# SELF-HARM ISSUES

Dan Hughes

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# Contents

## Note about the author

For most of his professional life, **Dr Dan Hughes** has been a clinician specialising in the treatment of children and young people with severe emotional and behavioural problems. Working primarily with fostered and adopted children and their carers and parents, Dan borrowed heavily from attachment, intersubjectivity and trauma theories and research to develop a model of treatment that he calls Dyadic Developmental Psychotherapy (DDP) – also known as Attachment-Focused Family Therapy.

Dan is the author of a number of books and articles, including his previous contributions to this series: *Parenting a Child with Emotional and Behavioural Difficulties* (2012) and *Parenting a Child who has Experienced Trauma* (2016).

Dan's current passion is training therapists in his treatment model. He has trained therapists in the US, UK, Canada and other countries for the past 20 years. He also provides ongoing consultation and supervision to various agencies and clinicians. Dan has initiated a certification programme for therapists interested in his treatment model.

Dan's website: www.danielhughes.org
For information on Dyadic Developmental Psychotherapy: www.ddpnetwork.org

## The series editor

**Hedi Argent** is an established author and editor. Her books cover a wide range of placement topics. She has written many guides and story books for young children.


## Acknowledgements

I am grateful to all the readers of the manuscript for their helpful comments.

I am indebted to Jo Francis, of CoramBAAF Publications, for her unfailing good humour and support throughout our work together on this series.

## Looking behind the label…

*Jack has mild learning difficulties and displays some characteristics of ADHD and it is uncertain whether this will increase…*

*Beth and Mary have diagnoses of global developmental delay…*

*Abigail's birth mother has a history of substance abuse. There is no clear evidence that Abigail was prenatally exposed to drugs but her new family will have to accept developmental uncertainty…*

*Jade has some literacy and numeracy difficulties, but has made some improvement with the support of a learning mentor…*

Prospective adopters and carers are often faced with having to decide whether they can care for a child with a health need or condition they know little about and have no direct experience of. No easy task…

Will Jack's learning difficulties become more severe?
Will Beth and Mary be able to catch up?
When will it be clear whether or not Abigail has been affected by parental substance misuse?
And will Jade need a learning mentor throughout her school life?

It can be difficult to know where to turn for reliable information. What lies behind the diagnoses and "labels" that many looked after children bring with them? And what will it be like to live with them? How will they benefit from family life?

Parenting Matters is a unique series, "inspired" by the terms used – and the need to "decode" them – in profiles of children needing new permanent families. Each title provides expert knowledge about a particular condition, coupled with facts, figures and guidance presented in a straightforward and accessible style. Each book also describes what it is like to parent an affected child, with either case studies or adopters and foster carers "telling it like it is", sharing their parenting

experiences, and offering useful advice. This combination of expert information and first-hand experiences will help readers to gain understanding, and to make informed decisions.

Titles in the series deal with a wide range of health conditions and steer readers to where they can find more information. They offer a sound introduction to the topic under consideration and provide a glimpse of what it would be like to live with an affected child. Most importantly, this series looks behind the label and gives families the confidence to look more closely at a child whom they otherwise might have passed by.

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Titles in this series include:

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- *Parenting a Child with Mental Health Issues*
- *Parenting a Child affected by Parental Substance Misuse*
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- *Parenting a Child with Autism Spectrum Disorder*
- *Parenting a Child with Developmental Delay*
- *Parenting a Child with, or at risk of, Genetic Disorders*
- *Parenting a Child affected by Domestic Violence*
- *Parenting a Child affected by Sexual Abuse*
- *Parenting a Child who has experienced Trauma*
- *Parenting a Child with Toileting Issues*
- *Parenting a Child with Eating and Food Issues*

- *Parenting a Child with Sleep Issues*
- *Parenting a Child with Difficulties in Learning caused by Trauma*

# Introduction

## What is self-harming behaviour in childhood?

Psychology books state that when children deliberately hurt themselves, they are engaged in self-harming behaviour. These behaviours are most often associated with a history of relational trauma, especially abuse and neglect caused by their primary caregivers. Having been subjected to extreme "punishment" by their parent, they are at risk of re-enacting these relational traumas by punishing themselves. When the parents of young children repeatedly hurt them, their children get the message: they deserve to be hurt. And too often, after a while, they take on the responsibility of hurting themselves. To them, self-harm seems right, it is how things should be. Psychology books are describing thousands of children, but often our introduction to self-harming behaviour is through our contact with one child – our foster or adopted child, a child in our classroom or our community. We need to understand this behaviour, one child at a time, and

through our understanding, hopefully, support and guide that child until their sense of self is no longer experienced as deserving to be hurt.

When children have been abused (physically, sexually, emotionally) or neglected (physically, emotionally) by their primary caregivers, it is little wonder that they are at risk of self-harming behaviours. The belief that they deserve to be hurt often emerges naturally when they have been harmed by the adults they trust to keep them safe. This leads to a chronic sense of shame: 'There is something wrong with me'. Their shame will assist you – their foster carer or adoptive parent – to understand why they do things that are seen to be wrong, as well as why they are unhappy, lonely, make mistakes and hurt themselves. Your child may be living in a world where things seem hopeless and they feel helpless to change it. Self-harming behaviours may well serve as an excellent reflection of your child's inner world.

This short book is addressed to foster carers and adoptive parents who both want to understand why their child would self-harm, and more importantly, want to make a difference in their child's life so that self-harming is no longer experienced by their child as necessary, desirable, or even strangely soothing. When your child realises that you are their best source of knowledge, guidance, joy and comfort, then – and only then – will your child be able to stop self-harming behaviour.

SECTION 1

# UNDERSTANDING SELF-HARMING BEHAVIOURS

# What is self-harm?

Self-harm is physical aggression against the self. The most common form is cutting oneself. Adopters and foster carers who are aware of potential self-harming behaviours will not leave dangerous objects lying about; however, children have also engaged in self-harming by hitting or scratching themselves, as well as pulling their hair out or banging their head. Some children may also poison or burn themselves or embed objects into their bodies.

If you define self-harming behaviour more broadly than physical aggression, you might include taking drugs, serious eating disorders, deliberately failing, spoiling special occasions, or engaging in behaviours meant to evoke rejection or ridicule from others. It is important to think about the possible reasons why children choose many ways to deliberately seek to hurt themselves.

Although children usually go to great lengths to hide self-harming behaviour, much too often it is seen as being "just" attention

seeking or an effort to manipulate others. Believing this to be the sole or primary motive for self-harm can mean that the seriousness of the behaviour will be underestimated and the interventions used to address it will either be insufficient or make things worse. Responding negatively to self-harming behaviour, or ignoring it so as to avoid "reinforcing" it, are likely to only generate more shame in your child and thus lead to a greater likelihood that the behaviour will continue or return.

## Reasons for self-harming behaviour

The following represent common reasons for self-harming behaviour. They are not mutually exclusive and they often overlap.

### Self-punishment and shame

Children who hurt themselves are likely to believe that they deserve to be hurt. The actions of previous abusive parents or other caregivers only made sense to them because of what they believed to be their bad, ungrateful, selfish self. They believed that they deserved to be hurt because of who they were, not what they did. Abused and neglected children are frequently hurt when they have done nothing obviously wrong – or what they did wrong was mild, common childhood misbehaviour and did not deserve an abusive reaction.

A child's sense of being bad rapidly becomes associated with the emotion of shame because they are likely to be convinced that they are unlovable. The experience of shame is itself a very painful emotional state. Children may well hurt themselves in an effort to reduce shame through self-punishment. Self-harming behaviours in this sense may represent an effort to begin again, to start afresh. But of course, instead, it only makes the feeling of shame worse. The immediate reaction to self-harming behaviour is often, 'I'm worse than I thought, I cut myself with a knife, how sick is that?'

To the degree that the reason for your child's self-harming behaviour is their view of themselves as not being worthy of good care or experiences, then the interventions that address the behaviour need first to address your child's self-concept. That is more difficult than simply telling your child that they are not bad. Children – and adults – will not easily change their experience of themselves in response to lectures and reasons.

### Inadequate coping skills

When children (or adults) are experiencing distress, they may develop coping skills to reduce that distress, which can often be effective (distractions, alternative behaviours, relying on someone they trust, positive self-talk, etc). But when children do not have the confidence to develop adaptive coping skills, they are at risk of engaging in coping skills that are self-harming. When children cut themselves, they may well be giving themselves specific, controllable pain to focus on, in order to take their minds off the more underlying chronic stressors of their lives. But that distraction from general stressors is very short-lived, and when the specific pain decreases, the distress is likely to return, and is often worse than ever.

### An effort to take control of pain

When children are exposed to habitual abuse and neglect, they are helpless to do anything to reduce or prevent the pain they are experiencing at the hands of their caregivers. This generates a chronic state of passive hopelessness that makes the pain even more unbearable. When children themselves are the source of their own pain, it seems like a choice that they can control, although with repetition, it often becomes a habit that is hard to break. Self-harming children know, however, that the pain will be specific and short-lived, and they may well believe it to be preferable to the chronic ongoing pain coming from a source outside themselves.

### Creating relief from pain

When children are able to focus on the experience of their self-harming behaviours, they are able to anticipate that the pain will end soon. It may actually feel "good" after the acute pain that they have created themselves ends. The "good" feeling is likely to be caused in part by their body's release of opioids to numb the pain and create a "high". This neurobiological response to self-induced pain makes it all the harder to reduce self-harming behaviours. (There is more about the neurobiological implications of self-harming behaviours shortly.)

### An effort to "feel something"

When young children experience chronic, intense pain, they may manage to numb themselves from their emotions. Such numbing does serve as a respite from the pain, but at the cost of not feeling connected to people, events or objects. These children experience life as being empty, bleak, with little meaning or energy. When they hurt themselves, they feel acute pain, which in turn helps them to feel alive, no matter how briefly. That sense of being alive can be pleasurable when the pain is brief and able to be controlled.

### An effort to inhibit aggression directed at others

When young children are placed in new families and are no longer being abused, they are both drawn into relationships with nurturing caregivers, and at the same time frightened by such relationships. Routine frustrations in their interaction with their foster carers or adoptive parents are often experienced more intensely than they would be if they did not have an abusive history. They are beginning to trust their new caregivers, and when frustrated by them, they may sense that their trust is being betrayed. By hurting themselves, they have less need to be aggressive towards their new caregivers.

### An impulsive expression of their pain; an unconscious cry for help

Children with a history of abuse are likely to be exhausted by their need for constant vigilance, for suppressing their pain, and for inhibiting symptoms that make their lives more difficult. Their impulse to give expression to how difficult their life is may become so intense that they react with self-harming behaviour to release the overwhelming pressure. They may also have a fantasy that if they could only convey how hard things were for them, their compassionate caregiver would meet their needs. Parents or teachers may express shock when some children who usually seem so "normal" react to a small frustration by banging their heads against the wall.

### A form of self-regulation and an effort to self-soothe

Abused and neglected children often do not trust that others will comfort them, nor do they feel that they deserve to be comforted. They believe that they have to manage their distress on their own because they cannot rely on others. They will need to experience a great deal of trust building with their new family before they begin to realise that genuine comfort, given by someone who cares for them, will reduce their pain a great deal better than their inadequate self-harming efforts. If they do not allow themselves to be cared for, the familiar experience of causing and controlling specific pain is likely to provide some sense of self-soothing relief.

## The neurobiological perspective of self-harm

Just as the experience of abuse and neglect is often a daily occurence for the traumatised child, so this same child's engagement in self-harming behaviours as a coping skill may also become habitual in an effort to manage the overwhelming distress of their lives. These behavioural patterns often reflect the child's

neurobiological system's response to the experience of chronic trauma. An overview of the impact of relational trauma on the child's neurological development, including interventions that are based on this research, may be found in *The Neurobiology of Attachment-Focused Therapy* (Baylin and Hughes, 2016).

I asked my colleague, Jon Baylin PhD, to provide a summary for this book of these neurobiological structural and functional developments. Here is his reply (Baylin, personal communication, 2021).

*Understanding the neurodynamics of self-harm starts with understanding the neurobiology of the separation distress, comfort-seeking, comfort-receiving cycle in a healthy parent–child dyad. Neuroscientists studying this process have linked it strongly to the pain system and there is now a large body of research showing that the "social pain" of separation or loss is very similar neurobiologically to physical pain. Animal studies first showed that when young mammals are separated from their mothers, they go into a state of distress associated with a decrease in opioid activity in the endorphin system. This creates a literal state of pain that triggers the separation call response in which the infant signals their distress to the caregiver whose brain responds, in kind, with a distress response that prompts the caregiver, mostly mothers, to find the young one and comfort them, return them to the nest, providing what neuroscientists call a "social buffering" effect*

*that literally is analgesic, that turns off the distress; the social pain system enabling the young mammal to feel safe again.*

*When a young mammal, including a young child, does not have reliable access to a comforting adult, the infant has to adapt to this environment of harsh, unpredictable care situations. This adaptation has to start automatically, without the benefit of conscious self-defence strategies. Nature has evolved ways to provide this automatic adaptation capability. One of the important aspects of this strategy is the triggering of opioids in the young to provide analgesia and the beginnings of a self-comforting process that supports survival without having reliable, comforting relief from the pain of separation provided by a trustworthy adult.*

*Starting very early in life to use the automatic pain management system, that relies upon the release of opioids rather than the decrease in opioid activity that typically supports the comfort-seeking process, leads to a potentially long-term strategy of coping with a lack of trustworthy connections with other people by self-comforting, based on triggering the release of opioids to suppress pain oneself rather than relying on the comforting response of another person.*

*In short, what appears to be a self-harming process*

*is typically more connected to self-comforting, pain management, a process that gives the person control over the pain and comfort system rather than having to rely on a relational interaction.*

*In a sense, the child takes individual control of what would typically be under the control of a dyadic relationship. This becomes part of a multi-dimensional process of survival that shifts from a passive strategy, e.g. learned helplessness, to a more proactive strategy in which the child, and later teenager, and maybe continuing as an adult, finds a way to reduce the uncertainty of not knowing when, or if, another person is going to be comforting and helpful. By taking control of their own pain and stress management, the child is able to decrease dependency on a caregiver, literally suppressing the felt need for comfort by blocking the separation pain response system.*

*In a neurobiological sense, this form of self-comforting by triggering one's own opioid system is literally rewarding, and probably also triggers the dopamine system that supports learning and remembering actions, to produce further relief from pain and distress.*

When we look at the abused child's self-harming behaviours from both psychological and neurobiological perspectives, we begin to see an organised pattern of behaviour meant to reduce the

experience of pain inflicted by an adult, or emanating from some other deep distress without an adult available for comforting, by gaining control over self-induced physical pain that will reliably end. Such behavioural patterns may well become set, if not rigid, habits that can be difficult to change.

If you can understand your child's self-harm as a means of control, you might then consider self-harm to also be a factor in your child's behaviour that is certain to evoke a negative response from you. When this pattern develops, it is likely that your child is getting some comfort from feeling that they are controlling the negative responses that are directed at them. Such responses are experienced as being more predictable than random abuse during times when they were constantly worried that an adult would mistreat them "for no reason". There is a sense of comfort for the child in creating a predictable world in which you believe that they are bad and will respond to them with anger or criticism.