors for the NSSI. We often came up with a range of possibilities. At times, having a number of perspectives made it challenging to consider the approach best suited to the youth.

I had access to a trial computer program to use for structured

symptom review. The youth readily answered questions about their mental health on the computer. It was helpful to use their answers as "talking points" with the youth and the team, to consider conditions such as depression and anxiety, mood swings, and attentional and behavioural struggles, which may be a biological, individual and/or environmentally based contributor to their self-injuring behaviour.

One of the things described by a number of youth was that their self-injuring "worked better" than anything I could provide in the short term in terms of "relief." When I looked for research on the subject, however, I found there had been little published on youth that pertained to what they were describing. We needed to understand a lot more.

With a colleague from the CHEO Research Institute, I developed a questionnaire designed to elicit research-based evidence on the subject. The Ottawa Self-Injury Inventory (OSI) asks some key questions, including questions about what motivates a young person to start or continue to self-injure and whether there is an addictive component.

The most common reason for self-injury given by the young people in hospital was the desire to manage difficult emotions, such as a depressed mood, anxiety, anger or frustration. Most youth indicated more than one motivation to self-injure. Some were using NSSI to manage and prevent acting on suicidal thoughts.

A number reported addictive features. Some had to self-injure more often or more severely to achieve the same effect they had achieved previously. Self-injury was interfering with their social, family and/or school life. Some felt that thinking about self-injury or the actions around self-injury had become time-consuming. These responses suggested that self-injury behaviours could, for some, be highly reinforcing, even for those who wanted to stop.

Based on more research by others, we expanded the OSI to include questions on how NSSI could be used to communicate a youth's distress indirectly to others, for example, "to show how hurt or damaged I am" or "to stop my parents from being angry with me." We found that social influencing was a function for the behaviour, and for others, it was sensation-seeking.

In Victoria, BC, around 2005, I collaborated with the Centre for Youth and Society at the University of Victoria, completing a population-based survey of nonsuicidal self-harm in youth (ages 14 to 20) in the Greater Victoria area. Of those who self-harmed, approximately one-third reported that they did so more than three times. Lifetime rates of NSSI, specifically, were almost 14%.

Recognizing that rates of NSSI were high in youth and that new research needed to be translated to those working closely with youth, I co-edited with Dr. Nancy Heath, from McGill University, the first evidence-based interdisciplinary text on NSSI in youth. We wanted to reach a readership including school professionals, youth mental health clinicians, those working with families, family physicians and pediatricians.¹ This text was the culmination of a personal goal to share as much information as possible to a wide readership and support others in their journey to better understanding this behaviour.

10 reminders

When working with NSSI in young people, here are ten key things I consider:

1. **Use the right term: "nonsuicidal self-injury."** Terms such as "self-harm," "parasuicide" and "self-mutilation" are too broad or confuse NSSI with suicidal behaviour. They can also be pejorative. Research results that lump together suicidal and non-suicidal behaviours may be confusing.

NSSI is defined as the deliberate destruction of body tissue (for

example, self-cutting or self-scratching), without the intent to take one's life, not socially sanctioned within one's culture and not for display. When a clear definition is used, more consistent research on the causes of the behaviour and on best treatment practices can occur.

2. **Educate others on your team.**

Help other caregivers understand that NSSI is not suicidal behaviour per se, but that the two types of behaviour can co-exist. We now know that NSSI can be a precursor to suicidal behaviour. It provides an opportunity to intervene before things potentially worsen.²

3. **Beware misdiagnosis.** NSSI in young people does not necessarily indicate borderline personality disorder. Young people who self-injure may be misdiagnosed when other mental health issues like depression, moods swings and anxiety, and concerns about sexual identity, as well as possible family and peer stressors, are significant factors. It is important to consider carefully one's formulation and/or diagnostic impression. For a review of major mental health issues in young people, see www.learninglinksbc.ca.

4. **Listen more than talk.** Most young people are willing to share information about their behaviour when you display "respectful curiosity."³ Each individual and family has a story; it is important to listen when asking key questions. The OSI questions can be used to encourage discussion about behaviour that the youth might

otherwise find difficult to talk about face-to-face: see the Ottawa Self-Injury Inventory under the For Professionals link on the INSYNC website, at insync-group.ca.

5. Encourage patience and hope.

While NSSI prevalence rates appear high in youth, they diminish with age. Cornell researchers report qualitative data that suggest such changes in an individual's behaviour may be attributable to changes in the individual's ability to regulate emotion, his or her self-awareness and important relationships with others.^{4,5}

6. Support the family's participation.

In our health systems, family members can often feel left out of the loop. In my experience, the whole family benefits from an increased understanding of NSSI behaviour and—to start—how to manage crisis situations. When we support families to raise their awareness and understanding, we can see improved outcomes. See insync-group.ca/for-family-and-friends/ and sioutreach.org/learn-self-injury/parents-and-families/ for further information.

7. Use a sequential, individualized approach.

While a number of therapies exist for the treatment of NSSI, evidence-based research regarding outcomes remains inconclusive. Dialectical behaviour therapy, emotional regulation group therapy and manual-assisted cognitive therapy, for example, have shown promise.⁶ Practitioners should use an approach that best meets the needs of the young people in their specific region/

culture. Easy and non-stigmatized access to a service that provides opportunity for assessment and targeted treatment is the ideal scenario. Sometimes, several one-on-one sessions with a counsellor or physician may adequately address a major stressor and set the stage for learning and reinforcing adaptive coping skills and linking with other resources.

8. Ensure the youth is an active agent in recovery.

In my experience, recovery can occur when a youth is open to considering change to his or her behaviour. Motivational interviewing may be a good place to start with those who are contemplating change but remain unsure. A discussion of harm reduction can also help. Check out the motivation-for-change scale in the OSI for a clearer picture of whether the youth is ready to explore recovery approaches and what approaches may work.

The OSI (or the briefer OSI Functions) can be used to assess and map out an individualized recovery approach. The following sites also include helpful assessment and treatment-planning information: www.ncbi.nlm.nih.gov/pmc/articles/PMC4495629 and insync-group.ca/for-professionals.

9. Be aware and use social media positively with regards to NSSI.

The advent of the Internet has introduced a complexity to parenting and to young people's social environments. The following link provides a helpful summary of the impact of social media and includes recommended guidelines.

The Internet and social media are here to stay. We need to support parents and youth to maximize the upside of these new communication forms and minimize the downside. See www.selfinjury.bctr.cornell.edu/perch/resources/the-relationship-between-non-suicidal-self-injury-and-social-media.pdf.

10. Use the school system. Some school boards are implementing mental health curricula as early as elementary school to help younger children develop a greater awareness of their emotions, improve their communication skills and learn appropriate tools to manage stress. Young brains can be very plastic, and many children can establish these healthy habits. Schools are great places to model and practise emotional regulation and healthy communication. See how your local school system might benefit from these programs: healthyschoolsbc.ca/category/11/positive-mental-health.

The subject of self-injury in youth can provoke a range of emotions and responses. We are challenged with understanding and managing our own reactions while we work with youth and families who courageously share their vulnerabilities with us. As guest editor of *Visions*, I am privileged to be a part of this broad presentation of perspectives. I encourage *Visions* readers to reflect on the experiences of these youth and families and the insights of the professionals who work with them. ▽

Nonsuicidal Self-Injury

SEPARATING FACT FROM FICTION

E. David Klonsky, PhD

Nonsuicidal self-injury (NSSI) is the intentional damaging of one's own body tissue (for example, cutting or burning the skin) without suicidal intent.

E. David Klonsky is a professor of psychology at the University of British Columbia. He is the lead author of Nonsuicidal Self-injury as well as many scientific papers on self-injury, suicide and related topics. Dr. Klonsky's Three-Step Theory (3ST) explains the development of suicidal ideation and the transition from suicide ideation to attempts



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Nonsuicidal self-injury does not include suicide attempts (that is, behaviours undertaken with the intent to die) and does not include intentional activities that are socially accepted, such as tattoos or body piercings.¹

For those who know little about the behaviour, NSSI seems counterintuitive. After all, people usually go to great lengths to *avoid* pain and injury. We take Tylenol when we have a headache, for example, and we heed “slippery when wet” signs. Many other forms of pain and injury control are a pervasive part of our lives.

Yet a significant percentage of the population has intentionally injured themselves at least once. More importantly, those who self-injure more frequently are at increased risk for emotional distress, mental illness and even suicide.² It is important that people in a position to recognize NSSI and provide help—including health professionals, school officials and parents—have an accurate understanding of the behaviour.

Nonsuicidal self-injury is often misunderstood and even stigmatized. This article provides clear, accurate, evidence-based information about

NSSI and also dispels some common misconceptions.

What is NSSI?

NSSI can take many forms. Common examples of NSSI include cutting, burning or scratching one's own skin, as well as banging or hitting one's body parts. Behaviours that may seem like forms of self-injury, such as substance abuse, alcohol abuse or eating disordered behaviours (binging, purging, over-exercising), are not considered by experts to be NSSI because the tissue damage in these cases is indirect and not part of the individual's intent. While NSSI often results in light bleeding or bruising and can leave scars, it rarely causes injuries severe enough to require professional medical attention.³

Who self-injures?

Youth report NSSI more often than adults (although NSSI can be found in any age bracket in the population). The lifetime rates among youth and young adults are 15-20%, whereas about 6% of adults report lifetime occurrence of NSSI.^{3,4} It is unclear if the lower lifetime rate in adults is due to a reporting bias (for example, a 45-year-old may not remember one or two instances of NSSI when he or she was 14) or to increases in NSSI for newer generations (for example, NSSI may be more common in youth now than it was more than 20 years ago). Typically, NSSI in youth begins around age 13 or 14, though approximately one-third of cases of NSSI begin after age 18.^{1,3} Generally, rates of NSSI are similar around the globe.⁴

Nonsuicidal self-injury is slightly more common in women than men, but the form of NSSI is the most obvious

gender difference. Women more often use cutting, whereas men may be more likely to use hitting, banging or burning.⁵ Rates of NSSI are noticeably higher in people who report non-heterosexual orientations (for example, homosexual, bisexual, transgender, gender-nonconforming or questioning). Rates of NSSI are also higher among Caucasians than among non-Caucasians.³

NSSI is especially common among people receiving mental health treatment.¹ Perhaps the most common characteristic of those who engage in NSSI is emotional distress. Those who self-injure experience more frequent and intense negative emotions than others, especially negative emotions that are high-arousal (for example, anger) and self-directed (like self-hate and self-criticism). Perhaps for this reason, diagnoses associated with negative emotions, such as mood disorders, anxiety disorders, borderline personality disorder (BPD) and eating disorders, are strongly associated with NSSI.³

It is important not to equate NSSI with any particular mental illness or condition, however. There is a misconception, for example, that NSSI is first and foremost a symptom of BPD. This belief has been reinforced in part by the Diagnostic and Statistical Manual of Mental Disorders (DSM), which for decades has included NSSI only on the symptom list for BPD.⁶ But BPD is a severe personality disorder and a stigmatized one, so it can be quite harmful for a young person with NSSI to be automatically labelled as having BPD.

In fact, there is overwhelming evidence that NSSI is distinct from BPD. For example, rates of NSSI are much higher than rates of BPD, and there are many cases of NSSI in the absence of BPD, as well as many cases of BPD in the absence of NSSI.⁷ For these reasons, the most recent version of the DSM proposes a definition for an independent NSSI diagnosis.⁸

Why do people self-injure?

There are many theories for why people self-injure. Careful research has helped separate fact from fiction, and more accurate theories from less accurate ones.⁹ By far, the most common motivation for NSSI is *emotion regulation*. In other words, people use NSSI to reduce intense negative emotions and achieve a sense of calm and relief.¹⁰ We do not yet completely understand the mechanisms behind this effect, but researchers have suggested both physiological and psychological explanations.

Many people who self-injure also describe additional motivations.⁹ For example, some use NSSI as a way to express self-directed anger or punishment. Others use NSSI to interrupt dissociative experiences (for example, feeling "unreal") or stop suicidal urges. Less often, NSSI can be used to influence or bring out reactions from others.

In the past decade, researchers have developed ways to assess the functions of NSSI.^{12,13} It can be useful to think of the different NSSI functions as falling into one of two larger categories: self-focused (for example, emotion regulation, self-punishment) and social/other-focused



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Although nonsuicidal self-injury is distinct from a suicide attempt, it represents ‘double trouble’ for suicide risk.

(for example, influencing others, help-seeking).¹¹ Contrary to the common misconception that people who use NSSI are usually seeking attention from others, self-focused functions are far more common than social/other-focused functions.¹²

Some early theories about NSSI have led to the misconception that NSSI is caused by childhood sexual abuse. While there is a correlation between childhood sexual abuse and NSSI, it is a modest one.¹⁴ For some, the abuse can contribute to the negative emotions that drive NSSI, but many individuals with a history of abuse do not use NSSI, and many who use NSSI do not have any history of childhood sexual abuse.

NSSI and suicidal behaviour

The relationship between NSSI and suicide is frequently misunderstood.¹⁵ Some practitioners and researchers view NSSI as a form of suicidal

behaviour, and others assert there is little overlap. The truth is somewhere in the middle. On the one hand, NSSI is

- more common than suicidal behaviours
- used with greater frequency than suicidal behaviours
- likely to involve different methods (e.g., cutting rather than purposely overdosing)
- results in less medically severe damage³
- most often used in the absence of suicidal thoughts¹⁶

When NSSI is mistaken for attempted suicide or suicidal behaviour, self-injurers can feel misunderstood, invalidated and mistrustful of those who might otherwise be able to provide help.

On the other hand, NSSI more strongly predicts suicide attempts than other suicide risk factors (such

as depression, anxiety and personality disorders).^{15,17} Contemporary suicide theories suggest that both suicidal wishes *and* the capability to act on such wishes are necessary for potentially lethal suicide attempts.^{15,17} Even among people with high distress and strong suicidal wishes, fears of pain, injury and death may be barriers to suicide attempts. A person can become more or less capable of overcoming these barriers and attempting suicide through various life experiences that get them accustomed to pain, injury and death.

Not only is NSSI associated with emotional distress, which increases risk for suicidal intent, but NSSI represents experience and practice with self-inflicted injury, which increases the capability for attempting suicide. People who use multiple methods of NSSI or engage in NSSI frequently are at especially high risk for suicide attempts. In short, although NSSI is distinct from a suicide attempt, it represents “double trouble” for suicide risk because NSSI increases risk both for suicidal desire and for the capability to act on that desire.¹⁵

NSSI is an important mental health concern. Fortunately, research over the past 15 years has greatly improved our understanding of who self-injures and why. Research has also increased our understanding of the relationship between NSSI and suicidal behaviour, where the two types of behaviour overlap and where they do not. Armed with this knowledge, health providers are in a much better position to help those in need. ▽

Leave Self-Harm Behind

PACKING PROPERLY FOR YOUR MENTAL HEALTH JOURNEY

Amrita Sunner

When I was four, I had my first panic attack. I didn't know it was a panic attack at the time. I remember sweating a lot, my vision blurring and sounds fading away; everything slowed down and then sped up. I remember wishing that other people would notice and do something to help.



Amrita Sunner

Amrita is from Richmond, BC. She is nineteen years old and currently in her third year of a psychology undergraduate degree at the University of British Columbia. She hopes that by sharing her story she can help encourage others to speak up about mental health

Around 11, I cried myself to sleep for the first time. By the age of 14, I cried myself to sleep almost every night. I just thought it was something all kids did. By the time I was 16, I felt lost at sea and had difficulty finding reasons to live. It was then that I self-harmed for the first time—and it wasn't the last.

Let's backtrack a bit. My parents separated when I was a toddler, but they had an on-again, off-again relationship until they finally divorced when I was 10. During those years, there were a lot of fights. They would scream and cry and throw things at each other.

After they separated, my brother and I moved around a lot—between my mom's many basement suites and my grandparents' house (where my dad lived). We wanted to stay with our caretakers—in our family, our grandparents—but my mom was granted 60% parenting time. My brother and I were less than thrilled.

Don't get me wrong: I love my mother. But as children, we wanted stability. Unfortunately, neither one of our parents could provide that.

My mother worked two jobs, she didn't have a supportive family and she suffered from depression for



Photo credit: ©iStockphoto.com/Gioez

As human beings, we need to share our experiences with each other—in our schools and in our communities—in order to help young people navigate difficult life transitions.

much of my youth; only now can I understand that she was trying to be the best mother she could be. My dad wasn't around very much. When he was, he played the role of "fun dad." But as I got older, I started to feel angry when he didn't show up to my hockey games or take us out for breakfast as he promised. When it came to my dad, I felt mostly disappointment.

Over time, my relationship with both my parents has improved. Luckily, I have a loving extended family who welcomed me into their home when life with my parents became too distressing. My aunt, my uncle and my grandparents held me when I needed to cry and laughed with me when my tears dried.

Understanding life as you grow is a complex process. As human beings, we need to share our experiences with each other—in our schools and in our communities—in order to help young people navigate difficult life transitions. I share these details about my childhood so you can understand how family dynamics played a role in my mental health. At the time, I didn't have the tools to deal with the emotional challenges I faced. Having had to find my own way, I have resolved to talk about the importance of mental health with other young people; this article is a way to start that conversation.

Despite my parents' difficult divorce, I didn't experience real emotional challenges until Grade 7. From the

outside, I was a happy-go-lucky girl. I had the best of friends and we would climb trees and adventure through made-up fantasy lands. I loved every minute of my time spent with friends.

Then, I would go home. Instantly, I would be hit with a wave of exhaustion, a wave that made me want to isolate myself, lock myself in my room. A wave that made me cry for hours on end.

No one in my school or my family had prepared me for this. Nothing added up. Why was I always so sad? Why did little things make me angry? Why wasn't anything I did good enough?

I now understand that this was the start of my depression. Kids aren't supposed to have those kinds of thoughts constantly on a daily basis. I want readers—especially youth readers—who recognize themselves in this story to know that these may be symptoms of mental illness and to seek help. I don't want what happened to me next to happen to anyone else.

By Grade 10, I needed to cry at night in order to function the next day. I no longer felt like myself; I didn't even know who "myself" was anymore. I started feeling uncontrollable anger, and my actions became unpredictable—even to me. At home, I would slam doors and yell at family members. At the hockey rink, my aggression grew and I began picking fights during games. I started drinking alcohol and smoking cigarettes and marijuana.

This inner battle carried on for another year. I suffered—the kind of pain you experience when everything

inside of you feels like it's dying, as though someone is stabbing your very soul, again and again *and again*. I felt heavy and slow. I lost sight of what was going on around me, why I was still alive. I stopped playing sports. I wasn't participating in class. I barely ate any food, and I rarely spoke more than a few words to my family. I was utterly exhausted. Looking back, I can recognize my depression at its worst. I wish I could have labelled it at the time. Being able to name it might have helped.

One morning in Grade 11, after a particularly exhausting, restless night, I realized that I was beyond frustration, beyond anger. I was utterly broken. I needed to let my unbearable pain out. I grabbed the sharpest object beside me and started clawing at my wrist, sobbing, just so I no longer had to feel the pain inside my soul. It felt good to feel physical pain instead of emotional pain. It felt good to have control. At least, it did at the time—but only at the time. Within minutes I became fearful and I felt more defeated than ever.

The next few days are a blur. I remember feeling ashamed, worried that someone would notice the cuts on my wrist and ask me what was wrong. My friends and family saw I was not myself. Everyone was telling me to talk to the school counsellor, so I did.

When I walked into the counsellor's office, she just let me cry. Then she told me something that saved my life: "You are not alone, Amrita. You will get through this and we will help you every step of the way."

She immediately referred me to Children's Hospital, where I was

diagnosed with severe depression and generalized anxiety. I started antidepressants and began seeing a psychiatrist regularly. I can't say things were easy. Suddenly everyone was concerned for my well-being and I was overwhelmed.

Committing to continuing therapy was a challenge—and it still is. I tried several therapists, and during that time my urges to self-harm grew stronger and my scars grew deeper. But finally finding the right therapist—having the right non-judgemental shoulder to lean on—has been one of the biggest keys to my recovery.

The Dialectical Behaviour Therapy Centre of Vancouver (the DBT Centre) has also been helpful. It taught me a range of coping strategies to manage anxiety and stress, including mindfulness techniques, skills for strengthening my interpersonal relationships and tips for regulating my emotions. Through practice, I have learned how to recognize when my behaviours aren't justified, and I have the skills to change those behaviours. Because of this, I have been self-harm-free for more than one year.

I am forever grateful to my school counsellor. Since that day in her

office, I have never felt alone. And I have made it my mission to encourage others in the same way she encouraged me. If you are in pain, there is *always* someone who will listen; you just have to find them. *We are here for you.*

I'm now in my third year of a university psychology program, with the hopes of one day being there for someone when they need it, just like my high school counsellor was there for me. Many wonderful people have given me guidance, support and shelter along the way. I still have bad days, and I still have urges to self-harm, but I have found alternative, healthier ways to cope with those urges. My mental health journey hasn't been easy, and I know it hasn't ended. But I'm better prepared for the trip, with a backpack full of tools to use whenever I need to care for myself in a compassionate, healthy way.

I encourage anyone who is struggling with an urge to self-harm to keep seeking support until you find it. If you don't have family, friends or a school counsellor to talk to, the DBT Centre of Vancouver is a great place to start. Things may get tough, but there will always be a light at the end of the tunnel. ▽

related resource

For more information on the DBT Centre of Vancouver and its dialectical behaviour therapy programs and other services for mental health issues, see www.dbtvancouver.com

Cutting Through the Binary

SELF-INJURY AND SELF-ACCEPTANCE FROM A GENDER-NONCONFORMING PERSPECTIVE

Elliot*

I have been fascinated by pain for as long as I can remember. As a young child, I secretly relished the sting I felt when I stubbed a toe or skinned a knee. When my playground wounds healed over, I would rip the scabs off to watch the blood ooze out. In hindsight, I understand that the pain was a sort of distraction from the nagging overstimulation I have always felt.

*Elliot is a visual arts student currently living in Vancouver, BC. They** enjoy gardening, volunteering and playing music in their free time, and hope to pursue a career working with LGBT youth*

* pseudonym



Photo credit: ©iStockphoto.com/gawrav

At five years old, I was diagnosed with sensory processing disorder (SPD). With SPD, sensory information that doesn't bother most people—such as textures, lights, smells and sounds—can feel exaggerated and unbearably uncomfortable. As I grew older, the intensity of my SPD symptoms faded. But as a young child, I was unable to wear certain fabrics because they felt like sandpaper on my skin. I couldn't go to concerts or places with large crowds because the noise made me feel as though my head was going to explode. When I got overstimulated

by, say, a loud noise or an intense smell, often the only way to make the discomfort go away was for me to physically remove myself from the source of the discomfort.

As I got older, it became less acceptable to have the sort of loud, often public, meltdowns I would experience as a result of my sensory overstimulation. Looking back, I believe part of the reason I began hurting myself was that self-injury acted as a sort of replacement for the physical release of a meltdown. Since

** *Visions* supports the use of personal pronouns that contributors feel best reflect their gender identity, including the gender-neutral singular "they/them."

it was shameful to outwardly break down, I began to direct my negative energy inward.

The first time I cut myself, I was 13 years old. At that point, I had been dealing with depression and anxiety along with my SPD for quite a while. And as I entered my teenage years, I began to realize that I wasn't straight. There wasn't a particular event or trauma that caused me to run a pair of scissors across my wrist that day. I was feeling overwhelmed, and it just seemed natural, like the right thing to do at the time.

I remember feeling guilty afterward. I covered the thin red cuts on my wrist with a sweatshirt, cursed myself and swore to never do it again. But I would go on to repeat the behaviour a few more times over the next few months. Eventually, cutting myself became a daily ritual.

When I started self-harming, I knew only a couple of other people my age who did so. I didn't think of myself as anything like them, nor did I come to see myself as a "self-harmer" or "cutter" until years later. Interestingly, though, there was a very significant similarity between us: we were all LGBTQ. Specifically, we were all transgender.

Self-harm, like suicide, is over-represented in the LGBTQ community, particularly with LGBTQ youth, yet it is rarely talked about. On average, about 15% of young people in the general population report engaging in some type of self-injury.¹ In contrast, around 35% of LGBTQ youth report having self-harmed.² While there is virtually no data specifically on

Trans people face bullying, discrimination and non-acceptance, which can lead to depression, isolation and feelings of self-hatred, all of which increase the likelihood of self-harm.

transgender youth and self-harm, I suspect the number of transgender youth who self-harm may be higher.

Practically all transgender and gender-nonconforming people I know have engaged in self-harm at one point or another. We don't talk about it, but we exchange knowing glances of solidarity when we see the scars on each other's bodies. It's no secret—being trans isn't often easy. Trans people face bullying, discrimination and non-acceptance, which (as I know from personal experience) can lead to depression, isolation and feelings of self-hatred, all of which increase the likelihood of self-harm.

I realized I was non-binary in Grade 10. I don't fit within the gender binary of male or female, despite having been assigned female at birth. I have always felt this way, though while I was growing up I didn't have a way to verbally express my discomfort. I didn't realize it was possible to "not identify" as a particular gender until I came out as bisexual at 14 and started learning about—and getting involved in—the LGBTQ community.

At some point, I half-heartedly came out as gender-nonconforming to my friends and the Gender-Sexuality Alliance (a club at my high school composed of other LGBTQ youth

and allies, and a sponsor teacher). I requested that people call me by a different name and use neutral "they/them" pronouns for me, but people were generally confused and rarely used my preferred name or pronouns. Outside of close friends and other trans people, few accepted my nonconforming gender identity.

At about the same time, my brother came out to our family as a transgender guy. He and I had discussed our gender identity before, so it wasn't a surprise to me. But our immediate family was taken aback. Although they claimed to accept his statement of identity, they didn't make an effort to use his new name and pronouns. They seemed to think his "new" gender identity was just a "phase." While the family has since become more accepting, I didn't exactly feel encouraged to come out officially given my brother's experience.

At school and at home, I continued to present as a girl. My self-harm increased, as did my anxiety and loneliness. There were very few other out trans and gender-nonconforming kids at school, and all of them were dealing with their own issues—which often included mental illness and addiction along with self-harm.

Self-harm thrives under conditions of secrecy and shame, and those were the conditions I lived in. I was too ashamed and embarrassed to be who I actually was, and the other trans people I knew in my life were equally miserable, if not more so.

Luckily, as my high school years drew to a close, things began to get easier. With the encouragement of my school counsellor, I began seeing a therapist and receiving cognitive-behavioural therapy (CBT) for depression and anxiety. I was skeptical at first, but I began to apply my newly learned coping skills in my everyday life and found they actually helped. I've continued being an advocate

for LGBTQ and social justice issues, which in turn has made me feel better about myself. My new work environment is accepting of gender variance. And at my university, there is a fairly large transgender/gender-nonconforming population.

I am more forthcoming about my identity now, and I present in the way I want to. I am still receiving CBT and starting to understand more about my self-harm process and the triggers that cause it. I haven't stopped self-harming completely, but I see recovery in my near future. Every day I feel more comfortable with myself and my gender, and I look forward to what the future holds. ▽



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Cutting Class

A MOTHER'S PERSPECTIVE ON SELF-HARM

Joleen*

I recall my girl, prettiest doll ever: blond curly hair, the bluest eyes, her grandfather's dimples, and a smile that lit up the universe—a sight to see, like a glimpse of the dancing northern lights. Her inner core pure, strong and true: my kind-hearted, loving Leo, Sierra.*



Photo credit: ©iStockphoto.com/Halfpoint

Joleen is 43 years old and has a 23-year-old daughter. They both live in the Interior of British Columbia. Although Joleen and her daughter's father separated when their daughter was about two years old, they have an amicable relationship and shared custody of their daughter

** pseudonym*

Troubles began in kindergarten. The other kids were relentlessly mean. One of her teachers told her she was stupid and wouldn't amount to anything—in front of the whole class! When I confronted the teacher, I was told that that my daughter had provoked the bullying and the comments.

It was painful to watch my baby's self-esteem wither. For Grade 8, I registered her in what I thought would be a better school, uptown, away from where she had grown up. It was a chance to meet new people, take advantage of new opportunities.

Her aunt taught at the school, which was a bonus: if she needed to talk to someone, she could go see her aunty.

The move was a big mistake. Sierra constantly worried about what the other kids thought. For example, the kids at the new school wore designer clothes. I couldn't afford designer clothes for Sierra, let alone all the accessories that went with a designer wardrobe. Sierra felt like she didn't fit in, and she started withdrawing further into herself. At home, most of the time she sat in her room alone with the door closed.

I tried to stay calm and not over-react. I said, “Oh, my baby girl,” and I reached out and pulled her close. I held her tighter than I ever had.

At school, rather than reporting to a teacher when she was bullied, Sierra would retaliate by saying hurtful things to the children who taunted her. These children would then tell a teacher, and Sierra would get mislabelled as the bully who initiated things. This label stuck with her. Once, Sierra witnessed a group of children lock another child in a dark cupboard. When she told me about the incident later, she said how horrified she had been, how scary it must have been for the child. She immediately went to help, but a teacher walked in and accused Sierra of having locked the child in the cupboard. Both children corrected the teacher’s false perception, but it was distressing for Sierra to be the automatic target of the teacher’s accusation.

Things got worse. Sierra stopped taking her lunch to school. When I expressed concern, she told me a teacher had said she was going to get chubbier if she kept eating so much, and the other kids had started calling her fat. It became difficult to convince Sierra to go to school. Often, she would leave the school grounds after I dropped her off.

One day in conversation, Sierra referred to herself as “emo.” I had to look up the word. My online research turned up pages of images of teens

in black clothes with dark hair and makeup, even black nail polish— exactly how Sierra had begun to dress. When I scrolled further, I saw images of cuts on an arm, slashes to a leg.

I began to wonder if Sierra might be cutting, particularly when she stopped wearing shorts and dresses and started wearing pants all the time, even in summer. I bought a book on self-harm and read why young people might choose self-harm as a way of coping with their inner demons, including childhood trauma, depression, the feeling that they don’t fit in and the need to feel in control.

As strange as it sounds, cutting may be the only pain the cutter feels in control of. When the emotional turmoil becomes too much, the cutter “controls” the emotional pain through self-harm. And self-harm behaviour can be easy to hide. Sharp objects can be concealed, and scars can be hidden under clothing. I didn’t confront Sierra about my suspicions then, but I tried to keep a closer eye on her.

At the end of Grade 8, Sierra decided she wanted to move in with her dad. She figured things would be better in a smaller town. She was also curious; she had never lived with her father

and his new partner or her several younger siblings.

While she lived with her dad, Sierra and I talked often and she visited me in the summer. But she seemed to be withdrawing more and more. She told me that her temper scared her. She didn’t know what to do to calm herself; she would go out at night drinking at the lake a few minutes away from the house, get angry and punch things.

In Grade 10, Sierra dropped out of school. Her temper continued to affect her relationships with the adults in her life. Once when she came to visit me, we argued and she became really angry. She was screaming and slamming doors; I was worried that if she left the house, she might not come back. Finally, she yelled, “*Do you want to see my legs?!*”

Without waiting for an answer, she pulled her pants down. On her legs were millions upon millions of tiny little cut scars—even full-out words, quotes. One in particular is burned into my mind: “I hate lies and liars.”

I tried to stay calm and not over-react. I said, “Oh, my baby girl,” and I reached out and pulled her close. I held her tighter than I ever had. She cried in my arms, and I stroked her hair and told her that everything would be okay.

Afterwards, we talked. She told me how long she had been self-harming and how frequently. We talked about why she cut and how dangerous it was. I didn’t freak out, and I didn’t judge her. I just listened. I think I was able to do this because I had prepared

myself for this moment—I had read the right books, I had practised what to say ahead of time.

We also talked about other coping mechanisms she could try when she felt the urge to cut. She began to wear an elastic band on her wrist to snap against her skin when the urge came. We talked about how she could go for a walk when she was upset, leave the room if a conversation upset her.

She refused to see a counsellor. Finding the right services in a small community can be difficult. But after we talked, things slowly started to improve, and she cut less and less.

Sierra is now 23 years old and doing much better. She still self-harms, though rarely, and she isn't as sad as she used to be. But she refuses to talk about the childhood bullying, and she never returned to school.

Sierra still deals with some difficult issues. She has depression and severe social anxiety. She won't go out without me to the grocery store or the bank; she won't even talk on the phone. While she has always been anxious, these problems have become more severe since she quit school. She is now on medication under the care of a physician, but her mental health issues are challenging and improvement is slow.

Despite this, Sierra and I are close, and she's now comfortable talking to me about her feelings. I think my ability to be available to Sierra, to listen to her pain without judgement and without expressing my own fear, has been an important part of her recovery. I will always be proud



Photo credit: ©iStockphoto.com/petekarici

My ability to be available to Sierra, to listen to her pain without judgement and without expressing my own fear, has been an important part of her recovery.

of the beautiful young lady she has become, despite—perhaps because of—her battle. I'm more than ecstatic to be her momma until the ends of the earth and home again.

I'd like to emphasize to other parents how important it is to love your children unconditionally. Educate yourself, try to understand their perspective, empathize with them,

give them hope and accept them for who they are—as a whole package. They will always be your children, whose tiny hands grasped your fingers tightly when they were small, who will walk with you, look up to you and perhaps always expect you to pull them out of danger. We do a lot for our children, but perhaps the most important thing we can do is listen without judgement. ▽

related resource

As a parent of a teen who self-harmed, I found Steven Levenkron's *Cutting: Understanding and Overcoming Self-Mutilation* very helpful.

From Self-Harm to Self-Care

HOW I CAME TO UNDERSTAND THE GAP BETWEEN SELF-HARM AND SUICIDAL IDEATION

Kat Zettler

From 2011 to 2013, I lost track of how many times I pulled myself up off the bathroom floor, post-vomit-session. My weeks consisted of extreme self-criticism, weighing myself after the smallest morsel of food, hiding my meals under napkins at restaurants so that the people I was eating with wouldn't suspect I was restricting my food intake.

Kat is the FamilySmart™ Youth In Residence at Foundry Campbell River, on Vancouver Island. Along with sharing her lived experience, she provides education, peer support, resources and advice to youth and families on navigating the mental health system

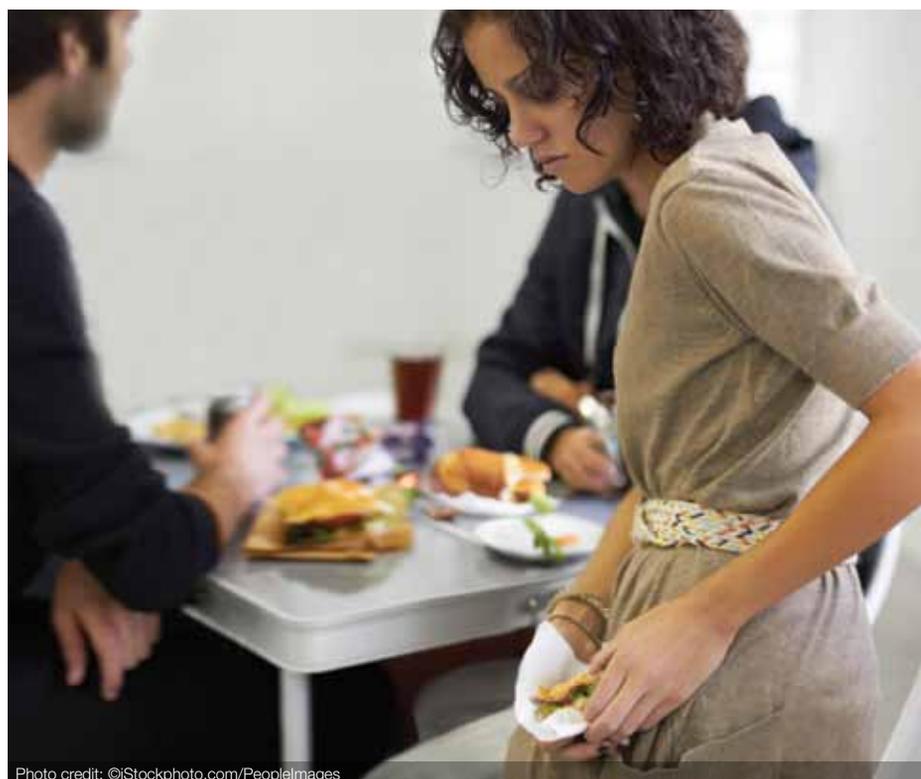


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On some occasions, I'd go so many days without eating that I would wake up physically ill, eventually dry-heaving for hours on end.

After one of these sessions spent with my head against the cool porcelain, I would drag myself in front of the mirror and examine my post-vomit appearance. I would be ashamed and

disgusted at what I'd just put my body through; the reflection in the mirror felt alien to me.

Today, looking back on those years is still painful for me. Although I no longer restrict meals, it's still a work in progress to eat three meals a day, and I still encounter frequent bouts of guilt when I eat. But with years of

recovery behind me, I now understand what led me to engage in self-harming behaviours and to develop an eating disorder.

When I was younger, I would often experience a shaking, head-to-toe sensation that would last for hours on end, making me feel light-headed. My mother can remember me saying, when I was as young as five or six, "I've done something terrible. I have no idea what it is but I should be punished." I remember wondering often, *Why am I shaking so hard? Why do I feel ashamed? There must be something wrong with me.*

Over the years, this feeling escalated, often presenting itself in the most inconvenient of situations. I'd begin shaking so bad that I would drop things and hyperventilate; I would have to excuse myself to the bathroom to "re-centre." Feeling ashamed, powerless and sick to my stomach, I'd have to actually lie down in order to avoid vomiting.

When I was 10, my father died of alcoholism. When I was 13, I disclosed to my mother that I had been repeatedly sexually abused by another family member. In hindsight, I know these events were likely closely related to my childhood anxiety and my eventual decision to self-harm. At the time, however, I didn't connect the dots.

At that point, I frequently showered during bouts of anxiety to calm down. During one shower of panicked breathing and shaking hands, the razor slipped against my skin while I was shaving. The cut was surprisingly deep. As the water washed the blood

away, I was suddenly overwhelmed by a euphoric release: the nausea in my stomach lessened, and the pressure in my chest lifted. Curious and confused, I stood for a moment, wondering what this meant.

And then I made another incision ...

Fast-forward two years, and cutting had become a once-weekly insurance practice to keep the Anxiety Demon at bay. I developed strategies. Cut in the wrong area, and the scabs would be noticeable. Cut too deep, and the scars would be noticeable. Too many cuts? Pick the scabs, or cut into an old wound. Nothing to cut with? I'd slap myself continuously until I achieved the same euphoric rush. But while cutting temporarily freed me from anxiety, in the days following a cutting session, my sense of worthlessness and emptiness would escalate, creating new anxieties that would lead me back to another session.

I was acutely aware that my behaviour was unhealthy. By the time I was 15, I had made several attempts to discuss my self-harm with counsellors and other adults. Each time, I was asked the same question: "Well, are you feeling suicidal?"

Understandably, this is an important question to ask. But unfortunately, as soon as the adult knew I was *not* suicidal, my self-harming behaviour was immediately taken less seriously—or dismissed as a cry for attention.

The irony was that I *was* crying for attention! I had no idea how to cope in a healthy way with my life

experiences. I could not understand why that very real cry for help wasn't being taken seriously!

When I was 16, my best friend died by suicide. When I saw the impact that her suicide had on the community, I vowed I would never make the same choice. But I was still far from healthy. I had run out of places on my body that I could cut and still keep hidden. I was desperate to change my behaviour and yet every time I reached out for support, I was characterized as being melodramatic. I felt unheard and exhausted.

One morning, after I'd been fighting the urge to cut for days, I woke up with anxiety so strong that I couldn't leave my house. I tried to drag myself from my bed into the shower, but I collapsed on the floor, sobbing, overcome with the desire to throw up.

With the simple goal of not feeling ill, I forced myself to vomit. To my surprise, I experienced the same rush of euphoria that I experienced when I cut. The relief was immediate, and a new behavioural pattern was born.

When I cut, relief was fleeting. But with daily meal restriction, I was acutely aware of bodily harm each day. This sense of control gave me *daily* release. If anxiety overwhelmed me, I'd purge until that sense of release soothed my body. Why continue to cut when I could do something that was far less "scarring" and had "better" results?

But with that new sense of control, I really *did* lose control. Within a little over two months I had lost one-third of my body weight. I was hospitalized



Photo credit: ©iStockphoto.com/MundusImages

While the road to recovery has been long and hard, I know I have moved mountains since those nights on the bathroom floor.

and diagnosed with anorexia nervosa. I was immediately referred to several care providers—suffice to say that my eating disorder was not treated as a melodramatic “cry for attention.”

After the diagnosis, navigating the complex mental health system in my small-town community was difficult. Finding the right care provider can be a frustrating course of trial and error. But these challenges are compounded in rural settings. In my hometown, there are few mental health resources. Referral lists can be several months—even years—long. Until recently, the closest youth-care facility was a five-hour drive away.

But while the road to recovery has been long and hard, I know I have moved mountains since those nights on the bathroom floor.

Although I experienced a few particularly low points, I can honestly say I wasn’t ever suicidal. My experience with my father’s death and my best friend’s suicide helped me to see the impact my own death would have had on my community. This prevented me from being at a substantial risk for suicidal ideation.

Ironically, it was *because* I wasn’t at high risk for suicidal ideation that my self-harming behaviour was dismissed for so long. Yet I can’t help

but feel that if I’d been able to access proper supports during those earlier years of self-harm, my experience with anorexia may have been entirely avoidable. If self-harm can be a pre-cursor to suicidal ideation, why do we continue to stigmatize those who self-harm without the wish to die?

Now, at the age of 23, I’m honoured to be working in a new health services building in my hometown—one that provides integrated youth services for youth up to age 24. It feels incredible to work with other youth, to hear their stories and provide support.

I’ve come to accept that there is a huge gap in our understanding of the difference between self-harm and suicidal ideation. As a society, we must work hard to bridge this gap so that those who aren’t suicidal can still receive the supports they need to achieve wellness. I hope that by sharing my story, I can help do that. ▽

Salvation in a Photo

DISILLUSIONMENT, SELF-INJURY AND RECOVERY THROUGH A PHOTOGRAPHER'S LENS

Stephan Pawloski, BSocSc

My story does not begin with a childhood of grief and tragedy, but rather one more akin to a scene from television's famous idyllic town of Mayberry. I was raised by parents who were happily present in their kids' lives.



Stephan Pawloski

Stephan is a nature photographer and husband. When not with camera in hand, he serves as a feline butler and a local volunteer. While still passionate about the social sciences, Stephan spends most days behind the lens. He lives in Langley, BC, with his wife and their 18-pound mask-and-saddle cat, Moose

Life at home was safe and predictable, minus the occasional bad decision on my part—such as the time I built a campfire in my wooden wagon so I could take it to my friend's house for a marshmallow roast. I didn't make it to my friend's house that day; neither did the wagon.

I grew up under the illusion that kids brought up in happy, functional homes would become happy and healthy adults who, upon finishing their university education, started a family in their new house, ideally located within walking distance to

an excellent little café. I suspect that many people with chronic illness can relate to the feeling of watching their perfect life plans dissolve into the painful disillusionment that real life brings.

By my late teens I was experiencing anxiety and I found my last year of university abnormally stressful, but soon I was a graduate of the social sciences, ready to take the world by storm—or at least research the heck out of it while keeping my local coffee house well in the black. I was offered an opportunity working in the federal

criminal justice system, the kind of job where you believe in the inherent societal value of the work.

In retrospect, I should have been more alarmed by my growing levels of anxiety and stress, but I still believed I could work through anything. When I began to falter in the early days of training for the new job, I brushed it off and pushed harder.

As the days and weeks passed, however, I knew I was in trouble. Instead of acclimating to the new environment, I was coming apart under the stress. I honestly felt like I was having a continuous heart attack while my brain was stuck in a frenetic short circuit. I had no idea what was happening; I had never experienced anything so horrifying and disorienting. Later, one of my doctors suggested that I had experienced a psychotic break during this time.

The effects of my anxiety (eventually diagnosed as social anxiety disorder and generalized anxiety disorder) were compounded by this career move to another province—and now, on top of that, I was literally losing my mind.

I believe this was when I first began to self-harm. I don't consider myself a runner—at least not a natural one.

I ran throughout university for exercise and as a stress reliever. But now when I ran it was different. I would run past the point of being sick and push on until it hurt so bad I cringed in pain—and then I would run some more. I'd experienced a "runner's high" often before, but the high wasn't what I was chasing now; it was nothing compared to the psychological whitewash offered by the pain that followed. Not until every part of me from my lungs to my feet felt like it was being poked with hot irons would the noise in my head stop. As long as I kept running, I could think. But I knew I needed to get to a place where I could be still. I wanted to feel human again.

I took stock of my situation. I was in a city where everything felt foreign. Normally this would be the perfect place to start an adventure, but this time everything felt hostile. I had just spent the last five years in university to get here, and now it felt like being here was killing me. With feelings of regret and relief, I resigned from my training position and moved back home to heal.

Upon returning home, I found my footing and started a fine-woodworking business. This slowly but steadily grew into a

good lifestyle. But six years later, I experienced my second psychotic break while wrestling with the stress of what was the highest-profile project my small shop had yet landed.

Something odd happens to me at this stage: I get really quiet and calm on the outside, even though the inside feels like a re-enactment of Passchendaele. I can see now how it is possible for someone to take his own life without anyone knowing it was coming. It's as if the only real warning sign of inner despair is the lack of recognizable warning signs.

I was living in a state of mental anguish, continuously feeling the sort of grief one feels when told that a family member has died. Again, I found myself looking for options—anything other than suicide. I would tell myself, "Suicide is always there, it's not a limited-time offer, so try something else first."

And so, without seeming to make any sort of conscious decision, I found myself cutting—eventually cutting over 200 times before seeking help. I became really good at cleanly gluing together my wounds, and I would explain away the red lines as some sort of feline intervention gone wrong.

I lost a lot after that second psychotic break. I had to shut down my business, and the wealth I had worked to build evaporated in the two years of recovery that followed. But with the love of family and friends comes help and support. I was never shamed by friends or loved ones for self-injuring. I only felt their respect and positive affirmation.

know a lot of people working in mental health or addictions in Central or Northern BC?

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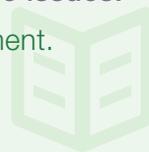




Photo credit: ©iStockphoto.com/Narathip12

Photography grew beyond being a distraction. It became a process of mindfulness. The camera was a catalyst for healing.

I was two months into a nine-month waitlist to see a psychiatrist when I found the Mood Disorders Association of BC. In a matter of weeks, the association had me in for assessment and I was diagnosed with bipolar disorder 2—a diagnosis that made sense of the whole picture. On one hand, the diagnosis was frightening: my perception at the time of what bipolar disorder is and what it entails was grim. Yet I also experienced a sense of relief. Now I knew what I had been coping with for the past eight years.

In the midst of this chaos, I kept picking up my camera and photographing the outdoors.

What had always been a casual hobby was growing into a healthy distraction, even a lifeline. Making a good photograph requires the photographer to be present in the moment and to fully engage with the environment. You can't just think about filling the frame with your subject. You have to consider the foreground, the background, the composition and the lines you want the eye to follow. You need to see in terms of light and shape, and when handholding a telephoto lens under the muted light of a forest canopy, you must control your breathing and fine muscle movements. If you want to consistently take good photos, you have to work for it.

As I spent more time outdoors with a camera in hand, I cut less. The urge was still present, but now I had a healthier outlet. At the time, I thought photography was just a way to keep myself busy, but I can see now that photography grew beyond being a distraction. It became a process of mindfulness. The camera was a catalyst for healing.

It's been a couple of years since I last cut as a way to cope with the mental anguish associated with bipolar disorder. It's naive to believe the romanticized depiction of mental illness being a gift in disguise, but that doesn't mean that there aren't positives to be found in the daily challenges it brings. As I continue to share my story with others, many have confided in me their own struggles with mental illness. Often these people break the stereotypes that society has of the mentally ill: they are successful professionals in their field or have dedicated their life to raising an incredible family, living outwardly enviable lives. In essence, they have become masters at editing the photo album that is their life, carefully choosing which photographs of their life to display and which ones are never developed.

As it turns out, this was the recipe for Mayberry all along, hand-picking the idyllic shots and never showing anyone the mess of crops lying on the floor. But as it also turns out, walking with mental illness has taught me that truly living is being willing to experience and share with others an authentic and unbridled life, including the less-than-picture-perfect moments that are lived in the cropped margins. ▾

Working with Ayla

A SCHOOL COUNSELLOR'S STORY ABOUT STUDENT SELF-INJURY AND RECOVERY

Nicole Paley, BEd, MA, RCC

I work as an elementary school counsellor for the Vancouver School Board (VSB). Not so long ago, I was a secondary school counsellor for the VSB. In that rewarding position, I was fortunate to meet and work with Ayla* while she navigated her early years of high school.

Nicole is a school counsellor and a registered clinical counsellor in Vancouver, BC. She believes that creativity and movement are important components of well-being. Currently, Nicole is playing with the uncertainty and complexity of life with more fierceness than fear, enjoying lightheartedness and humour and continuing her practice of self-compassion

**pseudonym*

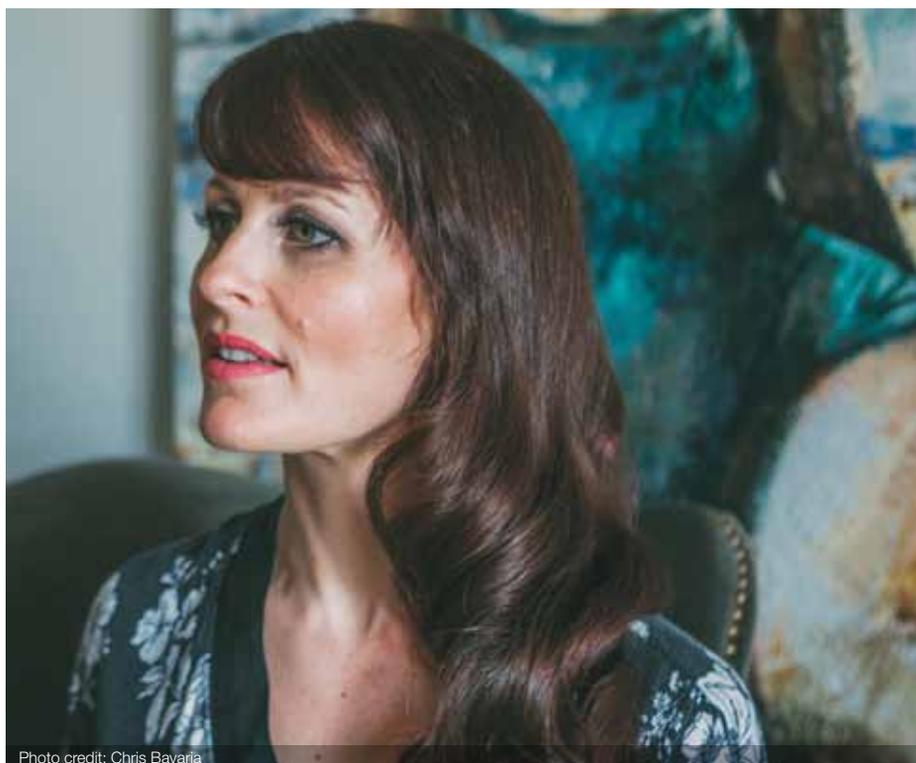


Photo credit: Chris Bavaria

Nicole contemplating what brings the most emotional nourishment for her student-clients

As a school counsellor, I provide individual, family and group counselling to young people who are dealing with a wide range of mental health matters, including mood issues, anxiety and stress, body and self-image concerns, and social and family problems. Fortunately, self-injuring is rare in my school counselling practice. But in more than 10 years as a counsellor, I have worked with many students who were self-injuring.

Depending on the severity and the intention of the self-harm, I sometimes refer students to a Child and Adolescent Response Team (CART) counsellor. CART specializes in providing care to young people who are self-harming and could be at risk to themselves. I have also had the good fortune of being able to consult with adept counselling colleagues on a case-by-case basis. As a therapist, I always feel privileged to be able

to work with the individual to heal and to establish healthier coping strategies. Ayla and I worked together to do just that.

Ayla and I met when she was in Grade 8. At first our connection was practical: as her school counsellor, I helped her establish her course schedule and we chatted lightly about unimportant things. But in Grade 9, Ayla decided to share her struggles with me, and to seek my help for her mental and emotional anguish and her self-injuring.

If you saw Ayla in class, hanging out with her friends at lunch or after school, or out and about in the city, you would likely believe that she was a free-spirited type who approached day-to-day life with enthusiasm, bright eyes and an open heart. On paper, she excelled in school. She had a bevy of pals around her, and she had a stable and successful family life (a high-achieving older brother, caring and hard-working parents, a beautiful home). She played on a number of sports teams and was kind and polite to people of all ages.

Behind closed doors, though, and in the privacy of her own mind, Ayla suffered. What the outside world, including her family, couldn't see was that Ayla found life overwhelming, anxiety-producing and sometimes quite dark. She worried incessantly about how others saw her: Was she interesting? Was she funny? Was she too much or not enough for others? Was she ... weird? And how could she keep up her straight-A average and her rigid, no-room-for-error study schedule? On top of all of that, Ayla worried about how she could be more

beautiful—and by more beautiful, she meant skinnier.

All of this worrying left little time for joy or relaxation. When she achieved a good grade, got a compliment from a friend or saw a lower number on the scale, her feeling of happiness lasted only a millisecond before she was back on the twisted and confounding path of worry.

The only way Ayla found relief was by cutting her arms or throwing up what little food was left in her system. The pain she experienced during these acts gave her a momentary feeling of relief. She also felt on some level that she deserved the pain, telling herself, "I am not a good person and I don't deserve happiness."

Through her Grade 9 and Grade 10 years, Ayla and I met regularly for therapy sessions. Our therapeutic relationship started off warmly and softly. My intention, as it is with all of my clients, was to create a safe and supportive atmosphere for her to feel free to share the thoughts and feelings that were hard for her to live with. I talked about my office and our relationship as being like a diary where, hopefully, she could share anything she needed to get out. By encouraging her to release the difficult stuff, and providing her with compassionate responses and suggestions for emotional wellness, my hope was that Ayla could start experiencing herself and her life in an empowered, gentle and healthy way.

Through our counselling sessions, we discussed how she could develop healthy ways to cope with the harsh human realities she was facing, such

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By encouraging her to release the difficult stuff, and providing her with compassionate responses and suggestions for emotional wellness, my hope was that Ayla could start experiencing herself and her life in an empowered, gentle and healthy way.

as her perfectionism, her anxiety and her self-criticism. We would talk about the battle in her mind—between her rooting-for-health self and the part of her that felt darker and weaker. We spoke about how one can't eliminate feelings, but one can work lovingly and patiently to manage challenging feelings and thoughts in ways that make one feel strong and safe in the world.

We also used many creative activities that explored how Ayla could live more from her healthy, strong self while having empathy for the darker parts of her mind. I would also assign her counselling homework, like writing a daily log of all of the moments throughout the day that she felt peaceful, relaxed or happy. I asked her to make a note of what was going on at the time, and what she thought contributed to her positive feelings. I also assigned Ayla some books to read at home about body-image and self-compassion and then to report back to me the parts of the books that really resonated with her.

By the end of Grade 10, Ayla had stopped using cutting and purging to feel better when she felt overwhelmed or when anxiety or sadness kicked in. She found new, healthier ways of

caring for herself during those rough moments. For example, instead of rushing off to the washroom to self-injure or purge, Ayla would choose instead to go for a walk in nature or listen to music. She also discovered that she could use her sensitivity and empathy to be “the counsellor” for her friends, a skill that made her feel strong and confident and useful. Through our therapy sessions and her own reflections, she learned how to experience her difficult negative emotions without running away from them or feeling consumed by them. She learned it was okay to be an emotional person, even an anxious one or an imperfect one, without hating herself or feeling she had to present a false happiness to the outside world.

I can relate to Ayla. When I was in my young teenage years, I had an eating disorder that stemmed from being highly sensitive and not having the right skills (as many don't!) to cope in a healthy way with difficult thoughts and overwhelming emotions. By the time I was an adult, I had become passionate about my own overall health—I believe our mental, emotional, physical and spiritual health are all interconnected—and about helping others with theirs. I

am grateful to have been a witness to Ayla on her journey of developing greater self-knowledge and, over time, a deep desire to choose self-compassion and take loving care of her precious being.

Psychological issues usually arise from a complex set of factors. In Ayla's case, I believe what she needed most was a space for all of her feelings and thoughts to breathe, to be heard, to be validated and tended to in a way that made her feel comforted—and from this, to begin developing greater self-knowledge. She also needed to trust her inner voice when it encouraged her to make healthy and empowering choices, while having empathy for that part of her that wanted to be self-destructive.

While Ayla responded to this sort of therapy, other youth who are self-harming may benefit from attending therapy groups with other young people who face similar issues, reading about the subject matter or accessing online resources. A particularly good online mental health resource for young people is www.keltymentalhealth.ca.

If you are concerned that a young person in your life is self-harming, please encourage the individual to talk to his or her school counsellor, or help the youth get in touch with a counsellor online at www.youthinbc.com. ▼

Starting to SHARE

My self-harm wasn't frequent in my early teens, but due to a variety of factors, I experienced an extended period of increased use and dependency during my first few years of study at the University of British Columbia.

It was always a struggle to find proper support, especially in the beginning stages of my recovery. I sought help from mental health professionals, but at the time, their understanding of self-harm was inadequate. For example, when I disclosed that I had self-harmed prior to our appointment, one psychiatrist asked me, "Can't you just stop?" I thought to myself, *If I could have stopped, I would have stopped, and I wouldn't be seeing you.*

Though there was some online peer support, in-person peer support for self-harm was non-existent in Vancouver at the time. While there were groups like Alcoholics Anonymous and Narcotics Anonymous—even Sex Addicts Anonymous—there was no similar group for people who self-harm. I felt dejected and had no one to relate to.

One sleepless night in March 2013, particularly fed up with the lack of in-person peer support, I decided it was time to do something about it. Soon after, I started to share my experiences with those around me. As I did so, I realized that I was not the only one who self-harmed and not the only one who noticed the lack of support.

And so, one rainy afternoon, my friend Natasha and I tucked ourselves into a corner booth at Prado Café on

Commercial Drive and began our first planning meeting to establish SHARE, a support group for people who self-harm. Natasha, whom I had met in a third-year psychology class, also struggled with self-harm and shared many of my frustrations. Accompanied by the intoxicating aroma of roast coffee and the low chatter of the other customers in the background, we delved into passionate discussion.

The idea of SHARE, or Self-Harm Anonymous Recovery and Education, was born out of the need to create a space for people to share their experiences and knowledge so that others who are struggling can find the support that we couldn't find when we needed it. In addition to providing support, SHARE aims to educate the wider community about self-harm, promote the importance of self-care and prevent people from turning to self-harm in the first place.

Defining and preventing self-harm

At SHARE, we employ a broad definition of self-harm. Instead of restricting the definition to self-inflicted body tissue injury, we include behaviours such as substance use, binge eating, risky sex, risky driving and other activities.

Having struggled with self-harm and its consequences (in my case, habitual dependency on self-injury and the secondary problem of visible scars), I don't want anyone to have to walk the same road. If I could have prevented harming myself in the first place, if I had other tools at my disposal, I would have chosen another option.

While we can't change the past, we can change the future. With our support

group meetings, SHARE aims to help whoever comes to us for support and to prevent people from further harming themselves. We hope to expand our education component to reach more teens and young adults and to teach productive coping and stress management skills in order to minimize the risk of an individual turning to self-harm.

Why SHARE with peers?

There are many benefits to peer support. Since SHARE uses a lot of the same training as The Kaleidoscope, a peer-led mental health support group, members of both groups got together and brainstormed some of the benefits we see from participating in a support group, both as attendees and as facilitators.

One of the key features of a peer-led support group is that it's not top-down care. Rather than receiving support and care from an "expert," we receive and share support with one another as equals. In this setting, there are fewer power dynamics at play. Some peers take on a facilitator role, but their task is to keep the group focused (in terms of time spent on a topic and the content of discussions, for example) and create a safe space for all—not to act as an authority or professional figure.

Many peer support groups encourage people to speak from their own experiences and leave out any advice-giving. This helps to ensure that people who seek peer support feel heard and do not feel intimidated. We have found that people are more likely to listen to a peer than to an authority figure who doesn't have similar experiences. Peer support can help instill a sense

of confidence and empowerment, and can reduce self-stigma for all those involved.¹

Community awareness and self-care

SHARE is promoted through social media channels, through UBC's wellness resources and services and by word of mouth. We also host information booths at university events. At the end of our group meetings, which welcome anyone who self-harms as well as friends and family of those who self-harm, SHARE always tries to wrap up with an educational component, which usually depends on what has been discussed during check-in. For example, we've brainstormed self-care activities, discussed how to incorporate harm reduction in our lives, come up with a list of distraction techniques and devised individualized coping strategies.

Throughout the school year, we host two to four workshops about self-harm for the UBC community. Our intention is to increase awareness and understanding and to promote the importance of self-care. Self-care doesn't have to be something big or effortful; the little things that we do for ourselves, often even without our full awareness of them, are great examples of self-care. We don't always have to make a point of going to the gym or eating a healthy salad or practising progressive muscle relaxation. Simply shutting our eyes and resting for a few seconds or reading something we enjoy or taking in the trees and the sounds of nature as we walk to work are all great examples of self-care.

The importance of the self-hug

The SHARE logo is a visual

Self-care doesn't have to be something big or effortful; the little things that we do for ourselves, often even without our full awareness of them, are great examples of self-care.



representation of many of the key principles of the group. The image (left) is a stylized representation of an individual hugging themselves. The entwined arms form an "S" at the centre of the logo, symbolic of self-compassion, self-care, strength and SHARE. The idea behind the logo is that an act of self-compassion—the self-hug—serves to counter an act of self-harm. Turn the logo upside down and you will see the image of a fist, symbolizing the strength that we all have inside of ourselves but which is often unacknowledged and which we have to take that extra step to see.

A SHARE in our future

Self-harm no longer controls my day-to-day life. I've learned healthier coping skills, and I've learned to prioritize self-care. This doesn't mean I don't have days when self-harm urges re-emerge, and sometimes I have lapses, but I have a better understanding of how to use stress reduction and self-soothing techniques before it gets to that point.

It was a lonely road to face by myself. Today, people who self-harm have more supports. If you are in the Vancouver area, contact SHARE and drop in to one of our peer-led support meetings. If you aren't in the Vancouver area, you can still

check out our website for helpful information and resources.

If you aren't ready for in-person support, or don't have access to it, there are many other resources available, including the Kids Help Phone (their website, phone line and online chat), YouthinBC and YouthSpace. Facebook groups can be helpful, as long as they have a solid community agreement and a set of group guidelines that you feel comfortable with. The website of the non-profit Self-injury Outreach & Support has a lot of information as well, including tips on how to cope with urges, guides for loved ones, school staff and health care professionals, and personal narratives about self-injury.

We hope that SHARE continues to be a leader in self-harm peer support. For more information, go to the SHARE website at www.vivreshare.org, or email us at info@vivreshare.org. ▽

You Can't Know If You Don't Ask

HOW TO ASSESS NONSUICIDAL SELF-INJURY

Sarah E. Victor, PhD

Many teens who self-injure do not get the help they need, even when they reach out to others. A recent study of high school students found that 83% of self-injuring teens asked for help for an emotional or behavioural problem, but only 59% told someone about their self-injury, and less than 10% talked about self-injury with an adult.¹

Sarah studied clinical psychology at the University of British Columbia and is now a postdoctoral scholar at the University of Pittsburgh School of Medicine. Her research and clinical work focuses on understanding nonsuicidal self-injury, suicidal behaviours and the relationship between the two, particularly in adolescence and young adulthood



Photo credit: ©Stockphoto.com/ClarkandCompany

This means that no news is *not* good news when it comes to a youth who may be struggling! If you're worried that a teen or young adult in your life may be self-injuring, the best thing to do is *ask* him or her directly.

Some people worry that asking about self-injury will "make" people start self-injuring. Thankfully, research shows that asking about self-injury doesn't cause an individual to self-injure, nor does it make an existing situation worse.^{2,3} The same is true when it comes to talking about

suicidal thoughts and actions: *asking* about a possible behaviour doesn't cause someone to *engage* in the behaviour.⁴

But how can you start a conversation with someone about such a difficult topic? You might feel awkward, uneasy or nervous about having this kind of discussion. That's normal. This article outlines some important things to think about when discussing self-injury, as well as providing some tips that might help make the conversation go more smoothly.

When and where to have the conversation

Self-injury is often associated with uncomfortable emotions, like shame and guilt.⁵ Because of this, it's important to ask about self-injury in a way that makes the person feel comfortable instead of making the individual feel more ashamed or guilty. Ask about self-injury in private, away from other people. Make sure you have plenty of time, and avoid discussing the topic at a time when one or the other of you is already upset.

How to start the conversation

Before you start asking questions, tell the person that you've noticed that he or she is having a hard time, that you care and that you want to help. For example, you might say, "I've noticed that you've been really down the last few times we've met, and I'm concerned. Can we talk about how you've been doing?" If the person seems nervous, you might even say, "I know it can be tough to talk about these things, but I think it's important enough that we should talk anyway, even if it's awkward."

What questions you should ask first

It's important to be clear and direct. Avoid using generic phrases like "hurting yourself," because these can mean different things to different people. You could start with something like "Sometimes when people are struggling, they do things like cutting or burning themselves, not as a way to die, but to try to feel better or to get help from other people. Have you ever done anything like that?"

Then, if the person is self-injuring, there are lots of different aspects of the self-injury that you may want to

It's important to ask about self-injury in a way that makes the person feel comfortable instead of making the individual feel more ashamed or guilty.

ask about. For starters, it's important to know the severity of the self-injury, and the motivation (or function) of the self-injury.

How to ask about severity

Knowing the severity of someone's self-injury will help you to help the person stay physically safe. Most self-injury causes minimal physical harm, but some self-injury can cause major health problems or even accidental death. Here are some good questions to ask:

- *What specific methods of self-injury have you used?*
- *How often have you been self-injuring?*
- *Have you ever needed medical attention for self-injury?*
- *Have you ever thought you needed medical care for self-injury, but didn't get it?*
- *Have you had thoughts about other kinds of self-injury methods? If so, which ones?*

These questions can help you understand whether the self-injury may be medically dangerous. If you're not sure, you can always refer the person to a physician or the nearest emergency room for more assessment. We know that those who self-injure are more likely to report a suicide attempt.⁶ Even if the person is not currently in need of medical attention, it is important to know about self-

injury severity because people who self-injure are more likely to also experience suicidal thoughts and behaviours, and self-injuring more often or with more methods of self-injury can be related to a greater risk of suicide attempts.

How to ask about motivation

We all have reasons for doing the things we do. This is true for self-injury, too. Even if others can't understand the person's reasoning, everyone who self-injures does so because it seems like the best option at the time—even if it causes problems later. Knowing why someone self-injures will help you understand and support the person. Your knowledge may also help mental health professionals provide the best care possible.

People usually self-injure for two types of reasons: they wish to change something within themselves (most common), or they wish to change something about their relationship with another person (less common).⁷ Most people who self-injure say that self-injury helps them feel less sad, scared or angry immediately afterward, even though they may continue to have those feelings (or worse feelings) later. Many describe self-injury as a way to punish themselves. Less often, people use self-injury as a way to reach out to

others for help, or to avoid interacting with other people.⁸ Here are some good questions to ask:

- *What usually happens right before you self-injure?*
- *How do you feel before you self-injure? How do you feel right after?*
- *What does self-injury do for you?*
- *What about your self-injury is helpful to you? What isn't as helpful?*
- *Do you want to stop self-injuring? Why (or why not)?*

These questions let the person know that you care, and that you won't dismiss the self-injury as "attention-seeking" or "irrational." Knowing what self-injury means to someone is the first step to helping him or her find other coping strategies to use instead.

Where to go from here

Once you've talked to someone about self-injury, what's the next step? Here are a few options to consider:

- Let the person know there's help available 24/7 if he or she is struggling. In British Columbia, the Crisis Centre offers phone and chat counselling specifically for youth; you can find information about the centre at crisiscentre.bc.ca.
- Develop a safety plan. What can the person do instead of self-injuring? Who can the person call or text? What else could help when he or she is upset? Some ideas for coping with self-injury urges can be found at sioutreach.org.
- Find a school counsellor, physician, therapist, psychologist or another professional who can help. In British Columbia, you can call 811 to get free, non-emergency health

information, including information about mental health concerns.

Asking someone about self-injury can feel intimidating and distressing, but it can also be a very important step to getting someone the help they

need. By being respectful, genuine and compassionate, you can provide support and resources to someone who might otherwise feel alone and hopeless. For more information about assessing self-injury, see the sidebar below. ▾

where can I learn more about self-injury assessment?

Depending on the setting, your training and other factors, you may want to use a more structured method to ask about self-injury in more detail. Here are a few useful assessment tools:

- **Inventory of Statements About Self-Injury**
This questionnaire asks about self-injury methods and motivations or functions for self-injury. It is very brief and frequently used, although it does not cover some aspects of self-injury, such as medical severity. You can find the questionnaire at www2.psych.ubc.ca/~klonsky/publications/ISASmeasure.pdf.
- **Ottawa Self-Injury Inventory**
This questionnaire asks about self-injury methods, motivations and characteristics. It is very thorough and includes many items, but it does take longer to complete than others. You can find this questionnaire at www.insync-group.ca/publications/OSI-2015-English-v3.1.pdf.
- **Self-Injurious Thoughts and Behaviors Interview**
This interview asks about nonsuicidal self-injury and suicidal thoughts and behaviours. It gives the user information about different kinds of self-injury, both suicidal and nonsuicidal, but does require that someone ask questions in an interview format rather than allowing the interviewee to self-report. You can find the interview at projects.iq.harvard.edu/files/nocklab/files/sitbi_longform.doc.
- **Nonsuicidal Self-Injury Disorder Scale**
This questionnaire is meant to go along with other measures of self-injury methods, to assess whether the person meets diagnostic criteria for Nonsuicidal Self-Injury Disorder in the DSM-5. You can find the questionnaire at www2.psych.ubc.ca/~klonsky/publications/NSSIDS_measure.pdf.

Opening the Gate to Suicide Prevention

TELL, ASK, LISTEN, KEEP SAFE

Dammy Damstrom-Albach, MA, MSW

The Canadian Mental Health Association (CMHA) BC Division recently received a grant from the BC Ministry of Health to bring suicide prevention training to communities throughout the province.



Photo credit: ©iStockphoto.com/martin-dm

Dammy manages CMHA's Community Gatekeeper Training Project. She is a therapist, former manager of SAFER (Suicide Attempt Follow-up Education & Research), past President of the Canadian Association for Suicide Prevention, and co-author of Strengthening the Safety Net: Report on the Suicide Prevention, Intervention, Postvention Initiative for BC

In collaboration with the BC Crisis Line Network, the First Nations Health Authority and other community organizations, the CMHA's Community Gatekeeper Training Project intends to train 20,000 British Columbians in basic suicide prevention. That includes knowing what to look for to determine if a person is thinking about suicide, learning how to ask the person directly about this and knowing what to do if the person is indeed at risk of taking his or her own life.

But wait a minute, you say: What does suicide and suicide prevention have to do with self-injury?

It's a good question. Self-injury is usually not about suicide at all. Instead, it is a way to deal with painful or challenging feelings. But it is not always possible to know the purpose of someone's behaviour without first talking with the individual about this, taking time to listen and understand the reasons and intention behind the person's actions.

What if an individual is engaged in self-injury but not thinking about suicide? Will discussing suicide lead the person to think about suicide or cause the individual to be offended?

Most of the time, self-injury functions as a coping mechanism—albeit a maladaptive one. But we know that sometimes the psychological struggle or emotional pain that led to an individual’s use of self-injury may also lead him or her to see suicide as an option, especially if for some reason self-injury no longer works to alleviate the individual’s distress, or if the distress increases in severity.^{1,2}

The practice of self-injury may over time serve to habituate the individual to acting in ways that are self-destructive, enabling him or her to more easily engage in increasingly dangerous behaviour. In some cases (certainly in the case of cutting, one of the most common forms of self-injury), self-injury itself can cause severe or even lethal damage, even if that was not the intended outcome.

There may also be a good deal of shame, secrecy and self-isolation associated with self-injury. Not only can this add to the emotional pain a person carries but it also makes it more difficult for the individual to reach out for help if problems multiply. Feeling alone, ashamed, hopeless and helpless are states often associated with suicidality.

In fact, young people with a history of nonsuicidal self-injury (NSSI) are

nine times more likely to report suicide attempts of their own and six times more likely to report a suicide plan for themselves.³ From this, we can assume that someone who self-injures might be thinking about suicide in one way or another. The only way to find out for sure is to ask. This is where suicide prevention training comes in. It helps us become more comfortable with knowing what to look for that might indicate someone is at risk, how to ask directly and specifically about suicide and what to do if we discover that the individual is indeed thinking of suicide as a possibility.

The half-day safeTALK workshop developed by LivingWorks Education is currently being delivered throughout BC as part of the Community Gatekeeper Training Project. It teaches participants to use four simple steps to talk with someone about suicide: tell, ask, listen and keep safe.

Briefly, if we are thinking about suicide as a way out of our own pain or turmoil, we need to **tell** someone. If we are concerned that someone else may be thinking about suicide, we need to **ask** the individual about it, clearly and directly, so that he or she can tell us. We then need to **listen** carefully, long enough to learn

more about what the person is going through. Then, if the person is indeed thinking about suicide and based on what we’ve learned, we need to help the individual find supports and resources to **keep safe** for now.

What if an individual is engaged in self-injury but not thinking about suicide? Will discussing suicide lead the person to think about suicide or cause the individual to be offended?

Experts agree that discussing suicide with an individual does not suddenly open up the individual’s mind to the previously unconsidered possibility of suicide as an option.⁴ Instead, discussing the matter shows the individual that you care enough to notice their distress and ask about it. Beginning this dialogue can lead to the possibility of help.

On the off-chance the individual is offended by your questions, you can respond by assuring the person that your questions come from a place of care and concern. You might even take the opportunity to talk about what the individual *could* do if things ever got so bad that suicide seemed like a possibility. It will still be important to provide a compassionate listening ear and to provide resources (particularly if we know the individual is engaging in NSSI), and to let the individual know that if he or she starts thinking about suicide, help is available. A good first step can be the province-wide 24/7 helpline 1-800-SUICIDE (1-800-784-2433), a family physician, a walk-in clinic or a local mental health resource.

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Cutting Through the Urge

OVERCOMING SELF-INJURY

Stephen P. Lewis, PhD, and Nancy L. Heath, PhD

Self-injury is a significant mental health concern facing today's youth and young adults. As many as one in five young people will report having self-injured at some point in their lives; many do so on more than one occasion.¹



Stephen is an associate professor in the Psychology Department at the University of Guelph and an international expert in self-injury. In 2015, he shared his lived experience with self-injury in a TEDx Talk (see youtu.be/G17iMOw0ar8). He is co-founder of Self-injury Outreach and Support (SiOS) and current President of the International Society for the Study of Self-Injury

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Individuals who struggle with self-injury say they also experience anxiety, depression, eating disorders and other mental health difficulties.¹ This may help to explain why most youth and young adults who self-injure say they do so to help cope with difficult emotions such as sadness, distress and anger. In fact, this is the most common reason for self-injury.^{2,3} There are other reasons for self-injury, however. For example, some young people self-injure to express anger towards themselves or to communicate something to others, such as their need for help.

Although self-injury can be a very difficult experience, it is important to keep in mind that recovery is possible. Overcoming self-injury involves many things, particularly learning how to cope with urges to self-injure. There are various strategies that can help with this. One thing we know is that not all strategies work for everyone. In other words, what may work well for one individual who self-injures may not work well for another person. This is why it is important to recognize that there are many strategies, and that it may take time to find the strategies that work best.

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We have aimed this article at those who struggle with self-injury. But we also provide information for those who care about them. Below, we describe a few possible strategies that may help you to cope with self-injury urges. At the end of the article, we provide more information and resources to access other strategies.

Following the 15-minute rule

One strategy that you might find helpful is to follow “the 15-minute rule.” This strategy involves trying to resist an urge to self-injure by not acting on it immediately but instead allowing 15 minutes to pass. You can even keep track of the time with a watch or clock (the timer on your phone, for example). This strategy may sound odd at first, but it can be quite helpful. By waiting 15 minutes, you may find that the urge to self-injure decreases over time. During the 15 minutes, you may also find it helpful to use some of the other strategies we describe below. Combining strategies in this way can be more effective.

Riding the wave

Another strategy that can help is to “ride the wave.” When you experience an urge to self-injure, it can be helpful to learn how the urge starts and how the intensity of the urge can change over time—just like a wave. Like any wave, the urge may start out small. Over time, the urge

may get stronger. If you can learn to picture yourself “riding the wave” (or even surfing it), you may find that you can “ride out” the urge as it increases, peaks and then gradually weakens and disappears.

This kind of exercise can be helpful for two reasons. First, it allows you to realize that you can have an urge and not act on it. Second, it can help you understand what might lead to an urge and at what point an urge begins. This can help you to identify ways to cope—both when the urge starts and before it becomes stronger.

Getting active

Doing something active can also help you deal with self-injury urges. Specifically, if you feel an urge to self-injure, you might find it helpful to do some kind of physical exercise. Any kind of physical exercise will do: running, jumping, climbing stairs, cycling, dancing, fast push-ups—the list goes on! What’s important is to make sure the activity is intense and that it lasts until the urge has passed.

You might find it helpful to do some kind of creative activity. This could involve playing a musical instrument, singing, sketching, painting, writing or sculpting something with clay, among other things. Creative activities can help you express some of the intense emotions that go along with self-injury while at the same

time distracting you from the urge to self-injure.

Reaching out

Talking about self-injury is difficult for many people. But while it can be hard to reach out to someone and find social support when you’re having an urge, it can be helpful.

Luckily, there are a few ways you can do this. First, you can share your current urge with someone and talk about what you’re experiencing and how to not act on it. This approach may be difficult, though, if you have not already told that person about your self-injuring. If this is the case, you could reach out to someone and just talk about your feelings generally, without discussing your urge to self-injure.

If you find it too difficult to share your urges or your feelings generally, it can still help to talk to someone and distract yourself from the urge. The conversation can really be about anything, but it should last until the urge goes away. In all cases, it can help to have a list of people you can call (or text). This way, you can contact someone else on your list if the first (or second) person is not available.

Finally, if you find yourself unable to call or text anyone you know, you can go online. For instance, you can see if a friend or relative is available to chat on Facebook. You might try calling a helpline in your area, such as the Kids Help Phone (1-800-668-6868 or kidshelpphone.ca) or a local distress line.

These strategies are just some of the ways that people learn to cope with

urges to self-injure. To learn about other strategies to cope with urges and difficult emotions that often go along with self-injury, we encourage you to access our mobile-friendly website at Self-injury Outreach & Support, www.sioutreach.org. In addition to offering different coping strategies, we collect and share recovery stories and words of inspiration from others who have struggled with self-injury. Sometimes reading about others who

have overcome self-injury can be very helpful.

The SiOS site also has social media content. You can read about self-injury and mental health topics and get regular updates. In addition, the website has information for those who play a supportive role in helping people who self-injure, providing guidance for friends, romantic partners, families, schools

and medical and mental health professionals.

Remember, recovery is possible. ▼

self-injury outreach & support

- Visit www.sioutreach.org
- Follow “sioutreach” on Twitter, Facebook or Youtube

OPENING THE GATE TO SUICIDE PREVENTION—CONTINUED FROM PAGE 36

In addition to safeTALK, the Community Gatekeeper Training Project also offers Applied Suicide Intervention Skills Training (ASIST). ASIST is a two-day interactive workshop in suicide first aid. It provides a more in-depth look at suicide prevention, including how to develop a collaborative plan to help someone keep safe and how to use brief intervention as a way to ensure an individual’s immediate safety until longer-term options for well-being can be established. Brief intervention might include collaboration to reduce or limit the individual’s access to lethal means, encouraging the individual to agree to limit or not use alcohol and other de-inhibitors in the short term, and ensuring that the individual is not alone until the immediate crisis passes or alternative supports and resources are put in place.

In 2015, 614 British Columbians died by suicide.⁵ Each death devastated the lives of many more—spouses and lovers, family members, friends, colleagues, teachers, coaches,

helpers. These deaths are particularly tragic because suicide is for the most part preventable.

Suicide prevention is everybody’s business. Anyone can learn how to help another individual, whether it is someone close or a stranger who may be at risk. If you want to participate in a workshop or help bring a workshop to your community or workplace, contact one of our five regional coordinators for the Community Gatekeeper Training Project. Regional coordinators can help plan and organize a workshop for your community, workplace or organization, and can advise you of public trainings you could attend in your area.

- Vancouver Island: Judy North at judy.north@cmha.bc.ca

- Lower Mainland: Steve Baik at steve.baik@cmha.bc.ca
- Interior: Shannon Hecker at shannon.hecker@cmha.bc.ca
- North: Devon Flynn at devonflynn@cmhapg.ca
- Kootenays: Lyle Stuart at lstuart@cmhakootenays.org

As the provincial manager for the Community Gatekeeper Training Project, I am always very pleased to answer questions and talk with people about how they can help build suicide-safer communities throughout our province. You can reach me at dammy.albach@cmha.bc.ca or 604-688-3234 (or toll-free at 1-800-555-8222), local 2714.

To learn more, see www.cmha.bc.ca/communitygatekeeper. ▼

related resource

For more information on self-injury and recovery, see the Cornell Research Program on Self-Injury and Recovery at www.selfinjury.bctr.cornell.edu.

resources

Self-Injury Outreach & Support (SiOS)

www.sioutreach.org

SiOS offers information for people who experience self-injury as well as parents, partners, school professionals, mental health professionals, and medical professionals. Learn more about self-injury, find coping strategies, explore research, and see where you can do for help.

Self-Harm and Suicide: A suicide prevention toolkit

www.suicideinfo.ca/wp-content/uploads/2016/10/Self-Harm-Toolkit.pdf

This toolkit from the Centre for Suicide Prevention discusses self-injury, the differences between self-injury and suicide attempts, and what to do if you are concerned about a loved one.

Self-Injury and Recovery Research and Resources

www.selfinjury.bctr.cornell.edu

The Cornell Research Program on Self-Injury and Recovery offers information and resources on self-injury, including a course for parents of young people who self-injure.

Self-Harm info sheet

www.heretohelp.bc.ca/factsheet/self-harm

Learn what self-injury can look like, who it affects, and where to go for help in BC.

Pinwheel Education Series: Self-Harm & Healthy Coping Tools

www.keltymentalhealth.ca/r/pinwheel-education-series-recording-self-harm-healthy-coping-tools

This is a recording of the Self-Harm & Healthy Coping Tools education session from Kelty Mental Health Resource Centre, which discusses self-injury, coping strategies, and different treatment options.

in the know: Self-Harm in Young People

mediasite.phsa.ca/Mediasite/Showcase/itk

This recording of an *in the know* education session helps parents and caregivers understand self-injury in young people, respond in supportive and helpful ways, set realistic expectations, and seek help.

 This list is not comprehensive and does not necessarily imply endorsement of all the content available in these resources.

have more questions about supporting someone around self-injury?
join an upcoming Q&A in early November!



Some of our Visions contributor experts will be available for a discussion panel on twitter, a tweet chat. The tweet chat will take place in early November.

Follow us now on Twitter at @HeretoHelpBC to find out the day, time, and hashtag.



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