

**TOWARDS A PASTORAL STRATEGY TO COUNSEL TEENAGERS IN THE
NORTHERN FREE STATE AREA WHO ARE SUBJECT TO
SELF-MUTILATION**

by

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Declaration

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and has not previously in its entirety or in part been submitted to any institution for a degree.

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Date: March 2019

Acknowledgements

Firstly, I want to thank my Lord and Saviour Jesus Christ for once again showing me his grace in granting me the desire and ability to do his will and write this academic article.

To my family and friends - thank you for all your support throughout my life and for making it possible for me to pursue my calling.

To my friend who suffered from self-mutilation - my grateful appreciation for trusting me with your deepest secrets.

Abstract

The occurrence that is called self-mutilation is a real and dangerous threat to defenceless people worldwide. School counsellors in the Free State, coaches, youth workers and even social workers must all admit that this occurrence is more stubborn and widespread and cannot be swept under the carpet (Gregston 2006:9; Penner 2008:18).

In a study by Princeton and Cornell universities in 2006, researchers found that more than 3 000 students, 17 percent (one out of five girls and one out of seven men), had self-mutilated at some stage in their life. The statistics indicate the seriousness of the matter.

In this research study the phenomenon of self-mutilation, and more specifically, cutting, is investigated. The root causes for self-mutilation are explored, with specific reference to deeper emotional wounds. Counselling strategies are examined, and a fresh approach is offered. This approach is based on a combination of narrative therapy and the healing of memories.

The study further supports the notion that self-mutilation incidents take place in secret, and that known cases are just the tip of the iceberg (Penner 2008:18; Whitlock 2010: 2).

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CHAPTER 1

INTRODUCTION

1.1. Background

The need for assistance in the field of self-mutilation has escalated in recent years in the world in general, and also in the northern Free State.

Since the commencement of my research the statistics of the Free State has been non-existent. After interviewing several Pastoral Counsellors, teachers and Youth Workers the need for assistance in this area became overwhelmingly clear and it was the starting point of the research. According to Robert Whittaker, a clinical psychologist at the Akeso psychiatric clinic in Milnerton, Cape Town, the occurrence of self-harm is increasingly common in teen populations. Statistical analysis over 50 empirical studies reporting on the prevalence of Non-Suicidal Self-Injury (NSSI) in adolescent across the globe, showed that 18.0% of these adolescents engage in NSSI, he points out (IOL, 2017).

According to the South African Depression and Anxiety Group (SADAG) non-suicidal self-injury is “more common than people realise. It is the only coping skill some people have when they feel emotionally overwhelmed. Frequently mistaken for a suicidal gesture or failed suicide attempt, it is not intended to kill; it keeps people alive in the face of intolerable mental pain or provides time out from stressful situations.” (IOL, 2017)

The statistics made available by Healthy Place, America’s Mental Health Channel (Gluck 2013) indicate the severity of the phenomenon. Each year, 1 in 5 females and 1 in 7 males engage in self-injury. 90 percent of the people who engage in self-harm begin during their teens or pre-adolescent years. Nearly 50 percent of those who engage in self-injury activities have been sexually abused. Females comprise 60 percent of those who engage in self-injurious behaviour. About 50 percent of those who engage in self-mutilation begin at around age 14 and carry on with the behaviour into their twenties. Many of those who self-injure report having learned how to do so from friends or self-injury websites. Approximately two million cases are *reported* annually in the United States of America (USA).

According to VL Robertson (2008), the effects of self-mutilation are seen not just in the United States of America, but can also be seen in South Africa. While working as a student counsellor at a high school in Stellenbosch the researcher encountered several cases of self-mutilation and realised that there is a need for clear information to guide the supporters of adolescent girls who self-mutilate. Since the researcher personally experienced this lack of guidelines for practitioners, she researched the effect in her region and created clear guidelines for the supporters (Robertson 2008).

The researcher's interest in the topic started in 2004 when she came across several persons in the northern Free State province of South Africa, who self-mutilated. This study is thus centred on the northern Free State area, and on the pastoral counsellors in the Free State and youth workers working in the region. 'Pastoral counsellors in the Free State' in this study refers to psychologically trained ministers, teachers and lay workers who work for a religious organisation, and who provide counselling services.

1.2. Literature Review

The Mayo Clinic (1998-2007) describes the phenomenon of self-mutilation or non-suicidal self-injury as the act of deliberately harming the surface of one's own body, such as cutting or burning oneself. This is not meant as a suicide attempt. Rather, this type of self-injury is an unhealthy way of coping with emotional pain, intense anger and frustration. Even though the act of self-mutilation gives a sense of calm and provides a way to cope with the intense emotions that are bottled up, feelings of shame and guilt follow (Mayo Clinic Staff 1998-2007). The intense emotions also return. With this coping strategy, the victim can also cause unintended, life-threatening injuries. Thus, the need for appropriate treatment is of extreme importance for healthier ways to cope.

Clark and Henslin (2007:10, 23) stated that most professionals within the field of counselling do not have sufficient knowledge or know the complexity of the phenomenon of cutting.

It is evident, according to the Word of God, specifically in the Old Testament, that self-mutilation is not theologically sanctioned. Cutting of the skin was mainly used in

pagan religions in their practices. In 1 Kings 18:24-29¹ we read about the worship of Baal. Elijah invited worshippers to test their false god, but when Baal did not demonstrate any power, 'they cried aloud and cut themselves after their custom with swords and lances, until the blood gushed out.' Deuteronomy 14:1 mentions the cutting skin as an act of mourning for the dead. Even though it was accepted practice in the Ancient Near Eastern context of the Old Testament, God established a rule against the practice. Leviticus 19:28 says, 'You shall not make any cuttings in your flesh for the dead, nor tattoo any marks on you: I am the LORD.'

From a psychological perspective, self-injury is viewed as a relational and emotional problem, requiring relational and emotional solutions (Self-Injury Institute 2013). Often, the self-injurer is not mentally ill but is using self-mutilation as a coping strategy. Proverbs 26:2 states that every effect or symptom has a cause. Counsellors in the Free State tend to make the mistake of concentrating too much on the external actions of self-injury, namely the symptoms, rather than the causes, such as the inner emotions and pain that need to be diagnosed and healed (Cheatham 2017:80). A wounded heart often leads to a wounded body requiring emotional and spiritual healing (Cheatham 2014:80). To the self-harmer, self-injury is a momentary fix, but the feeling of being fixed by self-injury is misleading at best. It's not a solution or true healing, everyone needs to love and be loved (Mayo Clinic Staff 2018). This is confirmed by the research of Sim, Adrian, Zeman, Cassano, and Friedrich (2009). Their research shows the important role of emotions with regards to the phenomenon of self-mutilation.

The capability of teenagers to express their emotions stems from their social relationships. Research has proved that the external environment in which a child resides gives the child a better understanding of its own emotions, the way to communicate and a better understanding of others' emotions (Selekman 2002:7; Sim et al. 2009:86). The optimal external environment can thus positively develop a child's way of dealing with its emotions (Sim et al. 2009:77-78). In addition to the research of Sim et al. as background, the correlation between the emotional ability of a child and its family environment and self-mutilation is supported by Brown, Williams and Collins (2007:791-803; Gratz and Roemer 2008:14-25).

¹ Biblical quotations are from The English Standard Version (ESV) unless otherwise mentioned

Many children grow up experiencing little or no unconditional love, respect or affirmation. As a result, many people feel empty, unlovable and worthless (Selekman 2002:7; Sim et al. 2009:86). Self-harm is often linked to intense feelings of self-hatred. Such inner torment is at the crux of self-injury. To conquer that self-hatred, one desperately needs God's kind of love (Selekman 2002:7; Sim et al. 2009:86).

Clark and Henslin (2007:33-60) explain that, self-harmers chronicled feelings of anger, anxiety or sorrow so deep that it seemed the world was unravelling around them. And during this chaos a thought 'just popped into their mind': 'You can cut (or burn or break) this out of you.' Or, even more insidiously, 'you must cut (or burn or break) yourself until the pain goes away.'

Emotions thus play a cardinal role in the phenomenon of self-mutilation. The capability to express emotions lies deep within one's capability to have social relationships. Children's choices on how to express their emotions, and their way of dealing with them can be linked to their social environment. Research shows that there is a correlation between their way of expressing emotion and child-psycho pathology (Sim et al. 2009:77).

Self-mutilation is thus a real and dangerous threat to people worldwide (Axis Recovery 2017). Untreated depression and other health issues lead the victim down the rabbit hole that leads to unhealthy ways of dealing with their problems. There is no denying the seriousness of this occurrence, since young people are more and more involved with self-mutilation (Self-Harm UK 2018). School counsellors in the Free State, life coaches, youth workers and even social workers should all accept that this occurrence is severe and cannot be swept under the carpet (Gregston 2006:9; Penner 2008:18).

Instances of self-injury and cutting are increasing and warrant thorough research to explore not only how to interpret the behaviour, but how to help self-injurers to terminate the behaviour. The action of self-mutilation, as an addictive behaviour, has become a theme within literature (Penner 2008:97; Gratz and Roemer 2008:14; Aizenman and Jensen 2007:27).

The above-mentioned research indicates the cardinal role research plays in equipping counsellors in the Free State to be able to assist the victims of cutting, as a form of self-mutilation, in a holistic manner that includes the bio-psycho-social

aspects as well as the Christian spiritual dimension of the phenomenon. This will be done by centring on the Bible as a guide to assist a client in need.

1.3. Problem deliberation

The above discussion shows that self-mutilation is increasing, and the need to equip counsellors in the Free State with the necessary knowledge on how to assist a self-harmer holistically, is evident.

The main research question is: what fresh strategies might be employed by pastoral counsellors in the Free State to assist teenagers in the northern Free State area who engage in self-mutilation? The question requires the following subsidiary questions to be answered: what is the current situation among teenagers in the northern Free State who are subject to self-mutilation? Why are teenagers in the northern Free State participating in self-mutilation? What do the scriptures teach about issues related to self-mutilation? What strategies could be employed by pastoral counsellors in the Free State to assist teenagers in the northern Free State area who subject themselves to self-mutilation, or who might do so in the future?

1.4 Research objectives

The objective of this thesis is to increase the counsellor's understanding of self-injurious behaviour, and to equip pastoral counsellors, youth workers and pastoral lay counsellors in the Free State to assist youth trapped in this behaviour.

A secondary objective concerns the knowledge of pastoral workers whose path may cross with self-harmers. The researcher's personal stance is that Jesus Christ is the ultimate healer, and therefore the researcher will apply a holistic approach to delve deeper into self-mutilation, with specific reference to cutting. A holistic approach involves a multi-dimensional view of the human being, which includes the spiritual dimension of functioning (a relationship with God), the physical dimension and the soul dimension (willpower, intellect and emotions) (Clark and Henslin 2007:16, 97). The thesis will focus on cutting, as it is the most well-known type of self-mutilation. This research will contribute to new trends in the study of practical theology, by exploring the appropriate way of dealing with this phenomenon through the guidance

of the Holy Spirit, as well as equipping the researcher and others in the role of counselling a victim of self-mutilation.

1.5 Purpose

When dealing with self-mutilation as described above, the counsellor is dealing with various root causes, such as emotions, depression and self-esteem. The purpose of this thesis is to assist the counsellor and lay workers in the process of assisting the victim of self-mutilation, using the Bible as a guide by looking at the theological, as well as psychological aspects of this phenomenon. This thesis aims to equip counsellors in the Free State and lay-workers with the necessary information to be able to see the warning signs, identify the root causes and to assist victims to live a life on the highest plain under the guidance of the Holy Spirit.

1.6 Design and methodology

The researcher will be using a modified version of the research methodology of Osmer, as well as a qualitative approach to research. The Osmer model provides four phases that should not be treated in isolation. Osmer (2008) recommends a multi- and inter-disciplinary approach.

Phase 1: Descriptive Phase

This phase focuses on the descriptive-empirical task, which answers the question: 'What is going on?' Here the researcher will explore the phenomenon of self-mutilation using meta-analysis research method, by combining results from multiple studies to determine similar intervention across the studies. This will be divided into the history of self-mutilation, who are usually victims, and the different types of self-mutilation.

Phase 2: Interpretive Phase

The Interpretive task, which answers the question: 'Why is this going on?' is the focus of this phase. The researcher will use the qualitative research method to investigate the root causes of self-mutilation, especially the

reason why teenagers resort to self-mutilation. This will be combined with the impact emotions have on the person when dealing with self-mutilation.

Phase 3: Normative Phase

The Normative task, which answers the question: 'What ought to be going on?' is addressed in this phase. The researcher will combine the normative task and the pragmatic task by looking at how a counsellor can assist a victim of self-mutilation, by developing a Biblically-based therapeutic framework. This framework will be based on a study of what the Bible says about cutting according to 1 Kings 18:24-29 and Leviticus 19:28.

The central principles of the therapeutic framework will include the following: a focus on one's body as a temple of God, according to 1 Corinthians 6:19-20 and 1 Corinthians 3:16; trusting in the Lord, according to Isaiah 50:10, Psalm 9:9-10 and Psalm 56:3-4; resisting the devil and temptation, according to James 4:7, 1 Peter 5:8 and Ephesians 6:11-13; and God's everlasting love for us according to Jeremiah 31:3 and Romans 5:8. With the use of Scripture, damaged emotions and memories can be healed. Through various scriptures, a person's identity in Christ can be found, and the power to destroy the strong hold the devil has upon one's life.

Phase 4: Strategic Phase

This step is the pragmatic task. Osmer deals with specific guidance to move from a situation or context to the desired outcomes. In this phase the researcher will develop fresh strategies for dealing with self-mutilation based on the results of the previous phases.

The reason for combining Osmer's model with qualitative research methods is to be able to gain an understanding of the underlying reasons, opinions, and motivations of self-mutilation. This provides the researcher with insights into the problem and helps to develop ideas or hypotheses.

The thesis consists of six chapters.

Chapter one contains the introduction and discussion of the research design.

The second chapter contains the literature review and provides the reader with theoretical knowledge about self-mutilation, including the history of self-mutilation, who the self-injurers are, the different types of self-mutilation and their symptoms and warning signs.

In the third chapter, the researcher explores the root of the self-injurious behaviour with the aim of answering the question why a person resorts to self-mutilation.

The fourth chapter is a discussion of how a pastoral counsellor can assist the self-injurer using counselling techniques like narrative therapy, by using the Bible as the foundation for all therapy and healing.

The fifth chapter provides the reader with the therapeutic framework for the counselling of the victim. This includes the narrative approach to counselling and healing through prayer (Seamands 1981 ; 2001)). The Narrative therapy approach is a form of psychotherapy that assists people by helping to identify their values, so that they can confront their problems (Psychology Today 1991-2018). In healing through prayer, the counsellor looks at how the power of prayer can break the bondage of damaged emotions and memories by inviting Jesus into those aspects of their lives that the clients don't have control over (Seamands 1981; 1985; 2001).

The sixth chapter provides the conclusion of the study.

1.7 Hypothesis

Increased understanding of self-injurious behaviour and a biblically-based counselling framework could equip pastoral counsellors in the Free State with the necessary knowledge to assist youth who present with self-injurious behaviour.

Definitions and acronyms

For the understanding of the thesis, it is essential that certain terms are defined and clarified.

There are numerous terms to describe self-mutilation (SM): these include, deliberate self-harm (Suyemoto 1998:531-554) or non-suicidal self-injurious behaviour (Dyl 2008:4-6; Gratz 2007:1091-1103) (Olivier, Hall and Murphy 2005:591-599) and self-cutting behaviours (Yip 2006:134-146). Self-mutilation is a general term for a variety of forms of intentional self-harm without the wish to die (Eisendrath, Stuart and Lichtmacher 2001). It can also be described

as destructive, disfiguring actions toward one's own body (Miller 2003). And according to the *Dictionary of Modern Medicine* it is explained as the physical abuse of a person's body by its owner, often over a psychogenic substrate; SM is also an integral component of certain hereditary conditions, to physical confinement, deprivation, depression, often related to childhood experiences; SM may be a form of self-cleansing to cauterise the 'pain of living'. (McGraw-Hill 2002).

The DSM-V acronym stands for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). This reference book, published by the American Psychiatric Association, is the diagnostic standard for most mental health professionals in the United States (Farlex 2014).

CHAPTER 2

LITERATURE REVIEW

The purpose of this section is to provide pastoral counsellors in the Free State with a theoretical overview of self-mutilation. Furthermore, it aims to equip the counsellor with the necessary information to identify a teenager who is involved in a process of self-harming activities, and to have the knowledge of how to help a teenager in need.

2.1 The History of Self-mutilation

The history behind self-mutilation dates further back than one would think or even guess. Self-mutilation is first mentioned in the Bible in 1 Kings 18:20-28, where it is described as a religious practice by the priests of Baal. Furthermore, it is clear from Leviticus 19:27-28 and Deuteronomy 14:1 that the practice of self-mutilation was mostly associated with alien religious practices, and thus self-mutilation by any believer who wanted to live a Godly life, was frowned upon.

Delving deeper into the Hebrew word for 'cut', it seems that the term *lances* was used, which explains the use of self-mutilation as a common act of oriental frenzy. This was possibly a method used for human sacrifice, inspired by the notion that self-torture and the shedding of human blood must win divine favour (Ellicott and Limited 2015).

Throughout history there have been many instances where self-mutilation was used, as seen in the following timeline of the history of self-mutilation (Yimofeyev, Shariff, Burns and Outtersen 2002). During 496 to 406 BCE in ancient Greece, Sophocles wrote a play in which self-mutilation was described. In 460-370 BCE, Hippocrates, the father of medicine, entertained theories that asserted that, 'one should be rebalanced by bloodletting, blistering, purging by vomiting or anal purgatives or other potions that would cleanse the body.' In the 2nd - 4th century CE, the author of the gospel of Mark (9:47-48) wrote, 'And if thine eye offend thee, pluck it out: it is better

for thee to enter into the kingdom of God with one eye, than having two eyes to be cast into hell fire (Mark 9:47 in Hayford, Chappell, Ulmer, Hayden and Huntzinger 2002, NKJV), where their worm dieth not, and the fire is not quenched' (Mark 4:48 NKJ). And in Matthew 6:22-23 'The light of the body is the eye: if therefore thine eye be single; thy whole body shall be full of light.' (Matthew 6:22 NKJ), 'But if thine eye be evil, thy whole body shall be full of darkness. If therefore the light that is in thee be darkness, how great is that darkness! (Matthew 6:23 NKJ). During the 11th century self-mutilation was used by flagellant Christian cults; numerous nuns and saints of the Middle Ages were known for starving, purging, flagellating and scarring themselves, and SM is found even in the self-flagellation of today's members of the Roman Catholic Opus Dei movement. In 1846 the first care report on self-mutilation was published.

In 1888 the famous artist Vincent van Gogh cut off his own ear after a girl he was interested in had rejected him. In 1920 Sigmund Freud posited life and death instincts for everyone. He described that a person would withdraw from human connections, and retreat into a narcissistic position, silently driving himself or herself toward death. Freud emphasised that it was only through the activity of the life instinct that this deathlike force was projected outward as destructive impulses directed at objects in the outside world.

In 1983 Karl Menninger claimed that self-mutilation could be an attempt by the persons concerned to heal themselves. He wrote, 'Local self-destruction is a form of partial suicide that averts total suicide.' He also classified it into four categories, namely, neurotic, psychotic, organic and religious. The modern psychiatric interest in self-mutilation was marked by a paper by Pattison and Kahan, using fifty-six published reports of the activity. They classified it on a basis of lethality, method and repetition, constructing a chart in which all self-damaging behaviours could be classified (Pattison and Kahan 1983:867-872). During the 1960's African tribes used scarification as a cultural ritual to enhance beauty and social status.

By the 1990's, the most widely accepted classification of self-mutilation was constructed by Favazza and Rosenthal, presented in the book, *Bodies Under Siege* (Favazza 1996).

2.2 Who are the victims of self-mutilation?

According to *Mental Health America* it is estimated that approximately two million people in the United States of America (USA) injure themselves in some way. The majority of these are teenagers or young adults of all cultures, with young women outnumbering young men. Self-mutilation is not a respecter of persons; this can be seen in the victims it claims. Women and men of all ages, regardless of how rich or poor, or famous or not, can be counted among the victims. An example of this is Diana, Princess of Wales, who was one of the first celebrities to confess her battle with self-inflicted violence; but there have certainly been more.

When dealing with self-harm, it is very important to remember that any person can fall victim to it. According to statistics (Royal College of Psychiatrists 2014), the people who are the usual victims of self-harm are the following: young women, prisoners, asylum seekers, and veterans of the armed forces, gay, lesbian and bisexual people, this seems, at least in part, to be due to the stress of prejudice and discrimination; a group of young people who perform self-harming activities together; having a friend who does so may increase your chances of doing it also, and people who have experienced physical, emotional or sexual abuse during childhood.

Even though there is a wide range of victims of self-mutilation, in this paper the focus will be on teenagers in the Free State region of South Africa.

2.3 Types of self-mutilation

There are many ways in which a person can inflict self-harm (Royal College of Psychiatrists 2014) (Clark and Henslin 2007:22-223; Mind 2013). These include, inter alia, the intake of too many tablets, in other words overdosing, cutting oneself, burning oneself, banging one's head against a hard object, hitting or bruising, inserting objects into one's body, swallowing harmful objects/substances, interfering with the healing of wounds, biting, which can include injurious nail-biting, harmful scratching or picking of the skin, pulling or plucking hair to an excessive degree (Trichotillomania), the intentional fracturing of one's bones, deliberately avoiding medical care for serious injuries, poisoning oneself, over-eating or under-eating and exercising excessively.

The scope of this thesis does not allow for a discussion of all types of self-mutilation, so the researcher will focus on one specific type, namely, cutting. The decision to

focus on cutting is based on the prevalence of this type of self-mutilation, which is one of the most common forms.

2.3.1 Cutting

Cutting can be described as the deliberate harming of one's skin. Virtually anything can be used in this process. According to the DSM-V, cutting falls under 'Non-suicidal self-injury', which is described as the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially accepted. It includes behaviours such as cutting, burning, biting and scratching the skin (International Society for the Study of Self-Injury 2007). As can be seen, self-injurers can be very creative and persistent, using whatever they can until they find relief (Clark and Henslin 2007).

2.3.2 Methodology around cutting

Before investigating the symptoms, the indication or existence of cutting, the warning signs, and the indication of the presence of self-harm, it is important to eliminate some myths about self-mutilation. There are various methodologies around cutting as a form of self-mutilation. Some of the existing myths will be described and the reasons for their being classified as myths explained (Clark and Henslin 2007:42-45).

Self-harm is a failed suicide attempt

Self-injury is described as a form of self-help and a wounding embrace; by hurting oneself a feeling of pain can be comforting; with an expression of internal pain by wounding the person feels comforted. People engage in self-harm not to end their lives, but to attempt to temporarily relieve the pain they are feeling. Self-injury is usually used as a survival technique rather than an exit strategy (Clark and Henslin 2007:88). Another aspect that should be kept in mind is the fact that cutting is the external manifestation of internal pain, brokenness, loneliness, hopelessness and depression. If there are no other options or escape, the feelings can accumulate and

lead to suicide (Penner 2008:39; Gratz 2007:1091). In an extract from Penner, the words of Lindsey, a fifteen-year-old cutter, explain the difference between cutting and suicide (Penner 2008:35):

There is no hazy line. If I'm suicidal I want to die. I have lost all hope. When I'm Self-injuring, I want to relieve emotional pain and keep on living. Suicide is a permanent exit. Self-injury helps me get through the moment (Lindsey age fifteen).

When dealing with self-mutilation, the root of the problem needs to be considered, because self-mutilation is not self-destructive in nature. The reason behind it is to feel better, to have a release from overwhelming negative feelings. Committing suicide would be a permanent solution to a not-so-permanent problem, but self-mutilation is temporary relief for a permanent problem (Hicks and Hincks 2008:409).

Self-injury is a girl's problem

Even though the studies do show that a greater percentage of persons who self-mutilate are women and girls, Clark and Henslin (2007:43) stood firm around the statistics in this regard. Their findings, based on an examination of Dr Tracy Alderman's research, showed that the proportion of men to women who engage in self-inflicted violence is roughly equal. Men and women deal with problems differently. Men tend to display violence outwardly, and some focus on self-harm. Men in general are less comfortable than women when talking about psychiatric or psychological help. Women are thus more likely to be identified as the major candidates for self-mutilation (Selekman 2002:2).

Self-injury is a teenage problem that the person will grow out of

According to Clark and Henslin (2007:43), based on their study of 240 cutters, people do not just grow out of the habit of cutting. They described the 'typical' experience of self-harm as follows: 'A white woman of the age of 28 years who started cutting at the age of 14. She has hurt herself over 50 times, and with this she also has an eating disorder and is concerned about her alcohol misuse. She has already received psychological and medical help without any significant progress.'

As mentioned above, self-mutilation is not an illness with boundaries that selects only certain victims. Self-mutilation occurs across any race, gender, education, age group, sexual preference, religious beliefs and socio-economic status (Hicks and Hincks 2008:410).

Freeman (2003) investigated 50 incidents and trauma departments in England where persons who had self-mutilated were committed. According to him the age of people self-mutilating had dropped; the average age was about 11 years, while children as young as 6 years were committed for treatment (Freeman 2003).

According to Bubrick, Goodman, and Whitlock (2010) the tendency to self-mutilate can take place till late adulthood. Thus, it is concluded that it can happen to anyone, not just teenagers.

Physical pain is the purpose of self-injury

Self-injurers usually do not derive pleasure from the pain they feel. Some self-injurers describe it as an external bodily experience, while others view it as an issue of control over the injury or hurt, or even the situation. The victims want to be the ones to decide when and how they get hurt. They also want to manage and can savour the physical and emotional benefits of the act. It is an ironic fact that people who inflict self-injury use pain to ease pain.

Clark and Henslin (2007:45) report a self-injurer who wrote:

It's never about liking pain. If I liked pain, then it wouldn't help. I hate it. That's why it helps...I feel terrible. I must make my feelings go away. I just use very bitter medicine to make them go away.

Penner (2008:36) came to the realisation that it is important to note that at its core, self-injurious behaviour is not primarily about creating pain, but about managing the pain.

Self-injurers are not psychotic

According to Hicks and Hinck (2008:412), chronic self-mutilators are not generally psychotic. They are in contact with reality, and they realise that their actions will have consequences. This type of behaviour is not the symptom of psychological problems, sexual abuse or any other behavioural problems, but is a cry for help and

the expression of inner pain; most of the time it occurs in normal people (Gregston 2006: 6).

It is not attention-seeking behaviour

When looking at the root causes of self-mutilation there are situations that contain betrayal, loneliness and brokenness. This will be discussed in depth in the next chapter. As explained above, self-mutilation is the external cry for help for an internal problem; the ability to feel when the self-injurer feels numb. It's not to seek attention or to ask for help, it's a way to cope. If it was a way to receive attention the person could do something more drastic than just cut (Penner 2008:42; Kern 2007:47).

According to Penner (2008:43), the global phenomenon of self-injury has been pushed to one side by parents and communities, as well as churches. But because of this the Church needs to adapt, to create external ways to help those suffering from self-injury.

It is not something that will blow over

Penner (2008) points out that each generation feels the need to stamp on the world their own ways of doing things, their fads and trends, but self-mutilation is not one of them, and should be taken very seriously (Penner 2008:36).

It is not an external expression like a tattoo

There are many reasons why a person wants a tattoo, but the most common is that it is a way to upgrade their bodies by enhancing their looks, or to show their uniqueness (Wohlrab, Stahl and Kappeler 2007). However, cutting is not viewed as beautiful by the self-mutilator, and in most cases the injurers want to hide the scars (Penner 2008:38). According to Aizenman and Jensen (2007:27), there is a certain percentage of self-injurers who even though they cut, also try to modify the look in a socially accepted manner, for instance with multiple piercings and tattoos. If this is the case, and it is a scapegoat for emotional pain, then it is an act of self-harm (Clark and Henslin 2007:40).

2.3.3 Symptoms and warning signs of cutting

When dealing with a self-injurer there are several signs and symptoms to take into consideration. Several researchers such as Penner (2008:49), and Clark and Henslin (2007:119-121) describe the common symptoms of self-mutilation as follows: scars, from burns or cuts; fresh cuts, scratches, bruises or other wounds; broken bones; keeping sharp objects at hand; wearing long sleeves or long pants, even in hot weather; claiming to have frequent accidents or mishaps; spending a great deal of time alone; pervasive difficulties in interpersonal relationships; persistent questions about personal identity, such as 'Who am I?', 'What am I doing here?'; behavioural and emotional instability, impulsiveness and unpredictability; statements of helplessness, hopelessness or worthlessness; signs of depression, such as low mood, tearfulness or a lack of motivation or interest in anything; changes in eating habits or being secretive about eating, and any unusual weight loss or weight gain; signs of low self-esteem, such as blaming themselves for any problems, or thinking they are not good enough for something; signs that they have been pulling out their hair and signs of misuse of alcohol or medicines (Mayo 2014; NHS 2013; Penner, 2008:49; Clark and Henslin 2007:119-121; Whitlock 2010; among many others). Once a pastoral counsellor understands the general, theoretical overview of self-mutilation, it is possible to identify whether a counsellee is struggling with self-mutilation.

The counsellor should note that relieving the symptoms of self-mutilation alone cannot heal the client holistically, that is, heal the physical, emotional and spiritual dimension of the person. This is only possible when the root of the problem is identified and addressed. In the next chapter the root causes of self-mutilation will be explored.

CHAPTER 3

INTERPRETIVE TASK: ROOT CAUSES OF SELF-MUTILATION

Self-mutilation is an outward expression of a deeper emotional, physical, as well as, psychological pain (Gardner 2013:53-75). Cutting and other forms of self-mutilation are just the tip of the iceberg. The iceberg represents deeper areas of emotions and experiences (Dombeck 2015). Clark and Henslin (2007:48) assert that self-mutilation is a strong barrier that keeps others from seeing a person who is lost, in pain and in desperate need of help. Thus, moving beyond the presenting symptoms to explore deeper issues is imperative for understanding the reasons for self-mutilation. The reasons motivating self-harm are complex and difficult to identify. Sometimes emotions, such as depression and anxiety, become too much for a person to handle (Kern 2007:33).

In the previous chapter the researcher mentioned the fruits of the disorder, flowing from discussions on the symptoms and the warning signs. In the discussion below attention will be paid to the root of the disorder, thus, answering the question: 'What causes a counsellee or a teenager to fall down the rabbit hole of self-harm?'

3.1 Why does a person or teenager resort to self-mutilation?

Many people, including counsellors in the Free State as well as teenage counsellees, struggle with this question and earnestly seek an answer to it. What is the genesis of self-mutilation? Dr Tracy Alderman, a psychotherapist and author of *The Scarred Soul* (1997:13), explains: 'Most people who engage in self-inflicted violence have little or no idea of how they actually began to do so. An overwhelming number of individuals can cite no definite event. They cannot remember how they learned of self-inflicted violence and they state that their self-injurious behaviours just happened.' Looking at the counsellee, each one is unique, and their perspective on

the origin of the problem may differ. The subjects with whom the researcher worked over the year confirmed that the idea of cutting was described as a thought that 'just popped into their head'.

Clark (cited in Clark and Henslin 2007:34-38) explains: 'Self-harmers chronicled feelings of anger, anxiety or sorrow so deep that it seemed the world was unravelling around them. And during this chaos a thought just popped into their mind: You can cut (or burn or break) this out of you. Or, even more insidiously, you must cut (or burn or break) yourself until the pain goes away.' As described above, a person's emotions play a very important role in the way they come to experience self-mutilation, as the emotional turmoil becomes so much that they need an outlet; the thought pops into their heads that the only way for them is to cut the pain away.

When dealing with self-mutilation, the first question most people ask is how someone can do this to themselves, as it seems unlikely that a person would harm themselves deliberately. However, studies showed that the following are reasons steering someone to deliberately inflict self-harm, and they should be kept in mind (Kern 2007: 33; Robertson 2008:62-74):

It works

The pain accompanying the self-harming act is in most cases the most effective, strongest, most addictive means and an immediate way of dealing with the stress. Physical pain accompanied by the visual stimulation of the blood provides a sensation of relief from the situation or emotions that got out of control (Clark and Henslin 2007:46; Swannell, Martin, Scott, Gibbons and Gifford 2008:102). Gregston (2006:43) explains that self-mutilators temporarily inflict physical pain to take away other emotional pain.

History of sexual abuse

As the study of Hicks and Hincks (2007:410) showed, there is a close correlation between self-mutilation and a history of sexual abuse during childhood years (Penner, 2008:95; Aizenman and Jensen 2007:29; Whitlock 2010:5).

The need to externalise the pain

People have different ways of handling pain. Some cry, some laugh, and others scream, where others use aggression. Some, however, need something more intense, like self-harm, to cope with extreme negative feelings. Clark and Henslin (2007:47) state that there are times when it hurts too bad, too deep for tears, so, the person quoted cut, and it let out some of the hurt. It was comparable to watching the bad feelings bleed away. She could not cry, and bleeding was an alternative form of crying.

The ultimate release

Self-injurers describe the process of cutting in different ways, but it all comes down to the coping mechanism for internal emotional stress. According to Penner (2008:78) a cutter described it as follows:

... I do it because I cannot get mad at people, at least on the surface. Anytime someone acts mean to me or anything, I just sort of snap. Then I run upstairs as fast as I can and cut until everything goes away (Penner 2008:78)

Another cutter describes it as follows (Penner 2008:107):

I've quit cutting about a thousand times - once for a month, but mostly just for a week or so. I know it's a stupid dead end and it's easy to decide never to do it again - until I'm alone in my room after a crappy day at school and I feel gross and I just had a fight with my mom, and grabbing the knife seems like the most logical thing in the world.

Feelings of Loneliness

Self-harm can sometimes be used to deal with loneliness. It can also help to deal with the pain of parents going through a divorce, or even after a person has gone through a divorce themselves, or a loved one has passed away, or even after rejection by a group of friends (Clark and Henslin 2007:45-60; Kern 2007:33).

There's no other way to say it

Clark and Henslin (2007:51) assert that most young women today see their bodies as a noticeboard. They post messages with the way they dress, use makeup, modify their bodies, or even the message within that goes way beyond the exterior

looks. The cutting provides a way for the silent shrieks within. It is the cry for help that most people cannot utter a word about (Selekman 2010).

A need for control

For today's youth who feel that their world is chaotic or against them, self-mutilation is a way to take back control. By cutting they hurt themselves and they control the pain (Kern 2007:34). Clark and Henslin explain that self-mutilators like to control their own pain and numbness. Tragically, they choose a maladaptive means of attaining temporarily control (Clark and Henslin 2007:55). Freeman (2003) gave the following quote from a cutter:

I felt totally calm and rational when I did it, like I was finally in control of my life. And the whole experience was such a relief.

The experience of having control of something in their life overclouds the pain.

It is a way to feel something

Self-mutilators can at times experience the greatest negative feelings, and at other times no feeling at all. The question 'Am I really here?' arises. 'Is this feeling that I experience normal for someone still alive? Does anyone see me?' A young girl once explained that the greatest loss in life is not death. It's what dies inside while you're alive (Clark and Henslin 2007:49).

Some will say that when cutting, it gives them a feeling that they are still alive and that it is reality. Feeling pain is better than feeling nothing. Cutting gives a sense of feeling alive and it gives the ability to feel. Penner (2008:72) quotes a cutter:

For me life is often like seeing myself in an old black-and-white movie. It's dingy and grey. I watch myself going through the motions of my day, school, home, practice, work – and I don't feel a thing. But then when I cut, I see the red. It's the only colour on the screen and it reminds me that I'm not just a spectator to this boring bland picture show.

Self-punishment

After experiencing personal failures in the past, and the feeling of unforgiveness of oneself emerges, it leads to the need to punish oneself (Gregston 2006:39; Kern 2007: 34).

- No one can cite fixed reasons why people engage in self-harming activities. According to *Mind*, any difficult experience can be a stressor that can lead to self-harm. Examples of possible stressors could include: pressures at school or work, bullying, financial problems, sexual, physical or emotional abuse, bereavement, confusion about one's sexuality, breakdown of relationships, an illness or health problem and the difficult, unpleasant and unwelcome feelings such as depression, anxiety, anger or numbness, experienced as part of a mental health problem (Mind 2013).

3.2 The Importance of emotions

Emotions play a cardinal role in the phenomenon of self-mutilation. The capability to express emotions lies deep within one's ability to have social relationships. Sim et al. (2009) give a very good description of the practical guidelines. Children's choices on how to express their emotions, and their way of dealing with them can be linked to their social environment. Research shows that there is a correlation between their way of expressing emotion and child-psychopathology (2009:77). Being exposed to an environment where they discuss emotions, and understanding emotions, can assist in social, as well as emotional competence.

Therefore, the counsellor can see that the environment where children give expression to their emotions of rejection, as well as punishment, interferes with their emotional development and functioning. Within this emotional environment, where they have a lack of recognition, the child's developmental capability of expressing, as well as, experiencing emotion would be affected (Sim et al. 2009:78).

Gratz (2007:1092) describes the environment above and the emotional dysregulation; the counsellor can see it in the ways of responding to emotions, including non-accepting responses, difficulty controlling behaviour in the face of

emotional distress, and deficits in the functional use of emotions as information. As such, emotion dysregulation involves the inability to control behaviours when experiencing negative emotions and is distinguished from a temperamental emotional vulnerability.

Sim et al. (2009:78) showed that individuals who experienced punishment for the expiation of negative emotions would suppress their emotions, which increases the inner turmoil even more. Such persons have few opportunities to express their emotions, and thus do not learn how to express their emotions in the correct way. Cratz and Roemer (2008:15) and Brown et al. (2007:801) have found that there is a correlation between emotional shortcomings, family environment, and self-mutilating.

In times of stress the individual or teenager would show an inability to be able to identify their emotions correctly and due to that, they would find it difficult to be able to communicate to others. They will have the tendency to avoid such emotions and would try to escape by developing a coping mechanism such as self-mutilation (Sim et al. 2009:79). Self-mutilation has become an action where the emotional pain transforms to physical pain, which is easier to comprehend and easier to deal with.

3.3 Misery loves company

It is important for the counsellor to remember that self-harm often does not manifest in isolation. There are many reasons why people or teenagers perform self-mutilation and many illnesses that can lead the counsellee toward the beginning of self-harming activities. These often include one or more of the following (Clark and Henslin 2007:61-90): depression or other mood disorders; low self-esteem; eating disorders; parent-child conflict; manipulation and/or habitual lying; oppositional defiance; aggressive behaviour; suicidal ideation; a history of sexual abuse or present unhealthy sexual expression; post-traumatic stress disorder; dissociation; and addiction or addictive tendencies.

In the discussion in the thesis so far, including the previous chapter, it has been noted that self-mutilation is often in one way or another attached to feelings of depression and poor self-image. It is also known among victims, as well as therapists, that a poor or negative self-image/self-esteem very often goes hand in

hand with depression. The researcher recommends further research on these characteristics of self-mutilation.

When dealing with a negative self-image, the counsellor must also look at the damaged emotions behind the negative self-image, rejection, addiction and depression.

3.3.1 *Low self-esteem or low self-worth*

Satan's deadliest weapon is our self-esteem (Seamands 1981:47-56; 2001). If he can get us to think less of ourselves, he cripples us in the spirit and changes our relationship with the Lord.

When looking at a person with low self-esteem it must be determined what the source of the low self-esteem is. According to Seamands there are four sources of self-image which help a person construct their self-image: the outer world, the inner world, Satan with all the forces of evil, and God and his word. (Seamands 1981:60-65; 2001). The outer world is all the factors that have gone into one's makeup, one's heritage and birth, everything up to the present time. The world within us is the emotional, physical and spiritual equipment that a person brings into the world. This includes our senses, our nerves, and our capacity to learn, to register, and to respond. For some of us, this is a world which includes handicaps, deformities and defects. The third source is Satan and his evil forces. He uses our feelings of self-despising as a terrible weapon in the three roles he plays, namely:

- Satan is a liar. The Word tells us in John 8:44 that the devil is the father of lies: 'Ye are of your father the devil, and the lusts of your father ye will do. He was a murderer from the beginning, and abode not in the truth, because there is no truth in him. When he speaketh a lie, he speaketh of his own: for he is a liar, and the father of it.' (John 8:44 in Hayford, Chappel, Ulmer, Hayden and Huntzinger NKJV 2002).

He is an accuser. This can be seen in Revelation 12:10: 'And I heard a loud voice saying in heaven, now is come salvation, and strength, and the

kingdom of our God, and the power of his Christ: for the accuser of our brethren is cast down, which accused them before our God day and night.' (Hayford et al. 2002, NKJV).

He also blinds our minds. In 2 Corinthians 4:4, 'In whom the god of this world hath blinded the minds of them which believe not, lest the light of the glorious gospel of Christ, who is the image of God, should shine unto them.' (Hayford, et al. 2002, NKJV).

The fourth source of a person's self-esteem is God. When believing the lies of the devil and allowing someone other than God to shape our view of ourselves, we develop a low self-esteem which then causes us to feel fear, doubt, anger, hostility, worry and guilt that paralyse us and have an adverse impact on our potential, abandon our dreams, ruin our relationships with others, and sabotage our Christian service (Hunt 2008:357-364).

When dealing with low self-esteem, the counsellor is also dealing with the element of fear. As Christians, people wrestle not against flesh and blood, but against principalities, against powers, against the rulers of the darkness of this world, against spiritual wickedness in high places. (Hayford et al. 2002: Ephesians 6:12 NKJV).

The counsellee must identify the root of the fear. Possibilities that may be taken into consideration would include, inter alia, abnormal fear such as the fear of heights, snakes, and so on (Hunt 2008:155-166; Coetzer 2009:20-30). Another type of fear is emotional wounds that have not been addressed, which can lead to emotional infection (the fear of rejection). In addition to the above there might be financial insecurity (fear of failure to meet necessities, responsibilities).

It is very important for the counsellor to know that fear can block the healing process, and that existing fears and anxieties must be identified and dealt with as soon as possible for the healing process to be successful.

3.3.1.1 Rejection

Repeated rejection is one of the main reasons why teenage counsellees suffer from a false and inferior self-image or self-esteem, and damaged emotions. (Hunt 2008:357-364). Rejection can be described as the deprivation of unconditional love

as usually received from family and friends and important others (Hunt 2008:341-348).

The individual may experience such actual (or perceived) rejection as inconceivable and unforgivable abandonment by others or may turn to the inner self only to end up feeling trapped within a cluster of negative beliefs about the self, lashing out with severe and harsh self-criticism and in so doing demolish possible ways to cope or gain perspective (Hunt 2008:341-348; Seamands 1981:37-76; Seamands 2001).

It is very important for the counsellee to remember that other people do not define who they are. And even though the counsellee may not see the road he/she should take, the Lord's promises of accompaniment and support remain unchanged and steadfast. (Hayford et al. 2002: Deuteronomy 31:8 NKJV).

3.3.1.2 Lies that the broken-hearted believe

Five lies, among other lies, frequently emerge as those believed by individuals who are inclined to undermine and underestimate their own value or worthiness. The relevant lies/beliefs are listed below.

They believe (Hunt 2008:341-348; Coetzer 2009:31-44; Jantz 2006):

- That no one loves them;
- That something must be wrong with them and that is why no one cares for them;
- That they should achieve to be loved;
- That they are incapable of living up to expectations and will therefore be rejected;
- That it is up to them to compensate for the rejection, or to compensate beforehand to prevent rejection, that they should assume responsibility for it.

3.3.1.3 Types of rejection

Janz (2006) describes several types of rejection. These include:

- The use of words; Some people normally force their opinions down the throats of others and believe they are always right. They act as if they are both the judge and the jury; they belittle someone through the words they use, and

some use ridicule to break down the next person. There are those who would project guilt feelings on to others and then act as a 'preacher' to appear superior and blameless.

- A total lack of words, that is, remaining silent and ignoring, may also hurt and cause damage. The one on the receiving end may understandably experience feelings of rejection (Coetzer 2009:41-50; Jantz 2006).
- Through perceivable actions and conduct. A common example is taking advantage of a leadership position and gaining control in that way.

Through his ministry, Seamands has confirmed that there is a realm of problems that require a special kind of prayer and a deeper level of healing by the Spirit (Seamands 1981:10-13; Seamands 2001). Somewhere between our sins, on the one hand, and our sickness on the other, lies this area. In the scriptures, it is referred to as infirmities, indicating, inter alia, an inability to produce results. Romans 15:1 state: 'we then that are strong ought to bear the infirmities of the weak, and not to please ourselves' (Hayford et al. 2002, NKJV; Seamands 1981:10-13; Seamands 2001).

The next part of this chapter aims to help the reader to distinguish between the self-injurers' emotions and to help them bear their infirmities.

3.3.2 *Perfectionism*

Another problem that goes side by side with worthlessness and low self-esteem is perfectionism. Perfectionism can be described as the tyranny of 'ought to', the feeling of never doing well enough, self-deprecation, anxiety, legalism, over-sensitiveness, conscience and comprehensive guilt (Seamands 1981:77-88; Seamands 2001).

Symptoms of perfectionism include depression caused by damaged emotions and specifically by spiritual distortion. Perfectionism is counterfeit to Christian perfection, that is, holiness, sanctification or a spirit-filled life. This leaves us as spiritual Pharisees and emotional neurotics (Seamands 1981:77-88; Seamands 2001).

The only way to cure this is by the renewing of one's mind and the loving acceptance of God that has nothing to do with your worthiness (Seamands 1981:89-100;

Seamands 2001). His grace alone can break through and break all chains of anger and denial (Hayford et al. 2002: Matthew 11:28-30, Romans 12:2 NKJV).

3.3.3 *Super-you versus the real you*

Another root cause of self-mutilation is the effort to live up to someone else's expectations, whether these are realistic and fair or not, and the feeling of not being successful at doing so. Too many people have created the 'super- you' version of themselves and are always pushing themselves to be more, and to do better. This can be a cause of depression (Coetzer 2008:38-42). The question teenage counsellees must answer is: 'Do you know the real you?' The counsellor and counsellee must find the 'real you' in the counsellee's life. Because of their outer world's experiences on their lives they create a 'super you'. This is a part of their false self-image. They tend to think that they should be something or do something to be loved and accepted (Seamands 1981:101-110; Hunt 2008:227-232; Seamands 2001).

When they look at the 'super-you', they feel that they should never feel depressed, experience anger or any negative emotions that may not reflect a Christian way of doing, thinking and feeling (Seamands 1981:101-110; Seamands 2001). They must like and be liked by everyone. This is a very false image.

3.3.4 *Depression*

Depression is a very common illness from which many people suffer, and the researcher can even say that everyone suffers from a degree of depression at one stage or another .According to Dr Henk Gous, depression can be described as a feeling that floods over you like black water, and the harder you try to swim out of it the deeper you get caught up in it. Your efforts appear to be all in vain (Gous 2011).

3.3.4.1 Warning signs of depression

It is important for the counsellor to know what he or she is dealing with when working with a person who is suffering from depression. It is very important to keep in mind that the real causes of depression can be classified as being physical in nature, that is, due to the brain's amines which cause chemical imbalances that affect a person's

moods, mind and life. This can occur when the brain amines are in an imbalance, where the dopamine or serotonin is in an imbalance (Meier and Clements 2005:21-32). This can be caused by the person's genes when the person has an insufficient amount of the amines. This can be seen in Paul Meier's work in the Meier Clinics. He has also written a book about it, titled *Blue Genes*, in which he discusses his findings and share his insights on this matter (Meier and Clements 2005). He has proved that if the right combination of medicine and counselling is used, the person can break free from depression. (Coetzer 2008:30-32; Meier and Clements 2005:10-20). The guidelines for the counsellor and the support group will be discussed in the next chapter.

There is a wide range of reasons why people fall into the pit of depression. They will shortly be discussed in their physical, emotional and spiritual context.

Physical warning signs (Sue D, Sue D.W. and Sue S 2010:303-332; Coetzer 2008:12-19): chronic illnesses; addiction to drugs or medication; inappropriate eating or exercising habits; biogenetic amines imbalance, this is the imbalance of one's serotonin and norepinephrine; endocrine glands imbalance, pituitary gland's malfunctioning; electrolyte disorder, disorder that affects the body's sodium and potassium levels; virus infection; exhaustion; genetic illnesses; hormonal disorder; problem with the basal ganglia; hypothyroid functioning, problem with the thyroid; hypoglycaemia, problem with low blood sugar levels; sexual problems; heart palpitations; muscle spasms; tiredness and exhaustion; urine and bladder problems; skin infections and very dry skin conditions, and metabolism and stomach problems.

Emotional warning signs (Sue D, Sue D.W. and Sue S 2010:303-332; Coetzer 2008:12-19): problem with the temporal lobes, usually the dominant one, this influences the emotional stability of the person; deeper limbic system, the more active this part is the more negative the person will be; stress and suppressed fear.

Spiritual symptoms (Sue D, Sue D.W. and Sue S 2010:303-332; Coetzer 2008:12-19): feelings of guilt; disobedience; wrong interpretation of who, and what, and how God is, (securing meaningfulness of life, in relation to human being) and perfectionism.

Other reasons include (Sue D, Sue D.W. and Sue S 2010:303-332; Coetzer 2008:12-19): the passing of a family member, friend or loved one; divorce; empty-nest syndrome; anger turned inward; low self-image; post-traumatic stress syndrome; wrongly-felt guilt feelings; guilt feelings for something done wrong; wrong perspectives; attacks by the devil (oppression); putting too much pressure on oneself; wrong priorities, and manipulation.

3.3.4.2 Symptoms of depression

It is very important for the counsellor to determine whether the self-mutilating counsellee is depressed or not. Meier (*Blue Genes* 2005:10-20) mentions an instance where the counsellee was so deeply depressed that the condition first had to be treated medically before the intended counselling could proceed. Below are some of the symptoms that could alert the awareness of the counsellor, as well as the members of the support group (Sue D, Sue D.W. and Sue S 2010:303-332; Coetzer 2008:12-19): persistent sad, anxious, or 'empty' feelings; feelings of hopelessness or pessimism; feelings of guilt, worthlessness, or helplessness; irritability, restlessness; loss of interest in activities or hobbies once pleasurable, including sex; fatigue and decreased energy; difficulty concentrating, remembering details, and making decisions; insomnia, early-morning wakefulness, or excessive sleeping; overeating, or loss of appetite; thoughts of suicide, suicide attempts; and aches or pains, headaches, cramps, or digestive problems that do not ease even with treatment.

Physical symptoms (Sue D, Sue D.W. and Sue S 2010:303-332; Coetzer 2008:12-19): agony and nervousness; pessimism; stress and muscle pains; headaches; finer motor movement problems; heartache keeps increasing, person looks depressed, has negative body language, often cries and looks tired and stressed; lack of motivation; sleep apnea; eating habits disrupted; menstrual cycle terminated; and dry mouth.

Emotional symptoms (Sue D, Sue D.W. and Sue S 2010:303-332; Coetzer 2008:12-19): distorted thinking patterns, unrealistic responsibility belief, prone to feelings of guilt, feelings of solitude, inferiority feelings, intense introspection - the counsellee will constantly dwell on mistakes of the past and will feel guilty even when there is no reason for doing so. The counsellee feels responsible for situations quite

unnecessarily, lack of intimacy with others, lack of self-worth, social isolation, flood of feelings, lack of motivation, pessimism, increase of negative thinking and the decline in their mood. These symptoms include moodiness, irritation and clinical depression

Spiritual symptoms (Sue D, Sue D.W. and Sue S 2010:303-332; Coetzer 2008:12-19): lack of intimacy with God, decrease of time with God, feelings that God is far, or that prayers are not heard, less time and no desire to read the Bible, worshipping stops, fellowship with other Christians stops, and moral or spiritual preoccupation.

3.3.5 Addiction

Addiction is one of the roots of self-mutilation (Addiction Care 2014; Cornell Research Program 2013). It can be described as a condition in which the body must have a drug to avoid physical and psychological withdrawal symptoms. There are a few stages in dependence, during which the search for a drug dominates an individual's life (Smith and Segal 2014). An addict eventually develops a tolerance, which forces the person to consume larger and larger doses of the drug to get the same effect. The 'drug' mentioned above can be bulimia, anorexia, drugs and prescription drugs.

3.3.5.1 Warning signs of addiction

There are a number of ways to determine whether a counsellee has become addicted (Mayo Clinic Staff 2012): the feeling that the person must use the drug or method daily or even several times a day; failing attempts to stop the use; making certain that a supply of the drug is available; acting to obtain the drug or objects needed, even if it means stealing; feeling convinced that life is impossible without it and that it is essential for coping with problems; driving or performing other risky activities when under the influence; focusing more and more time on getting and using the drug or object

When working with a client who has this disorder the counsellor should keep in mind one size does not fit all. Each client may experience his/her situation differently and their coping mechanisms, roots and symptoms may differ from what we normally expect. Every situation the counsellor will be presented with is different, and for the

counselling process to be effective, counsellors in the Free State should be grounded in the Holy Spirit's guidance, and be a vessel for him to use, because through him alone healing can occur.

After having considered the possible roots of self-mutilation, the counsellor should be able to single out the relevant root cause that applies to the specific counsellee. In the next chapter the researcher will discuss possible ways of addressing the problem at hand.

CHAPTER 4

THE NORMATIVE TASK: COUNSELLING VICTIMS OF SELF-MUTILATION

In the previous chapter the counsellor was provided with the necessary tools to be able to identify the problem at hand in the Free State. The researcher is now going to look at ways in which the counsellor can help the teenagers in need.

It is apparent that the problem being discussed goes deeper than the self-mutilation as such. It will, therefore, be necessary for the counsellor to gather as much information as possible about the specific problem of the counsellee or teenager in need. The counsellor may have to deal with the following problems; cutting, addiction, depression, low or poor self-esteem / self-worth / self-image, distorted image of God and perfectionism.

We need to look at Self-mutilation as if it were fruits on a tree. All fruits stem from a deeper root; by dealing with the root of the cause the counsellor can accompany the counsellee on the road to healing. There are many roots that can lead a person to the point of self-mutilation. The most common are those described below (Clark and Henslin 2007:61-91).

4.1 Cutting

4.1.1 *Getting behind the blade*

It is imperative that the counsellor understands that cutting helps the person cope with his/her hurt and inner pain. It is a coping mechanism implemented by teenage counsellees to sustain them in the world they are in. Some of the reasons why teenage counsellees cut themselves include being able to express feelings that they cannot put into words, releasing the pain and tension that they feel inside, feeling in control, having their attention distracted from emotions that are overwhelming which

they should confront, and relieving the guilt they feel by punishing themselves. This makes them feel more alive instead of numb (Smith and Segal 2014; Clark and Henslin 2007: 33-60; The American Academy of Experts in Traumatic Stress 2012).

To allow counsellors in the Free State to provide help, teenage counsellees should tell why they harm themselves and do so in their own words. Relating their circumstances ('stories') is an important first step on the road to recovery. The counsellor must listen sensitively and carefully, to note possible causes or reasons for the counsellee's self-harm behaviour. Once the 'Why?' of the mutilation has been better understood, the teenage counsellees can be helped to a point where they can implement other coping skills and end the harmful behaviour. (Smith and Segal 2014; Clark and Henslin 2007; The American Academy of Experts in Traumatic Stress 2012).

When approaching the reasons why a person resorts to cutting the biological aspects need to be understood.

For the teenage counsellees to reach a point where they can end their self-harm behaviour, they should first find the root cause of the problem. As has been explained in the previous chapter the real reason for the coping mechanism must be dealt with.

4.1.2 *Why should they stop if it works?*

For the teenage counsellees to believe and realise that cutting is wrong and that they should stop the evil cycle, the counsellor should guide teenage counsellees to come to the crossroad of the truth versus the lie. They should come to a point of acceptance of the fault before healing can take place.

Smith and Segal (2014) as well as Dr. Daniel Amen point out a variety of aspects that should be observed for successful treatment to be achieved, and mention, inter alia, the following; teenage counsellees must realise that cutting offers a temporary relief only, and that the relief comes at a cost in the long run, this temporary relief is caused by endorphins, dynorphins and enkephalins assists the body in the pursuit of pleasure and control of the sensation of pain (Clark & Henslin 2007: 98-99) . The short-lived relief is, in any case, afterwards overtaken by feelings of regret, shame and guilt. The habit of mutilation prevents one from finding more effective ways for

dealing with one's problems. It causes the victim to become isolated, because of all the secrets that must be carefully hidden and maintained. It would appear to be easier to stay away from others than to keep up with the lies. As the victims get used to cutting as well as the accompanying pain, they may no longer derive the same satisfaction, and may resort to more severe cutting or other forms of self-mutilation. The risk of harmful infection is increased. If one does not learn more effective ways to deal with one's problems, it can cause more serious psychological problems down the line, such as major depression, drug and alcohol addiction and even suicide. Looking at the strategic task, the counsellee can find a way to cope with and be cured of self-mutilation.

It should be noted that cutting can become addictive (Victor, Glenn and Klonsky 2012) The person usually starts off doing something rather impulsively to gain a feeling of being in control of at least one thing in their life. The feeling does indeed manifest. However, it is soon reversed – it feels as if the cutting itself is in control. The activities develop into compulsive behaviour that seems impossible to stop. According to Dr Paul Hokemeyer, a sober doctor who has appeared repeatedly on Good Morning America and specialises on the topic, cutting is an impulse-control disorder. He explained that cutting has a calming effect on the counsellee, and added that 'the body releases endorphins, which are the body's narcotic: they minimise pain by providing a sense of wellbeing.' When our bodies experience pain, Hokemeyer explained, our brains release endorphins to soothe and energise us, so that we can act to get out of harm's way. 'The pain switches from being emotional to physical,' he says. 'The person sees blood coming out and thinks, "How great and absolute". And that's satisfying on a certain level because physical pain eventually goes away while emotional pain feels as though it won't—and it's that uncertainty which is so unsettling. The devil you know is better than the devil you don't.'" (Ackerman 2012)

Counsellors in the Free State should guide the teenage counsellees to a place of understanding and insight, and the realisation that cutting does not help to improve or eliminate the aggravating issues that caused the self-mutilation in the first place. True rest from these issues can only be found in the arms of our Saviour Jesus Christ. Furthermore, by working in association with different mental health

professionals, for example psychiatrists and psychologists, the need for chemical, nutritional as well as supplemental interventions can be met.

4.1.3 Guidelines when helping the counsellee

It is important that the person in question comes to a point where he/she wants to be helped. When looking at the next chapter the counsellor will find a framework for assisting a counsellee who suffers from self-mutilation. When the counsellee comes to an acceptance, and acknowledgement of an existing problem, the following guidelines may be taken into consideration for healing purposes (Working Group 2010:63-96; NHS Foundation Trust 2009).

It is important for the teenage counsellees or their loved ones to have someone they can talk to. When approached, the counsellor or support group should create an atmosphere of healing. An atmosphere of healing is creating trust conditions and a relationship of mutual trust. It is easier for teenage counsellees to talk and act in an unguarded fashion when they know there is no judgment, and that privacy and confidentiality will receive due respect.

According to Clinebell (1996) Christian counsellors in the Free State are in a ministry of reconciliation. Reconciliation can be defined as a process by which God and man reconnect (pp. 244-245). The reconnection is made possible through the blood of Jesus Christ. When the researcher talks about the process by which God and man are brought together, the researcher refers to the helping of the teenage counsellees to become what God wants them to be.

When talking to teenage counsellees who are self-harming, the counsellor should encourage them to open up about their feelings and emotions and help them to focus on the feelings. Give them the freedom to communicate in whatever manner that will make them feel comfortable and at ease. Remember to give them time to process what you are telling them.

4.2 Addiction

4.2.1 Steps to beating addiction

In Melemis's book *I Want to Change My Life*, he provides some steps to help the addict to overcome the addiction (Melemis 2010). It is important to know that addiction should be viewed with serious concern. The teenage counsellors should reach the point where they admit that they do indeed have a problem of a serious nature, because it can ruin their lives as well as the lives of those around them. Melemis's rules and advice contain concepts as set out below:

- Change your lifestyle, create a new life where it is easier not to fall into the same patterns and traps of addiction.
- Avoid high risk situations; the end of a day is usually the hardest time for addicts because it is the time of day when they are tired, hungry, perhaps angry and lonely, and probably less busy with demands and responsibilities. Do not sustain close relationships with those people who had joined you in addiction or encouraged you to be part of it all.
- Be careful of those people with whom you have conflicts, and who 'drive' you to a desire or preference to be drugged. Places, familiar places associated with previous addictive behaviour can be very strong reminders and may tempt the addict into surrendering to his or her 'old ways' of harmful and unwanted behaviour.

It is very important for the addict to avoid the situations mentioned above. (Prevention is better/easier than cure!). A positive step to take is for the counsellor and support group to help the teenage counsellors to compile a list of personal risks to avoid, and to assist them in their efforts to create new lifestyle patterns around themselves. Doing so will encourage them to break free from the grip of the cycle (Melemis 2010). Teach the teenage counsellors to relax. Help them to be honest. Help them to see that they must change their life for them to be able to change their addiction.

It is important when dealing with addicts to come to a point where you admit you have done all you could, and the addict has to be referred to a rehabilitation centre. It is very important for the teenage counsellors to know that through Christ alone can they do anything, and that if they commit themselves to change and to the Lord, that he will help them with the problem at hand. There is the testimony of an addict who

had been addicted to alcohol and smoking; after handing over his life to Jesus Christ completely, he never touched a drink or smoked again in his life, and from that time up to the present almost 35 years have passed.

4.3 Depression

In the previous chapter the researcher divided the symptoms and warning signs into three sections, namely physical, emotional and spiritual. The intention is now to present a discussion below on ways to combat depression in each of these three areas. Relevant guidelines will be suggested to assist the counsellor and support group when helping a person suffering from depression.

4.3.1 *Coping on the physical dimension*

4.3.1.1 Advice to counsellee

Stop the fortune-telling thought pattern. Focus on the here and now. Concentrate on your breathing technique. Take deep breaths. Use the 18/40/80 rule. When you are 18 you are worried about what people think of you, when you are 40 you do not care what people think of you, and when you are 80 you will start to wonder who is thinking of you. Learn how to deal with conflict. Concentrate on your diet, have a well-balanced diet. Distance yourself from alcohol and caffeine. Keep in mind the importance of physical contact. Surround yourself with lovely fragrances. Construct your own library of pleasant memories. Get a training programme (Coetzer 2008:16-18; Hunt 2008: 123-130).

Use medication when it is needed, (only if prescribed by a qualified medical practitioner, after the necessary tests have been conducted). Create healthy sleeping habits Talk to a friend or someone at least once a week about your frustrations. Make time for relaxing. Live one day at a time. Do not procrastinate. Set time limits to your worries. Accept that you cannot do everything and that you have limitations.

4.3.1.2 Confessions for peace of mind – Correcting thinking patterns

Dr Aaron Beck was a psychiatrist trained in the standard psychiatry of his day. He analysed thought patterns through the analysis of dreams. He also used Freudian tools to have a patient discuss their thoughts as they occurred. By the 1960's Dr Beck was dissatisfied with his approach, because he noticed that when patients let their thoughts run free, they typically left after their sessions feeling even worse. He later became known for developing a practical approach to problem solving. The improvement of the patients was significantly better. Based on these findings' Dr Beck began to work with his patients to help them recognise, argue, and re-program thought processes. This approach is known as cognitive behavioural therapy (Colbert 2009: 20-28; Hunt 2008:123-130).

By using this approach, the counsellor can recognise the toxic thoughts, dispute them and learn to reprogram the mindset. When looking at a reprogram of the mind, it is cardinal to use the Bible as foundation. As Isaiah 50: 10(b) (NIV) says: '...Let the one who walks in the dark, who has no light, trust in the name of the LORD and rely on their God.' By doing so, toxic thoughts can be identified and be dealt with, 'Because the LORD is a refuge for the oppressed, a stronghold in times of trouble' (Psalm 9:9).

Here is a table of confessions, the thoughts with which the devil tempts us, versus the powerful Word of God; for if we resist the devil he will flee (James 4:7; Colbert 2009: 107-109; Hayford et al. 2002, NKJV)

My Confession	Scripture
I refuse to be sad because the joy of the Lord is my strength	'Don't be dejected and sad for the joy of the Lord is your strength' (Hayford et al. 2002: Nehemiah 8:10, NKJV)
I choose to stay in Your presence, and I am full of joy	'You will show me the way of my life, granting me the joy of your presence and the pleasures of living with you forever' (Hayford et al. 2002: Psalm 16:11, NKJV)
I trust God. He gives me strength and I am	'The Lord is my strength and shield. I trust him with all my heart. He helps me, and my heart is filled with joy. I burst out in songs of

full of joy.	thanksgiving' (Hayford et al. 2002: Psalm 28:7, NKJV)
I trust God and believe that he has put my feet on solid ground. I praise him for the amazing things he has done.	'He lifted me out of the pit of despair, out of the mud and the mire. He set my feet on solid ground and steadied me as I waded along. He has given me a new song to sing, a hymn of praise to our God. Many will see what he has done and be amazed. They will put their trust in the LORD' (Hayford et al. 2002: Psalm 40:2-3, NKJV)
I will always be thankful and full of gratitude for what Jesus has done for me.	'Enter his gates with thanksgiving; go into his courts with praise. Give thanks to him and praise his name' (Hayford et al. 2002: Psalm 100:4, NKJV)
I have perfect peace because my mind trusts God, his Word, and his promises.	'You will keep in perfect peace all who trust in you, all whose thoughts are fixed on you!' (Hayford et al. 2002: Isaiah 26:3, NKJV)
I give Jesus all my griefs and sorrows; I refuse to carry them any longer.	Surely, he has borne our griefs and carried our sorrows' (Hayford et al. 2002: Isaiah 53:4, NKJV)
I have no condemnation, I cast down all condemning thoughts	'So now there is no condemnation for those who belong to Jesus Christ' (Hayford et al. 2002: Romans 8:1, NKJV)

Whatever the counsellee's circumstances may be, they must reconstruct their way of thinking so that they can be free from depression and anxiety. By putting their trust in

the Lord, they can rest assured and not be afraid (Psalm 56:3-4). For as the Word of God says, we need to 'put on the full armour of God, so that we will be able to stand firm against the schemes of the devil. For our struggle is not against flesh and blood, but against the rulers, against the powers, against the world forces of this darkness, against the spiritual forces of wickedness in the heavenly places. Therefore, take up the full armour of God, so that we will be able to resist in the evil day, and having done everything, to stand firm' (Ephesians 6:11-13, NASB).

4.3.2 Coping on an emotional level

4.3.2.1 Advice to counsellee

Improve positive thinking patterns and reinforce your connections with positive others. Come to the realisation that your thoughts are reality to you, and what you think may influence you positively or negatively. Realise what impact negative thoughts may have on your body. Be on the alert for reactions that may follow in the wake of what and how you think. Regard negative thoughts as pollution of your life. Realise that the automatic thoughts are not always representative of the truth. Modify your negative thoughts. Socialise with people who have a positive impact on your life. Do what you can to fight against stress and fear. (Coetzer 2008:95-104):
 For the teenage counsellees to be healed they must forgive and be forgiven. In the first place, they must ask God for help, not other people. They must live and receive all that he wants for them - his love, grace and salvation. He wants to heal us from all sins, infirmities and sickness. The teenage counsellees must simply reach out and take it from him (Seamands 1981:19-23; Coetzer 2009:88-93; Seamands 2001).

The question the teenage counsellees must answer is: 'Have you forgiven those who have sinned against you? And are you a graceful soul?' Here's a test (Seamands 1981:34; Seamands 2001):

TEST	QUESTION
1. Resentment	Is there someone you resent, that you've

	never let off the hook?
2. Responsibility	Do you wonder, or ask, 'if only'?
3. Remember and reaction	Do you react because someone reminds you of something?

4.3.3 Coping on a Spiritual dimension:

4.3.3.1. Advice to counsellee or teenager

Read Philippians 4. Pray constantly. Fight the battle in the Spirit, take up your armour of Christ, and stand firm in your beliefs (4:6). Recommit yourself to God. He will protect your thoughts if you come in right standing with God. First put your trust in him and he will provide for you in every aspect of your life (4:7); Ponder on positive thoughts (4:8). Focus on Godly behaviour (4:9). Place the focus on others and not on yourself (2:3, 4:10). Try to be content with what you have (1 Timothy 6:6, Philippians 4:11). Eliminate the fear of poverty (Philippians 4:19). Know that God's grace is with you (2 Corinthians 9:8; Philippians 4:23). Acknowledge your own sin. Stop your sinning. Forgive yourself, God and others, and Find your identity in Christ. (Hunt 2008:123-130):

4.3.4 How to defeat depression

For depression to be defeated we must allow the light of God to permeate our ditch of darkness and guide us to the road of transformation. Below are the steps one can take to C-O-N-Q-U-E-R depression (Hunt 2008;123-130; Hayford et al. NKJV 2002).

C - Confront your loss in your life, allowing yourself to grieve and be healed.

'There is a time to weep and a time to laugh, a time to mourn and a time to dance' (Hayford et al. 2002: Ecclesiastes 3:4, NKJV)

O - Offer your heart to God for cleansing and confess your sins.

'If we say that we have no sin, we deceive ourselves, and the truth is not in us. If we confess our sins, he is faithful and just to forgive us our sins,

and to cleanse us from all unrighteousness.’ (Hayford et al. 2002:1 John 1:8-9, NKJV)

N – Nurture thoughts that focus on God’s great love for you.

‘The LORD hath appeared of old unto me, saying, Yea, I have loved thee with an everlasting love: therefore, with loving kindness have I drawn thee.’ (Hayford et al. 2002: Jeremiah 31:3, NKJV)

Q – Quit negative thinking and negative self-talk.

‘Finally, brethren, whatsoever things are true, whatsoever things are honest, whatsoever things are just, whatsoever things are pure, whatsoever things are lovely, whatsoever things are of good report; if there be any virtue, and if there be any praise, think on these things.’ (Hayford et al. 2002: Philippians 14: 8, NKJV)

U- Understand God’s eternal purpose for allowing personal loss and heartache.

‘And we know that all things work together for good to them that love God, to them who are the called per his purpose.’ (Hayford et al. 2002: Romans 8:28, NKJV)

E - Exchange your hurt and anger for thanksgiving and give thanks even when you do not feel thankful.

‘In everything give thanks: for this is the will of God in Christ Jesus concerning you.’ (Hayford et al. 2002:1 Thessalonians 5:18, NKJV)

R - Remember that God is sovereign over your life and he promises to hope for your future.

‘For thou art my hope, O Lord GOD: thou art my trust from my youth.’ (Hayford et al. 2002: Psalm, NKJV)

4.4 Low self-esteem or self-worth

4.4.1 *How to heal low self-esteem?*

To heal our self-esteem, we must change the way we see ourselves. We need to see ourselves through the eyes of the Lord, as the Word of God says, ‘even though

we were sinners God loved us, and he loved us with an everlasting love' (Romans 5:8; Jeremiah 31:3).

Healthy self-image is based on four components (Coetzer 2009; Hunt 2008). Sense of belongingness, of being loved; Sense of worth and value; Sense of being competent; Understanding who we are in Christ.

If we can experience the above, we can have a healthy self-image. There are different sources of self-image, namely, the external world (how we view pictures of ourselves, how we perceive the way others see us and feelings about ourselves reflected in mirrors of family members), the world within us (the physical, emotional and spiritual equipment that we bring into the world), Satan and all his forces and God and his world. (Seamands 1981:47-76; Seamands 2001)

For us to destroy the strong hold of the devil we must start believing in ourselves and see ourselves as God sees us. The table below provides us with enough evidence that we can and may be free, and we should meditate on it every day (Hunt 2008: 357-364; Coetzer 2009:31-40; Hayford et al. 2002)

QUESTION	BIBLICAL ANSWER
What right do you have that compels you to belittle or despise someone whom God loves so deeply?	'For God so loved the world that he gave his only begotten Son, that whosoever believeth in him should not perish, but have everlasting life.' Hayford et al. 2002: John 3:16, NKJV)
What right do you have to belittle or despise someone God has honoured so highly?	'Behold what manner of love the Father hath bestowed upon us, that we should be called the sons of God: therefore, the world knoweth us not, because it knew him not. Beloved, now are we the sons of God, and it doth not yet appear what we shall be, but we know that, when he shall appear, we shall be like him; for we

	shall see him as he is.' Hayford et al. 2002: 1 John 3:1-2, NKJV)
What right do you have to belittle or despise someone God values so highly?	<p>'For scarcely for a righteous man will one die yet peradventure for a good man some would even dare to die.' Hayford et al. 2002: Romans 5:7-8,11, NKJV)</p> <p>But God commendeth his love toward us, in that, while we were yet sinners, Christ died for us. And not only so, but we also joy in God through our Lord Jesus Christ, by whom we have now received the atonement.</p>
What right do you have to belittle or despise someone whom God provided for fully?	<p>'If ye then, being evil, know how to give good gifts unto your children, how much more shall your Father which is in heaven give good things to them that ask him?' (Hayford et al. 2002: Matthew 7:11, NKJV)</p> <p>'But my God shall supply all you need per his riches in glory by Christ Jesus'. (Hayford et al. 2002: Philippians 4:19, NKJV)</p>
What right do you have to belittle or despise someone whom God has planned for so carefully?	<p>'Blessed be the God and Father of our Lord Jesus Christ, who hath blessed us with all spiritual blessings in heavenly places in Christ: According as he hath chosen us in him before the foundation of the world, that we should be holy and without blame before him in love: Having predestined us unto the adoption of children by Jesus</p>

	Christ to himself, according to the good pleasure of his will,' (Hayford et al. 2002: Ephesians 1:3-5, NKJV)
What right do you have to belittle or despise someone in whom God delights?	'To the praise of the glory of his grace, wherein he hath made us accepted in the beloved.' (Hayford et al. 2002: Ephesians 1:6, NKJV) 'This is my beloved Son; in whom I am well pleased.' (Hayford et al. 2002 : Matthew 3 :17, NKJV)

4.4.2. Guidelines for the pastoral counsellor

Helping someone with damaged emotions takes time and the help of the Holy Spirit. Below are a few suggestions with a view to reaching out to and helping teenage counsellees (Coetzer 2009:88-93; Hunt 2008:357-364). Lead them towards facing their problem squarely. Get them to accept responsibility - they are responsible for their actions and must stop blaming everyone else. Ask them whether they want to be healed. They should forgive everyone involved and themselves as well. Ask the Holy Spirit to guide you to the real problem and how you should pray.

Another way to help the counsellee is to use the 3-point test, to make sure that the person has forgiven everyone (Seamands 1981:34; Seamands 2001): Resentment test, is there someone you resent and whom you have never let off the hook? Responsibility test, do you ask, 'if only'? Remember and reaction - do you react a certain way because the person reminds you of someone?

When a person suffers from a low self-image or self-worth the counsellor must investigate how the counsellee experiences God, because the way he/she views God will influence the way he/she views himself/herself.

4.5 Distorted concepts of God

Concepts of God can be the source of many emotional hang-ups in Christians and can be considered as one of the strongest indicators for healing of memories.

Distorted concepts of God are created when people get caught between what they think about God compared to what they feel about God. Instead of trusting God, who is predictable in his steadfastness and reliable in his faithfulness, many are, however, still filled with fears and anxiety because they might perceive God as being untrustworthy. They might have been influenced by several people and incidents to arrive at their conclusions. It will be necessary to investigate and determine what they think / feel / believe about God and as far as possible why (Seamands 1981; Seamands 2001).

Some of the faulty images of God are (Seamands 1981; Seamands 2001): the legal God – Accounting for what we do. Got you God - Following at a short distance and waiting for one to make a mistake. The sitting-bull God - Relaxes in yoga position and waits for offerings. Philosopher God - Too busy running galaxies to get involved in our problems. Pharaoh God - Unpleasable taskmaster who is forever increasing his demands.

4.5.1 *Difficulties from the distortions about God*

A few possible difficulties, uncertainties, doubts are mentioned below (Seamands 1981:95-106; Seamands 2001): Inability to feel forgiven; for healing, a person must heal the primary relationship which has caused the problem and develop trusting relationships. Inability to trust and surrender to God; the memory of disappointing experiences is so strong that they are now unable to trust anyone enough to surrender. Intellectual questions; certain damaged Christians have unhealed hurts which are so entangled with their concepts or feelings about God that they have become a part of the way these people keep from feeling their pains. This will manifest itself by the questions they ask. Problems with neurotic perfectionism; the victims experience the strain of compulsively and constantly trying to make themselves acceptable to God and then to measure their relationship with God in terms of performance and accomplishment.

They are restive achievers not resting believers. The root cause is the concept of an unpleasable God. This leads to perfectionist Christians, who twist the truth by rating

their behaviour before God as more important than their relationship with him (Seamands 1981:95-107; Seamands 2001).

4.6 Perfectionism

4.6.1. *The process of healing of perfectionism*

For healing to begin it must be remembered that healing is a process and can only be accomplished by the grace and love of Jesus Christ. In almost all cases perfectionism will need to be healed, because it often has proved to manifest as an extremely tiring, demanding and devastating enemy of inner peace and satisfaction (Seamands 1981: 89-100; Seamands 2001).

Why do people develop emotional problems? These can often result from the kind of god, the kind of people and the kind of life we saw as we looked through the relational windows of childhood. The patterns of how we see a relationship take shape within family life - the influence coming from unpleasable parents and unpredictable home situations will certainly differ from the influence coming from accommodating parents and stable home situations. Apart from the difference of influences as such, the way in which the influences are absorbed and interpreted will also to a certain extent differ from individual to individual. ('I can relax at home because my parents live in peace and our household runs so smoothly' / 'I'm a failure because I cannot possibly live up to the expectations of this peaceful household that runs so smoothly.') (Coetzer 2009:8-17; Seamands 1981:89-100; Seamands 2001)

For healing to take place three things must happen, counsellees must; Acknowledge that what they are busy doing is wrong; Confront the deeper roots of the problem and Resolve the problem at hand.

This means forgiving every person involved in the hurt and humiliation; it means surrendering every desire for a vindictive triumph over that person, and it means allowing God's forgiving blood to wash over a guilt-ridden soul (Coetzer 2009:70-79; Seamands 1981:89-100; Seamands 2001).

Looking back on the journey through self-mutilation the counsellor can now more readily identify the problem at hand and deal with the deeper roots of the problem.

4.7 Damaged emotions

When dealing with a counsellee who has damaged emotions, the counsellor should remember that there is no quick cure for healing these emotional hurts. (Coetzer 2009:88-93; Seamands 1981:9-24; Seamands 2001). Those who seek assistance should be put at ease, reassured and encouraged to allow the Holy Spirit to work with special healing in their hurts and confusions. During the healing process the counsellor should not judge but should rather have patience with confusing and contradictory behaviour. (Coetzer 2009:88-93; Seamands 1981:9-24; Seamands 2001). The Bible points out that 'by their fruits you shall know them' (Hayford et al. 2002: Romans 8:26, NKJV), but it is also true that by their roots you shall understand and not judge them (Seamands 1981:12; Seamands 2001).

One of the most common, damaged emotions manifests itself through a sense of unworthiness (Seamands 1981:14; Seamands 2001). This can be seen in many forms, for example, a perfectionist complex and super-sensitivity (Seamands 1981:14-19; Seamands 2001).

Why do people struggle with damaged emotions? The simplest explanation can be seen in the parable of the merciful servant. Jesus puts life into his teachings about forgiveness.

It is important for the counsellor to know where the real root is situated. When dealing with damaged emotions, the root can be found in every incident where the teenage counsellees experienced pain, trauma, shock, rejection and emotional dismantlement (Coetzer 2009:8-19). In most of the cases and situations the teenage counsellees most probably received the message that they were simply not good enough.

The Lord warns us that we must be vigilant in all aspects of life through body, mind and soul (Hayford et al. 2002:1 Peter 5:8, NKJV). The easiest way for Satan to get you off track is to make you believe you are less worthy than you really are, and to miss the calling to which the Lord has called you (Coetzer 2009:31-44; Seamands 1981: 14-19; Seamands 2001).

Looking at the normative task, counselling the victims of self-mutilation, young people who are struggling with self-mutilation, the concern is not just struggling with the act, which is only the tip of the iceberg, but there are other spiritual aspects that

complicate the matter further. Many young people may feel guilty for not experiencing the healing power of God. However, looking at the roots of the cause as outlined above, the counsellor can help the counsellee come to a place of acceptance as well as healing. In the next chapter the therapeutic framework will be discussed, to equip the counsellor in assisting the counsellee in his or her healing process.

CHAPTER 5

STRATEGIC TASK: THERAPEUTIC FRAMEWORK FOR THE COUNSELLING OF SELF-MUTILATION VICTIMS

Christian counsellors in the Free State who work as children of the highest God have the responsibility to help teenage counsellees develop into what God has designed them to be. There is a saying that states that the Christian army is the only army that shoots its wounded (Carlson 1998). Many teenage counsellees who will come across the pastoral caregivers' path are broken and chained up in damaged emotions, and thus they are in dire need of healing. Such a desperate individual feels isolated and alone. The pastoral caregiver, as an instrument in God's hands, has the task of showing the teenage counsellees that there is hope. Casting Crowns, a contemporary Christian rock band, express this in their song 'Just be held', which says; 'If you look to the cross you will know that I have always loved you and I always will.' (Casting Crowns 2014).

In this chapter the researcher's main aim is to supply the pastoral caregiver with a framework for counselling self-mutilators, with specific reference to cutting. The framework entails guidelines for how to be an instrument of the highest God, and how to allow the Holy Spirit to guide one in helping a counsellee in need.

In this chapter attention will be paid to two counselling methods that go hand in hand, namely, the healing of painful memories through prayer, and narrative therapy. For the researcher this is the most effective way to deal with any problem; by deconstructing the problem into smaller parts, then dealing with the roots through the guidance of the Holy Spirit, healing the broken emotions and memories to become a vessel of honour. In the previous chapter it was shown that the healing of the roots is of the utmost importance. Looking at the approach of Seamands to the healing of damaged emotions, as well as memories, through prayer when dealing with a counsellee, the important aspect is to know that Jesus is the same yesterday, today

and forever, and can take the pain of the past emotions or memories away. He is the ultimate healer, he alone can heal us from our wounds in past as well as present times (Seamands 1981, 1985, 2001). By filling his love in all our hurt places that have been empty so long, once they have been healed and the counselees are drained of the poison of past hurts and resentment they can come to a place of healing and become the vessel of honour that the Lord destined them to be. In this chapter the researcher focused on finding the problem-saturated story and shining the Light of Christ on to it so that the counselee can deal with the roots of the problem.

Seamands' elementary argument is that people tend to carry deep wounds from the past, and these wounds are situated largely in the emotions. He compares these wounds to the biblical idea of 'infirmities', though he acknowledges that this word initially applied to physical defects and deformities. Seamands argues that we will forever be responding to our woundedness, and that these scars will manifest themselves through deep character and interpersonal deficiencies until they are honestly confronted, addressed, and handed over to Christ whom Seamands calls 'the wounded Healer'. (A Resource for the Pilgrim Church 2016)

The ways that these wounds manifest themselves, Seamands argues, is in feelings of insecurity, unworthiness, perfectionism, legalism, and anger. These emotions can be seen in a self-mutilation victim as described in the previous chapter

Seamands rightly situates the wounded believer's ultimate hope for healing in the cross of Christ. He also rightly argues that the cross destroys any notion of an experiential disconnect between suffering humanity and God, for in Christ God has stepped into and understands, and has himself felt the burden of suffering. This is a very important point and is well made (A Resource for the Pilgrim Church 2016).

Although this one method is not a simple fix for all victims, and with the guidance of the Holy Spirit, different techniques need to be integrated to be able to assist a victim to become a vessel of honour for God. The researcher believes that by combining the Narrative therapy approach as well as Seamands' approach the victims can come to a place of healing.

5.1 Narrative Therapy

Narrative therapy is a form of psychotherapy pioneered in Australia and New Zealand in the 1980's (Mucherera 2013). The father of this approach is Michael White, a social worker and family therapist. He developed a ground-breaking and highly real-world technique using storytelling to help patients of all ages to deal with childhood traumas (Pearce, 2008). In association with a colleague, David Epston, White explored the power of shaping individual accounts and recollections in facing the remaining effects of childhood insufficiencies and other hindrances in patients' lives. (Pearce, 2008).

This approach is from secular psychology, but many Christian counsellors in the Free State use this method in their counselling (Kutuzova 2010). They have adapted it into Christian Theology as a method of counselling. As Maarten Wisse of the University of Heidelberg Germany explained in his article, *Narrative Theology and the Use of the Bible in Systematic Theology*(2005), there was an important development in Christian theology during the second half of the twentieth century was what we might call the 'narrative turn', the idea that Christian theology's use of the Bible should focus on a narrative representation of the faith rather than the development of a set of suggestions construed from the information of revelation. (Wisse, 2005).

Narrative therapy emphasises the importance of the narrative (verbally transmitted) participation of the counsellee, telling/conveying/sharing his/her own 'story' or experiences to make known the development and expression of the counsellee's perceived and lived interpersonal and intrapersonal relationships and the accompanying problems encountered. Counsellors need to take care when listening, take note not only of what is said, but also of how it is being said (Mucherera 2013). It can, however, become problematic due to the one-sided view of the situation, and in some cases the information gathered has to be tested to make sure that the view of the situation is as it seems to the victim.

With the use of therapeutic questioning as well as the guidance of the Holy Spirit the counsellor can recognise and reflect on the discrepant positive elements of the

current problem-saturated story (self-mutilation), and by using this method help the counsellee to be better equipped to reformulate a more preferred life direction (Mucherera 2013).

Narrative therapy applies a non-blaming approach. Counsellors in the Free State endeavour to encourage teenage counsellees to make better use of their abilities, including skills of living and self-knowledge to deal with their challenges in their life. (AIPS 2010)

5.1.1 *Therapeutic questions*

A counsellor has different types of questions to use for gathering additional information, thus prompting the counsellee into opening up on specifically required information. Questioning may also serve the purpose of allowing an opportunity for a counsellee to tell more about a certain topic/incident to shed the burden (Filadelfia opleidingsentrum 2014). Open-ended space questions function as a unique outcome. They give the counsellee the ability to see another side of their story that they couldn't have predicted, by using the plot of a problem-saturated story to open up the exceptions to the problem (Freedman and Combs 1996; Filadelfia opleidingsentrum 2014). For example; 'When was a time when you had better control over the issue?' Rhetorical questions – these questions have been designed to reveal a response to help people see that they are separate from and have power over their problem. Example; 'Was the way you dealt with it effective?' (Freedman and Combs 1996; Filadelfia opleidingsentrum 2014). Story development questions, used in story construction, or re-authoring; story development questions invite teenage counsellees to describe the process and details of an experience and connect it to a timeframe, context, or other person by increasing the knowledge through space and time and adding people to it (Freedman and Combs 1996; Filadelfia opleidingsentrum 2014). Example: 'How will you know when this new story has begun to play out to you?' Re-authoring questions - this questioning is to inquire about how the client would like things to be, by including aspects about themselves that they have not yet discussed, because they do not seem to be applicable to the current problem-saturated story (Freedman and Combs 1996; Filadelfia

opleidingsentrum 2014). Example: 'What does this tell you about yourself that is important for you to know?'

These are just some examples of the questions that counsellors in the Free State could use to help the teenage counselees to open up and to tell their stories. In doing so they might be able to create distance between themselves and their problems - a distance that may well prove to be essential for creating and establishing changed perceptions.

5.1.2 *The process of narrative therapy*

With narrative therapy, it is important to know that the process does not always work in the same way. Each counsellee will be different. There are different stages of the therapy process, including the following: a) Dominant story; this story is a 'thin' (summarised) story where the client comes and tells a bit about the problem and themselves. b) Externalize story, during this part of the process the counsellor should use the questioning methods above to help the clients see themselves apart from the problem. c) Deconstruction, the counsellor and counsellee work together to take the story apart by taking the facts of the story, the historical proof, the lies that the counsellee believes, and rearranging these components in a balanced way. d) Unique outcomes; at this stage the clients are assisted to isolate the moments when the problem did not control their lives. The counsellor helps the teenage counselees to use their imagination to create a plan of action; doing so could inspire them to reach a point of commitment to change the problem. It is very important for the teenage counselees to know that they are the experts in this situation and stage. e) Alternative story; at this stage the teenage counselees have thickened or enriched or reconstructed their stories, based on their progress from the first stage up to this stage, and with the added 'new' detail as good as a 'new' story to the teenage counselees themselves (Filadelfia opleidingsentrum 2014).

Looking at the above it can be seen that by using Narrative therapy the suppressed emotion inside can be deconstructed, named and dealt with, and as a result the emotions can heal, and the inner turmoil of the counsellee can be resolved.

5.2 Healing memories through prayer

When dealing with teenage counselees who have practised self-mutilation, the counsellor must also look at the healing of the memories of the trauma they experienced.

The counsellor and counsellee will explore memories of the counsellee as a potential root of the problem of self-mutilation. The aim is to identify the specific incident that changed his/her life, and then to help the counsellee take the sting out of it (Seamands 1985:23-32; Seamands 2001).

5.2.1 *Mystery of memory*

Examining memory from a biblical perspective; it is viewed as a mystery (Seamands, 1985:9-22; Seamands 2001). The Lord made us so incredibly, that memory can originate even while we are in our mother's womb, as the Word of God shows us in the following scriptures: Luke 1:44 says: 'For, lo, as soon as the voice of thy salutation sounded in mine ears, the babe leaped in my womb for joy.'(NKJV); Jeremiah 1:5 : 'Before I formed thee in the belly I knew thee; and before thou camest forth out of the womb I sanctified thee, and I ordained thee a prophet unto the nations'(NKJV).

The mystery becomes even greater when looking at scripture that says that even God will remember our sins no more - as far as the east is removed from the west (Hayford, et al. 2002: Psalm 103: 12, NKJV). When God forgives, he really forgets as well; 'for I will forgive their iniquity, and I will remember their sin no more.' (Hayford et al. 2002: Jeremiah 31: 34 (b), NKJV).

5.2.2 *What is healing of memories?*

According to Seamands the healing of memories approach can be defined as applying Christian counselling techniques and prayer that focus on the healing power of the Holy Spirit and on certain types of emotional or spiritual problems (Seamands 1985:23-32; Seamands 2001).

Counselling can be effective, for God may use another person or group to bring about insights we have been unable to discover on our own. It is often necessary to uncover hidden hurts, unmet needs and repressed emotions that are preventing us

from getting to the truth, as it is written in the Word of God; 'And ye shall know the truth, and the truth shall make you free' (Hayford et al. 2002: John 8:32, NKJV).

When practising counselling, it is difficult to know when healing of memories is called for. The counsellor must be led by the Holy Spirit in order to know whether the healing is necessary. However, when it is called for it must be remembered that praying is essential, and healing cannot be brought about without it. When praying, the Holy Spirit can touch barriers to heal the memories.

5.2.3 *Why do some memories need healing?*

Not all memories need healing, and some can be healed over time. But some stay with one knowingly or involuntarily (Seamands 1985:33-42; Seamands 2001).

The well-known phrase 'time heals all wounds' is one of the greatest myths about memories, because not all wounds can be healed by time, or, for that matter, by all kinds of human efforts, which would prove to be too limited to work the miracle (Seamands 1985:33-42; Seamands 2001). If the mind consciously endures pain when it is experienced, as time passes the intensity of the memory will reduce. With sufficient time the memory will remain, but the pain will become less severe, or even in some cases vanish, and only a sensitive scar will remind us of what had happened. But what about those memories that are so painful that your mind cannot tolerate them? It has been proved that some experiences are as alive and painful ten or twenty years after their occurrence. These are the memories that would need to be healed (Seamands 1985:33-42; Seamands 2001).

People who carry hurtful memories will allow such memories to come into conscious recall only under certain conditions. Thus, it is very important for us to create a constructive atmosphere and to present the Gospel in the correct way (Seamands 1985:33-42; Seamands 2001).

5.2.4 *Biblical foundation for healing of memories*

To Christians, a solid foundation in Scripture is very important, because it encompasses the final and ultimate authority according to the Word, 'in the

beginning was the Word, and the Word was with God, and the Word was God'. (Hayford et al. 2002: John 1:1, NKJV). For memory healing to commence we must remember that Jesus is eternal, contemporary, the Lord of time and our healer, and his Holy Spirit is our present and our helper (Seamands 1985:61-78; Seamands 2001). This can be seen in the following scriptures:

- 'Then said the Jews unto him, thou art not yet fifty years old, and hast thou seen Abraham? Jesus said unto them, Verily, verily, I say unto you, Before Abraham was, I am' (Hayford et al. 2002: John 8:57-58, NKJV).
- Jesus Christ the same yesterday, and today, and forever' (Hayford et al. 2002: Hebrew 13:8, NKJV).
- 'John bare witness of him, and cried, saying, this was he of whom I spoke, He that cometh after me is preferred before me: for he was before me' (Hayford et al. 2002: John 1:15, NKJV).

Memory healing is the following (Seamands 1985:61-78; Seamands 2001):

- We use imagination to recreate the painful memory and visualise it as it takes place.
- We ask God to do for us what we would have asked if we had prayed then and there at the time of occurrence.
- We ask him to heal the little child/the despairing adolescent or adult who has undergone those experiences.
- For the healing process to begin we must be honest with ourselves and God about our sins, failures and needs. We need to respect the following biblical principles: honesty, transparency, repentance and confession.

We create lies to keep us from confronting our hurts, failures and sins. In psychology terms, they are called defence mechanisms. The psychologist describes them as follows (Seamands 1985:61-78; Seamands 2001):

Denial, denying that something has happened or is wrong.

'If we say that we have fellowship with him, and walk in darkness, we lie, and do not know the truth' (Hayford et al. 2002: 1 John 1:6, NKJV).

Rationalisation, finding reasons to justify our behaviour.

'If we say that we have no sin, we deceive ourselves, and the truth is not in us.' (Hayford et al. 2002: 1 John 1:8, NKJV).

Projection, blaming others for our problems.

'If we say that we have not sinned, we make him a liar, and his word is not in us.' (Hayford et al. 2002: John 10:14, NKJV).

The difficulty with the healing of memories is that we are unable to pray specifically about the incident. We fail to confess to God what we do not acknowledge to ourselves, we generalise forgiveness and end up in a hazy, foggy generalised relationship with God.

In conclusion, the kind of prayer needed for the healing process can be found in 'Again I say unto you, that if two of you shall agree on earth as touching anything that they shall ask, it shall be done for them of my Father which is in heaven. For where two or three are gathered together in my name, there am I during them.' (Hayford et al. 2002: Matthew 18: 19-20, NKJV).

5.2.5 *Indications for the healing of memories*

Previously it has been stated that healing of memories is not necessary for every counsellee. Who qualifies for this kind of healing? How do we determine it? These aspects are discussed below.

If the counsellee presents with certain symptoms, healing of memories should be implemented; for example, when teenage counsellees experience recurring mental pictures, scenes or dreams that bring about disturbances and disruptions in their emotional and spiritual life (Seamands 1985:79-94; Seamands 2001).

Some dreams' contents and pain seem to have certain similar or common denominators. These are: *Hurt*, anything which causes physical pain or mental and emotional anguish. Most painful hurt is rejection, during earliest years of life pre-school and early grades. *Humiliations*, chief cause of low self-esteem and depression. *Horrors*, fears and terrors that can lie embedded or latent in the lower layers of the mind, and one day unexpectedly rise to fill us with all kinds of anxieties.

Fears are rooted in frightening experiences, unhealthy teachings and poor relationships somewhere in the past - especially during early years of childhood. *Hates*, many illnesses may have roots in unhealed resentments. When Christians fail to express true feelings, their bodies cry out through voices of pain and illness (Seamands 1985:79-94; Seamands 2001).

5.2.6 *Preparing for prayer time*

Prayer time can be divided into three steps (Seamands 1985:123-138; Seamands 2001): *Preparation of teenage counselees* – the counsellor gives them homework. They should read certain assigned books and make notes of any memories that come up during this. No memories are too big or too small, and everything must be written down in detail. They must realise that no one can help them if they do not want help. *The counselling session* – this is the time when the counsellee confesses and opens up to the counsellor about memories, feelings, sins and anything that he/she feels is holding him/her back. The counsellor acts as the assistant and the Holy Spirit guides the counsellor to help the counsellee to identify the problems that had been buried for a long time. *Preparation for a counsellor* – the counsellor must prepare for crucial prayer time. Notes about sessions must be reviewed, and meditation and prayer are needed for the emotional as well as spiritual energy for the task at hand.

5.2.7 *Conducting the prayer time*

This is a very essential part of healing and must be planned properly. You must have unhurried time, because prayer time consists of going through memory healing processes step by step (Seamands 1985:139-162; Seamands 2001).

For prayer time to begin, you as the counsellor must explain and remind the teenage counselees regarding concepts of prayer and explain that they are going to use conversational prayer, and that Jesus Christ is Lord and therefore Lord of time. He will step back with us to the specific moment in your memory that will help you to confront it and help you to alleviate the burden and trauma and negative impact that deprive you of peace and happiness (Seamands 1985:139-162; Seamands 2001).

The session begins with the counsellor, who opens up with prayer. Then you as counsellor must be patient, waiting for counsellee to start praying. When praying you may guide and encourage the counsellee (Seamands 1985:139-162; Seamands 2001). (Also, hand over the healing to the Holy Spirit, who will be doing the healing not the counsellor).

The crux of memory healing is forgiveness. For forgiveness to start the counsellee must look at the following (Seamands 1985:139-162; Seamands 2001): Relinquish all feelings of resentment. Take responsibility for who you were and what you did. Get rid of the leverage. Stand beneath the Cross; pray for grace to surrender all claims on the future, for that too could have been a form of resentment.

When the prayer time comes to an end a follow-up session must be scheduled, and warning must be given that this is, and was, an extremely draining process and a kick-back reaction might be felt. This may include emotional and physical reactions.

5.2.8 *Healing memories of sexual traumas*

Sexual trauma is a very sensitive topic and should be dealt with as such.

When working with sexual trauma victims' counsellors should remember to wait for them to mention it. When a person says something aloud in our presence, he/she can never deny it to themselves again. We must keep in mind that they are dealing with contradictory emotions that can be extremely painful, because our sexuality is the heart of our identity, and sexual intercourse is a very powerful emotion (Seamands 1985:163-180; Seamands 2001).

When working with victims of sexual trauma we must understand their turmoil and confusion, and develop wisdom, skill and spiritual resources to help them find wholeness of body, mind and spirit.

5.2.9 *Follow-up cautions and conclusions*

We must remember that healing will take time, and therefore follow-up sessions are so important (Seamands 1985:181-189; Seamands 2001). We must reprogram the way we think, act or react. Because of destructive memories, we have distorted perceptions and are likely to have wrong coping mechanisms.

The healing includes new ways of relating to God, others and ourselves. We must renew our mind and start looking at ourselves as God looks at us.

And remember, memory healing is like being delivered from a prison of past hurts. We cannot change the fact that we remember, but we can work on preventing the adverse effects (Seamands 1985:181-189; Seamands 2001).

For the last part of memory healing we must teach the teenage counsellees how to do the memory healing by themselves. They will need to grow strong in the Spirit and find their power in Jesus Christ.

5.2.10 Guidelines for the pastoral counsellor

Counsellors in the Free State are advised to observe the steps below for conducting memory healing. Identify through the power of the Holy Spirit when healing of memories is needed; when identified that it is necessary, you must give counsellees homework, for example a reading list, so that they can make notes of the memories that need healing. This must be specific and in detail. Counselling session - Prayer Time - and Follow up.

Things to remember: Healing takes time, No one can be healed if he/she does not want to be healed, Praying is essential; never force a teenage counsellee to tell you something, wait till he/she wants to tell you, pray for wisdom, skill and spiritual resources when counselling; forgiveness is a key principle. Healing cannot be accomplished if there is no forgiveness for the self and others, help your teenage counsellees to find their identity in Christ, finally – Be a vessel of honour for God and let him guide you throughout the counselling session.

CHAPTER 6

SUMMARY AND CONCLUSION

In this study the researcher investigated the phenomenon of self-mutilation with the aim of proposing a pastoral counselling framework that could aid pastoral counsellors in the Free State in counselling victims of self-mutilation.

The research indicated that it is important to note that the act of self-mutilation is the deliberate injuring of one's own body without the intent to end one's life. There are many forms of self-mutilation, but the most common form is cutting. This is also the form of self-mutilation most frequently used in religious practices as described in 1 Kings 18:20-28, Leviticus 19:27-28 and Deuteronomy 14:1. In the thesis the researcher investigated this act by looking at the Hebrew origin of the word 'cut' used in these scriptures. It seems that for the word 'cut' the term *lances* was used, which explains the use of self-mutilation as a common act of oriental frenzy. It was also possibly a method of human sacrifice, practised in the belief that self-torture and the shedding of human blood must win divine favour (Ellicott and Limited 2015).

The Bible states that there is nothing new on this earth or in our lives. God sees it all and knows it all. In the literature review we saw the different historical occurrences of self-mutilation, as well as different studies that were conducted into this phenomenon. We can see in this study that self-mutilating is not a respecter of persons, and anyone can fall into the trap of self-harm.

It is concluded that self-mutilation is an outward expression of a deeper emotional, physical, as well as, psychological pain (Gardner 2013:53-75). Cutting and other forms of self-mutilation are just the tip of the iceberg. The iceberg represents deeper areas of emotions and experiences (Dombeck 2015). Clark and Henslin (2007:48) asserted that self-mutilation is a strong barrier that keeps others from seeing a person who is lost, in pain and in desperate need of help. Thus, moving beyond the

presenting symptoms to explore deeper issues is imperative for an understanding of the reasons for self-mutilation. The reasons motivating self-harm are complex and difficult to identify. It happens sometimes that emotions such as depression and anxiety become too much for a person to handle (Kern 2007:33).

Thus, the importance of inner healing cannot be overlooked. The roots of this phenomenon run extremely deep, and if not treated correctly can lead to death. In the process of the research into self-mutilation, the stories of victims who almost lost their life to this illness were one of the reasons for the researcher to undertake this study.

In the field of counselling, some cases heal and can live in the fresh newness of what the Lord wants for them; unfortunately, some backslide, and some fall short because their flesh is weak. Unfortunately, backsliding is part of the process of change, and it is the responsibility of the counsellor to prepare the counsellee in case it happens. According to Selekman (2002:165), counsellors in the Free State need to be aware that if the counsellee experiences a low point in his or her life, falling back to their old ways is a possibility, and the counsellor, as well as counsellee, needs to be prepared for this. There are different ways to assist a counsellee at that point. They need to know there is someone who can assist without judgement, and they need to have new ways of coping already in place, in the knowledge that if they fall, the fall must be reconstructed into a possibility of new growth.

To conclude, it is extremely important to come to a place where the counsellors in the Free State can let God lead them, because through oneself alone healing cannot take place. God alone can heal and have the power to heal. Counsellors in the Free State need to understand that they are just the vessel God uses to assist his Sheep on earth.

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