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Self-Harm in Psychodynamic
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ABSTRACT

The purpose of this exploratory study was to gain a deeper understanding of how individuals who self-harm develop ways of communicating about self-harming experiences in therapy. The study used semi-structured interviews with twelve participants to gather qualitative data about their experiences, with a focus on identifying what aspects of therapy were helpful to them, and what was difficult about engaging in therapy.

Participants spoke about the therapeutic encounter as one among many socio-cultural contexts in which changes of self-injury occurred. Findings suggest that engaging individuals who self-harm in therapy involves an understanding of self-harm as a communication of distressing experiences, much like verbal language and other bodily forms of expression. Findings also suggest a unique conceptualization of recovery within an injured body-highlighting the active and embodied nature of the emotion work done through self-harm, and how personal recovery processes and resources remain undervalued in therapeutic contexts focused on behavior cessation.

"TRANSLATING THE LANGUAGE OF THE BODY": ENGAGING INDIVIDUALS

WHO SELF-HARM IN PSYCHODYNAMIC PSYCHOTHERAPY

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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CHAPTER I

Introduction

Engaging individuals who self-injure in therapy is a multifaceted clinical challenge. Though there are many forms of self-harm, such as cutting the skin with a knife or razor, burning the skin, or bruising oneself repeatedly (Levenkron, 1998; Conterio & Lader, 1998), I define self-harm more broadly as an "intentional, self-effected, low lethality bodily harm of socially unacceptable nature, performed to reduce psychological stress" (Walsh, 2006, p.4). Such acts often constitute a form of expressing experiences that are too painful to be spoken or sometimes even thought about (Motz, 2010). Individuals who self-harm often have great difficulty in verbal expression of painful emotions associated with the inner and environmental experiences contributing to their behaviors. As posed by many theorists in the field of self-harm, the very act of self-harm is one way in which these individuals are able to express themselves.

Pre-existing literature about self-harming behaviors in adolescents suggests that there is very little offered in terms of specific interventions leading to better engagement or long term outcomes directly related to the communication challenges these clients face (Ougrin & Latif, 2011; Sinclair & Green, 2005). Considering most psychotherapeutic interventions involved shared dialogue between the client and clinician, the inherent framework of therapy poses a potential barrier to therapeutic process, specifically when engaged in talk about self-harming acts (Straker, 2006). There appears to be a combined lack of research in effective interventions, outcome measure, and other potential clinical barriers to engaging self-harming individuals in

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talk therapy. This indicates a need for further study designed to explore the early stages of the therapeutic encounter with self-harming clients to gain insight into how they learn to engage in talk therapy given their difficulties in communication. How do these self-harming individuals develop a way to communicate within the early stages of the therapeutic encounter around their experiences of self-harming? The proposed exploratory study will utilize a qualitative research design based on a semi-structured interview format.

In order to reduce risk to participation, participants will be over the age of 18 and identify as being "in recovery" from engaging in non-suicidal self-injury. For the purposes of this study, which maintains a framework that experiences of self-harm signify meaningful expressions on the part of the self-harmer, there is also an understanding that for the scarred body there might also be particular ways of accounting for the recovered self (Chandler, 2013). As such, I provide no additional inclusion criteria defining the bounds of "recovery" for potential participants. As this study is intended to gather information the early experiences of addressing self-injury within a therapeutic context, participants will identify as having had prior treatment for self-injurious behaviors. Due to concerns about participant safety throughout the interviewing process, an additional inclusion criteria will be the identification of an emergency contact for each participant. Finally, due to the sensitive nature of the research topic, restrictions on the researcher's time and monetary limitations, participants will live or work in western Massachusetts and be able to meet the researcher for an in-person interview.

Participants will be recruited from online forums providing opportunities for peer communication and access to resources for individuals who have engaged in self-harm. Based off prior research that recruited individuals engaging in NSSI behaviors from websites addressing people's experiences with self-injury, I believe this avenue will yield a small yet

substantial sample population for the purposes of an IPA study. For example, Sutherland, Dawcyzk, Leon et al., (2014) used Google to search terms such as "self-injury" "self-harm" and "self-mutilation" to identify websites with NSSI online content. Adams, Rodham & Gavin (2005) used similar recruitment methods, and followed this website search with recruitment of individual participants. I plan to use similar methods of recruitment, first through the identification of relevant websites with additional inclusion criteria such as frequency of use, number of members, location (catering to Western Massachusetts where researcher will be located) website rules pertaining to research (Adams, Rodham & Gavin, 2005). An introductory e-mail plus the research proposal and summary of ethical considerations will then be sent to the moderator of each site, and the participant recruitment notice will be posted to message boards of sites that have expressed and approved their interest in the study. Individual respondents who respond to this recruitment notice will be asked to confirm their age (over 18) before informed consent is established and data is collected.

CHAPTER TWO

Literature Review

Introduction

This literature review focuses primarily on research that explores the communicative functions of self-harm, as well as clinical factors that might impact the process of translating one's experiences of self-harm into a narrative in the early stages of psychotherapy. The chapter is divided into three sections. Section one describes biopsychosocial factors influencing individuals who self-harm, as well as resiliency factors. Section two provides an overview of theoretical frameworks that explore clinical work with individuals who self-harm. Finally, section three presents relevant information regarding the significance of early engagement in therapeutic work with individuals who self-harm.

Biopsychosocial factors influencing individuals who self-harm. Motz (2010) identifies self-harm as a behavior that replaces and prevents thinking. As a symptom of internal distress, self-harming acts and the wounds themselves convey private and public messages. There are many forms of self-harm, such as cutting the skin with a knife or razor, burning the skin, or bruising oneself repeatedly (Levenkron, 1998; Conterio & Lader, 1998), and most broadly deliberate self-harm can be described as a wide range of things that people do to themselves that are considered by dominant society to be damaging. Self-harm exists across a wide range of social categories, but most often begins in adolescence, with the average age of onset being twelve years old, and persists into adulthood (Nock, Teper & Hollander, 2007). A lack of

longitudinal data on self-harming behaviors persists in the literature, making the long-term

course of self-injury unclear. Though self-harming behavior is not always directly linked to

suicidal ideation, self- harming acts that receive no follow up or treatment increase the long-term

risk of completed suicide for individuals who engage in self-harm (Balcombe, Phillips & Jones,

2011).

In some cases, the behavior begins in adults for the first time following environmental

stressors and life transitions such as bereavement, a difficult childbirth, or in the context of a

depressive illness (Bunclark & Crowe, 2000). In a series of interviews with individuals engaging

in self-injury, Favazza (1996) found a range of self-harming individuals who were psychotic or

depressed gave religious or sexual explanations for the behavior (as cited in Bunclark & Crowe,

2000). Alternatively, those with personality disorders or clinical presentations of neurosis

identified anger and the need to relieve tension as the motivation behind their self-injury

(Favazza, as cited in Bunclark & Crowe, 2000). Theoretical models suggest a wide range of

purposes underlying self-injury, including boundary definition, anti-suicidal attempts, and self-

soothing (Nock & Cha, 2009). Chandler (2012) identifies the role of emotions as central to

explaining attempts at self-injury, citing the behavior as a means of regulating affects, such as

the stopping of negative feelings, relieving anxiety, and tension states.

Bunclark & Crowe (2000) break down the etiology of self-harming behaviors in three

sections; pre-disposing, precipitating, and maintaining factors. Predisposing factors such as

childhood abuse, both sexual and physical have a high prevalence in self-harming populations,

though many other factors may be present in those with an abuse history (Bunclark & Crowe,

2000). In addition to relieving tension, other precipitating and maintaining factors may include

the shedding of blood, the pain experienced, and the need for punishment (Bunclark & Crowe,

2000). Such precipitating and maintaining factors highlight the frequently addictive quality of self-harming behaviors, contributing to the prevalence of self-harming behaviors extending from adolescence into adulthood (Bunclark & Crowe, 2000). The long-term nature of self-harming behaviors may also be compounded by potential communicational barriers in treatment (Motz, 2010; McMain, Korman & Dimeff, 2001).

Recalling that individuals who engage in self-harm often face silences in their lives surrounding experiences of self-harm and contributing factors, research shows that self-harming clients experience states of incongruence between their verbal and nonverbal expressions and emotional experiences (McMain, Korman & Dimeff, 2001). McMain, Korman & Dimeff (2001) suggest that clients who engage in self-harm often fail to "accurately communicate his or her emotional experience to others in the environment" (pg. 186). For example, clients might participate confidently throughout individual and group therapy sessions, while expressing few of their intense emotional experiences such as feelings of anxiety and shame (McMain, Korman & Dimeff, 2001). Inside and outside of the treatment environment, difficulties in communicating distress and intense affects, as well as asking for help may serve as precipitants to further acts of self-harm (McMain, Korman & Dimeff, 2001).

At the same time, Motz (2010) stresses, "To view self-harm as simply the inability to verbalize fails to account for the high levels of literacy and eloquence of many self-harmers, and essentially misses the main function of self-harm, that is to create an autobiographical narrative and a sense of self" (pg. 84). The following section will continue to explore how self-harm functions to preserve feelings states very similar to other verbal forms of affective communication (Motz, 2010). This framework maintains that self-harm is not simply an

"inadequate form of language for the inarticulate," but rather a form of self-identification that cannot always be captured through spoken word (Motz, 2010).

Theoretical Framework

Dialogic practices of psychotherapy highlight the importance of linguistics in the therapeutic encounter. Dialogism is both the organization of exchanges between a therapist and a client, as well as the unique subjectivity each exchange has (Lehmann, 2014). In this sense, a clinical practice is a type of cultural setting that regulates and modulates between "talks" and silences (Lehmann, 2014). While expressions of meaning emerge through moments of silence and moments of talk, research from a psychoanalytic perspective has drawn attention to a need to focus on the construction and connection of silences throughout sequences of talk (Lehmann, 2014). Silences in particular can be applied in various ways in the therapeutic encounter and other interpersonal life domains for the purposes of affective regulation (Lehmann, 2014).

Individuals who engage in non-suicidal self-injury also encounter silence in their lives and use self-injury as a method of communicating painful emotions (Chandler, 2012). There has been little clinical attention given to how the wider sociocultural contexts of individual who self-injure and "how this might account for the emotional problems being reported" (Chandler, 2012, pg. 444). One aspect of this wider context is the therapeutic encounter itself, including the ways in which specific types of encounters and interventions impact how individuals in treatment "do" emotion work (Chandler, 2012). In literature and writing on self-harm, bodily practices of doing self-harm, as well as the ways in which these practices are accounted for and understood in the therapeutic encounter are frequently under examined (Chandler, 2012). Hochschild's (1979) formulation of "emotion work" suggests that the various forms, the cognitive, bodily and expressive are inseparable (as cited by Chandler, 2012). Recalling Merleau-Ponty's structural

model of "original silence," voices of the body, including self-harming acts, are a pre-condition for language "where violently enforced silence is the rule" (McLane, pg. 117). According to this theory, the self- mutilator "attempts to make the necessary reflexive structure of self, other, and world, all within the boundaries of herself" (McLane, pg. 117).

In place of spoken language, self-harming acts may substitute for a speech that encompasses "the entire range of her experience-good and bad, traumatic and beneficial" (McLane, pg. 116), however, it is also possible that through the recognition of one's own agency, and other mediums of expressing feelings that another more authentic voice emerges (McLane, 1996). The question becomes what aspects of the therapeutic encounter allow for this more authentic voice to emerge in the organization of language between therapist and client, and the unique subjectivities fostered between their dialogues. Addressing the pressing silence alive in the experiences of many individuals who self-injure, the clinical challenge presents itself of what as clinicians we can do to study and make sense of ambivalence and ambiguity in therapeutic dialogues, including silences. Therapists must consider the meaning behind self-harm as a way of communicating areas of intrapsychic experience that are too painful to voice, while at the same time not silencing the individual from engaging in the vocalization process in the first place (McLane, 1996).

Communicative functions of self-harm. Looking at the work of Gillian Straker (2006), Motz (2010) explores "the notion of the language of the body and the functions that self-harm performs… in relation to cutting as a way of signing" (Motz, pg. 82). Understanding self-harm as signifying what Winnicott (1956) described as "an attempt to find a helpful response to distress" (as cited by Motz, pg. 81) highlights the presence of self-harm in an attachment formation

between the clinician and client. Self-harm is an act which makes private pain public, with skin being the "boundary, the protective shield that separates between the self and other, but also the point of contact with another" (Motz, pg. 82). While injuring one's own skin may express a divided sense of self, the act of nursing self-inflicted wounds holds its own meaning in signifying the experience of being tended to and cared for. This "hopeful" and communicative aspect is another piece of the emotional work underlying experiences of self-injury.

Motz (2010) captures the significance of the embodied nature of self-injury, describing it as "a means of self-creation and such acts are sometimes felt to be closer to affective states than words" (Motz, pg. 84). Experiences of pain are particular gestural articulations in that they refer to the "disintegration of the wounded person and her need for reintegration" (McLane, pg. 108). Similar to language, these experiences have both referential and valuational content (McLane, 1996). For the self-injurer, experiences are communicated through the skin as well as the language that grows out of bodily existence, however, this transition from gesture to language is not simple (McLane, 1996). Individuals who self-harm are often faced with barriers of silences throughout various life domains, whether it be about the self-injury itself, experiences of trauma, or perceptions of powerlessness. Self-harm becomes a way of communicating, as Motz (2010) identifies, "anger, contempt and shame through injuring," (pg. 85) as well as asserting control over otherwise unspeakable areas of life.

Similarly, Chandler (2012) regards self-injury as a method of working on the self by managing emotions through the body. To better understand what allows an individual to translate this bodily "emotion work" into a management of emotions through the voice in a therapeutic context I will now turn to literature exploring the significance of early engagement in therapeutic

work. Particular attention will be focused on an overview of clinical practices related to early engagement with individuals who self-harm, as well as the role of language in the therapeutic relationship.

Engagement: Fostering Communication in Early Stage Psychotherapy

In the face of enforced silence, individuals who engage in self-injury must conform to the demands of normality (McLane, 1996). One of the primary therapeutic processes in psychodynamic work with self-harming individuals is the breaking down of these barriers of silence. How does the self-harming individual develop a way to communicate within the early stages of the therapeutic encounter around their experiences of self-harming? The underlying meaning of the self-injury, and silence surrounding certain areas of experience in the therapeutic encounter (such as a client withholding information regarding recent attempts at self-injury) contributes to an awareness of what is being talked about (Lehmann, 2014). Other aspects of the regulation of turn taking, pauses, and talks in therapeutic process may signify the development of a therapeutic alliance, and the therapist and client's attachment to the other (Lehmann, 2014).

For example, therapeutic silences in grief work are attempts at offering a space of non-abandonment, "where it is clear that the silence is not a rejection or a dismissal" (Capretto, 2015). Alternative to when a person is *being* silenced, this nonverbal way of joining with a client is symbolic of an "empty space" which voice may enter (McLane, 1996). While enforced silence prevents the possibility of such openness, thus leading to the potential replacement of this function through self-harming acts, making space for new structures of communicating in the therapeutic encounter allows for new ways for pain and wounding to be expressed (McLane, 1996). Eventually, this transition from bodily gesture to language might make it possible to act in ways that end pain (McLane, 1996).

Many theorists studying the treatment of self-harm suggest that therapy should center around an analysis of the thoughts and events that contributed to self-harming experiences and the functions the self-harm serves for the individual (Bunclark & Crowe, 2000; McMain, Korman & Dimeff, 200l; Motz, 2010; Muehlnekamp, 2006; Nock, Teper & Hollander, 2007; Nock & Cha, 2009). This critical first step of meeting the client where they are at to explore the meaning behind self-injury enables the individual to find less "violent ways to articulate her distress and alleviate her pain" (Motz, pg. 84). McLane (1996) provides some important clinical questions to consider with clients, including, "How can I get the pain to end, and when? Why do I hurt? Will it ever go away?" (pg. 108). By drawing upon a dialectic, or the combination of contradictory points (Nock, Teper & Hollander, 2007), the therapist supports the self-harming individuals in engaging with tension between silence and speech, pain and pain free, wounded and wished-for normality (McLane, 1996).

Overview of dominant treatment models for self-injury: Randomized clinical trials studying the effectiveness of psychological treatments for self-injury are rare (Nock, Teper & Hollander, 2007). As a result, evidenced based treatment is limited compared to those for other behavioral problems, and therapies tend to be catered to the individual (Nock, Teper & Hollander, 2007). Psychodynamic therapy is used widely with individuals who self-harm as the process encourages the individual to understand unconscious motivations behind their self-harming experience and to verbalize their feelings (Bunclark & Crowe, 2000). Additionally, Dialectical Behavioral Therapy is a treatment approach widely used in by clinicians when working with individuals who self-harm. DBT includes elements of behavior therapy, cognitive therapy, and client centered therapy (Nock, Teper & Hollander, 2007). Dialectical behavioral therapy identifies "target behaviors" to be changed using a comprehensive assessment of mental

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disorders, problem behaviors, and client functioning. Individuals in treatment use daily diary cards to measure these domains over the course of treatment. In therapeutic work with individuals engaging in self injury, particular attention is placed on the preceding events and "consequences" of self-injury (Nock, Teper & Hollander, 2007).

Another core tenant of Dialectical Behavioral Therapy is the balance between change and acceptance. The *dialectic* piece of DBT rests in this core feature, as it refers to a philosophical approach in which truth is obtained by combining contradictory points (Nock, Teper & Hollander, 2007). Considering that self-injury is often preceded by difficulty tolerating painful thoughts and feelings, the clinician and client confront this barrier by beginning to explore experiences of tolerating painful circumstances within the therapeutic encounter (Nock, Teper & Hollander, 2007). This can prove to be a difficult task for clinicians who may want to jump to early interpretations or push for behavior change too early in treatment. The DBT emphasis reflects acceptance based approaches to treatment in that the clinician is learning along with the client how to tolerate feared circumstances such as listening to depictions of self-injuring acts, bearing witness to scars, or simply sitting through uncertainty (Nock, Teper & Hollander, 2007).

This approach is a means of engagement in that it can prevent and preclude maladaptive escapes or avoidance behaviors in the therapeutic dyad. Additional barriers to engaging in treatment are addressed in the DBT model through environmental modifications, including working with family throughout treatment. Along with the clinician, parents and other members of the individual's network may need to learn management skills and explore their own ability to tolerate painful stimuli and emotion work (Nock, Teper & Hollander, 2007). Looking at a residential model of care for individuals engaging with self-harm, Bunclark & Crowe (2000) note that sometimes family therapy is offered to residents typically later on in treatment with the

goal of improving communication within the family system. A dialectic approach maintains a perspective that self-harming behaviors are an attempt at regulating intense affects and that emotions involve a "full system response." Identifying the various factors involved in the family system and the system of the individual in treatment, including physiological changes and action tendencies associated with various emotions (withdrawal with sadness, attack with anger, flight with fear,) expressive behaviors including body language, and verbal communication of the emotion as well as other nonverbal communication behaviors (hitting, running away hiding), are the foundation of therapeutic work (McMain, Korman & Dimeff, 2001).

In therapy, the clinician and client attend to the client's emotional vulnerability and reactivity to the environment. McMain, Korman & Dimeff (2001) highlight this centrality focus of treatment with individuals who self-harm, noting that individuals who engage in self-injury react as "if the slightest movement will result in unendurable pain and loss of all behavior control. It is as if people with this behavior astern are phobic of all cues associated with their negative emotions" (pg. 187). Identifying therapy interfering behaviors such as avoidance of emotional cues by withdrawing, escaping, or attacking are directly brought into the therapeutic work by involving strategies to change the expressive components of emotions. Along with daily diary cards identifying behaviors and preceding events, methods such as breathing, relaxation, and engaging in behaviors that are opposite to the negative affect (e.g approaching rather than avoiding in response to fear) are regularly used (McMain, Korman & Dimeff, 2001).

Describing an application of a dialectic approach in a milieu environment, Bunclark & Crowe (2000) identified a range of a range of alternative means of expression their team provided to program participants. These included creative writing, creative art, drama therapy, and projective art, allowing a variety of individuals to find a means of expression that met their

needs (Bunclark & Crowe, 2000). This particular unit is described as a place where individuals

engage in emotion work themselves by being allowed to negotiate their own needs and have

autonomy in their schedules. As part of this process is learning how to anticipate painful

situations and other's needs, the tools of therapeutic engagement include "limit setting and

confrontation, but also nurturing and stimulation" (Bunclark & Crowe, pg.). Staff, peers, family,

the milieu space, and the therapist's office in outpatient settings, "act as containers of anxiety"

(Bunclark & Crowe, pg. 51). A collaborative approach allows power dynamics throughout the

therapeutic environments and relationships to be more reciprocal; providers are not received by

the client as omnipotent, and clients maintain personal agency in their treatment (Bunclark &

Crowe, 2000).

Steps to therapeutic engagement with self-harming individuals. Engaging individuals

who self-harm in therapy, and managing repeated self-harm is a clinical challenge for both the

individual in treatment and the clinician. One difficulty is that individuals who self-harm are

often articulate and balanced in a multitude of life domains and are simultaneously silenced and

silent about acts of self-mutilation and the meaning behind them (Bunclark & Crowe, 2000).

Clinicians' accounts of working with individuals who self-injure in therapy suggests these clients

might provoke anxiety and fear in the countertransference, and indicate a pressure to find

measures to protect clients from themselves (Bunclark & Crowe, 2000). Linehan (1993), the

crusader behind DBT work, also notes the commonality in therapists working with clients

experience intense emotional distress to avoid validation strategies, stating that "therapists,

fueled by anxiety brought on by working with people who are desperate, often overemphasize

the role of change strategies (as cited by McMain, Korman & Dimeff, pg. 190).

Overemphasizing change too soon in treatment risks re-enacting the invalidating aspects of the

client's environment, and poses a potential barrier to long term engagement (McMain, Korman &

Dimeff, 2001).

Alternatively, a dialectic perspective suggests avoiding premature interpretations and too

much intensive therapy too soon while working with individuals engaging with self-harm in

treatment (Bunclark & Crowe, 2000). Drawing upon a DBT framework, the course of treatment

begins with at least two sessions of "commitment" before shift to behavior change is made

(Nock, Teper & Hollander, 2007). Commitment sessions are spent encouraging the client to

participate in treatment and identify motivation factors for being in treatment. Often, the whole

family or network take part in this process with the clinician working collaboratively to

understand each participant's motivation for treatment (Nock, Teper & Hollander, 2007). A

thorough assessment is also a crucial step in engaging individuals who self-harm in treatment.

Describing their milieu approach to treating individuals who self-harm, Bunclark & Crowe

(2000) suggest beginning with an assessment of individual level of risk, willingness to

contemplate change and psychological ability to engage in therapy. More specifically, the

assessment includes a full history of the self-harm. The clinician begins with acknowledging that

individuals who self-injure do not consistently use this behavior for the same reason, asking

about unique factors that maintain the behaviors for each client, as well as contextual factors that

influence experiences of self-injury (Nock & Cha, 2009).

In an overview of psychological models of non-suicidal self-injury Nock and Cha (2009)

present additional questions for assessment including, "What is the client's self-concept? What is

the client's family environment like, and might it contribute to engagement in NSSI? Where did

the client learn about NSSI, and is there an ongoing influence of peers or the media?" (pg. 73).

While these questions can potentially be distressing in an initial encounter, the assessment sets the frame of asking individuals to maintain their own safety, and thereby giving them autonomy in their recovery process (Bunclark & Crowe, 2000). More importantly, the early stages of treatment generate and holds all anxieties at a verbal level (Bunclark & Crowe, 2000). By verbally acknowledging the presence of self-harm in the individual's life, the treatment environment counters areas of the client's life in which their emotional experiences and experiences of self-injury have been silenced.

A dialectic approach to treatment remains highly structured following the initial assessment. In additional to assessment and commitment sessions, multiple means of engagement including a skills training group, telephone consultations, and consultation teams are common practices upheld during the engagement process to enhance both client and clinician's motivation to continue in treatment (McMain, Korman & Dimeff, 2001). The building of the therapeutic relationship is a process through which they dyad learns to work as a team versus an "expert" and a "subject" (Muehlenkamp, 2006). Such hierarchical positions only re-enforce other silencing interpersonal dynamics playing out in the self-harming individual's life. One method of resisting hierarchical treatment dynamics while building a therapeutic alliance is for the clinician to acknowledge the pain the client is likely experience while also learning about the functional meaning behind the self-injury (Muehlenkamp, 2006). Being able to acknowledge pain communicates the therapist's willingness and a sense of fearlessness in joining the client where he or she is at (Muehlenkamp, 2006). It also validates the self-harming individual's experience of expressing emotion in a way that is effective for them.

Collins (1996) and Orbach (2001) suggest that understanding self-harm as a coping tool reduces clinician stigma against self-harming behaviors and allows them to more easily employ an empathic stance in the treatment relationship (as cited in Muehlenkamp, 2006). As such, following the commitment stage of treatment, including the articulation of perceived adaptive coping elements, the dyad eventually transitions the more difficult work of behavior change (Muehlenkamp, 2006). McMain, Korman & Dimeff (2001) outline the hierarchical arrangement that DBT targets as the primary behaviors to be changed: decrease life threatening behaviors including para-suicidal behaviors such as self-injury, decrease therapy-interfering behaviors such as nonattendance, and decrease quality of life interfering behaviors, and finally increase coping skills. This approach holds the logic, "keeping these clients alive and engaged in treatment are necessary prerequisites to building a life worth living." (McMain, Korman & Dimeff, pg. 187). That is, the engagement stage of therapy continues following the commitment sessions in dialectic practice, and is a vital part of each subsequent phase of treatment.

In the third through twelfth sessions, the therapist and client being working on decreasing self-injury and therapy interfering behaviors. Because this transition increases the level of emotion work being done in session, engagement and therapeutic alliance remains a critical part of therapeutic practice (McMain, Korman & Dimeff, 2001). The therapist uses tools and take home assignments to encourage the client in recording the daily frequency of self-injury, alcohol use, and substance use (as well as the frequency and intensity of his/her thoughts of each) using a diary card. These cards are brought to treatment each week for review and can be used to identify what led up to episodes of self-injury at to generate alternative behaviors that can be practiced in the therapeutic setting (Nock, Teper & Hollander, 2007). The therapist continues to communicate validation throughout this secondary stage of treatment by listening, reflecting, and

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highlighting aspects of the client's "phenomenal experience" (McMain, Korman & Dimeff, 2001).

Once the client becomes more comfortable in voicing their own motivations and potential barriers to treatment, the therapist is able to move on to more open-ended questions to allow clients to deepen thee descriptions of their feelings without as much scaffolding by the clinician (Nock, Teper & Hollander, 2007; McMain, Korman & Dimeff, 2001). Though self-injurious behaviors may continue during these initial stages of engagement and therapeutic practice with self-harming clients, the self-injurer begins to find new ways of communicating with others and regulating their emotions (Nock, Teper & Hollander, 2007). Motz (2010) describes one experience of engagement as being inherently tied to a patient's need to sit in silence and project her feelings of powerlessness and pain onto the therapist. While the patient's self-harming behaviors increased during this time, the therapist was faced with the task of containing these feelings and in turn, slowly enhancing the sense of trust felt by the patient for the capacity to hold her mind. This intense period of sessions eventually took a turn, in which the patient was able to describe her scars and wounds symbolically "as signs of states of mind and embodied trauma. She began to be able to relate her feelings and the awful thoughts and memories that she wanted to discharge through violent actions, and to rely more on words to convey the force of these to me" (Motz, pg. 86).

Summary of Primary Literature

Final considerations about therapeutic engagement with individuals who self-injure relate to the prolonged and often silent processes in therapy that can go unrecognized. Dominant approaches to working with this population advocate for the recognition that both therapeutic talks and silences are active moments in therapy that should be addressed by meeting the client

where they are at while balancing an open process of inquiry into client experiences (Levitt, 2001). Though experience of affective phenomena may at first occurs in isolation of language for individuals who self-harm in the early stages of treatment, these absences of speech also allow space for caregiving and alliance building. However, few studies have developing evidence based practice with individuals who self-harm and practice with this population often remains up to the clinician's subjectivity and catered to the individual (Nock, Teper & Hollander, 2007).

Previous literature on therapeutic engagement with self-harming individuals indicate clinician's working with individuals who self-harm must first surrender to some of the inabilities and limitations of language in an effort to collaboratively overcome them and engage clients in developing new ways of communicating their pain (Capretto, 2015). The purpose of this study is to center participant experiences about what was aspects of therapy were helpful or challenging in their recovery processes, and to answer the question: how do self-harming individuals develop ways to communicate in the early stages of the therapeutic encounter about their experiences of self-harm? The next chapter describes the methodology used in this study to answer this question and to contribute to a growing body of literature exploration the communicative and embodied aspects of self-harming experiences.

CHAPTER III

Methodology

Introduction

This research was developed as a response to an apparent combined lack of research offering agreement between peers and providers about effective interventions, outcome measures, and other potential clinical barriers to engaging self-harming individuals in talk therapy. An exploratory approach was implemented to fill gaps in self-harm literature related to the important variables impacting treatment outcomes for individuals receiving treatment for self-harm, specifically what clients receiving services find helpful and harmful in psychotherapy. Literature suggests that while self-harming individuals are often articulate and balanced in a multitude of life domains and are simultaneously silenced and silent about acts of self-mutilation and the meaning behind them (Bunclark & Crowe, 2000) Considering most psychotherapeutic interventions involve shared dialogue between the client and clinician, the inherent framework of therapy poses a potential barrier to therapeutic process, especially when the client and therapist are engaged in talk about self-harming acts (Straker, 2006).

Interviews were centered on exploring the early stages of the therapeutic encounter with individuals who had lived experiences with self-harm. Using a semi-structured interview format, the research was guided by the question: How do self-harming individuals develop a way to communicate in the early stages of the therapeutic encounter around their experiences of self-harming? Participants were asked to speak about their early experiences talking about self-harm

in therapy, identifying what aspects of therapy were helpful to them, as well as what was difficult about engaging in therapy. Past research with self-harming populations has implemented similar autobiographical approaches to interviewing, as this approach allows for in depth descriptions of the ways people make meaning around experiences of self-harm (Sutherland et al., 2014). Subsequent analysis and coding of interviews aimed at capturing units of meaning that highlighted the factors and processes contributing to the development of communication around self-harm in therapy.

Sample

I, the researcher, used purposive sampling and then snowballing techniques. Recruitment began through outreach to a series of websites with content focused on non-suicidal self-injury Websites were identified through a Google search of relevant terms such as "self-injury," "self-harm," and "self-mutilation," to isolate websites solely focused on non-suicidal self-injury content as opposed to websites more broadly focused on mental health. Moderators from the websites mirror-mirror.org and selfinjury.com responded to the inquiry, and both websites identified parameters pertaining to advertising research studies which primarily require recruited participants be over the age of 18. As this study met these age parameters, myself and website moderators determined no barriers to participant recruitment on these platforms, and participant recruitment notice were posted upon approval by the Human Subjects Review Committee. I then used networking and snowball sampling to access additional participants, such as contacting professionals who work with self-harming populations, and reaching out to peers through advertisement of the participant recruitment notice on social media platforms.

To participate in this study participants were required to be over the age of 18 and identify as being "in recovery" from engaging in non-suicidal self-injury. Participants must have

had previous mental health therapy related to their self-injurious behavior, and identify as having completed therapy specifically related to self-harming. Understanding that many individuals continue to attend therapy even when no longer engaged in self-harming acts, this inclusion criteria stressed that participants must be able to identify that recovery from self-injury is no longer the main focus of time spent in therapy. A final criterion for inclusion asked that participants no longer actively engaged in self-harm activities for which they had previous treatment.

Other criteria defining "recovery" were left undefined in this study in order to explore the complex and non-linear nature of experiences of recovery from self-injury (Chandler, 2013). During the recruitment process potential participants were provided with an explanation of the study, including the definition of self-injury/self-harm being used throughout the study: "There are many forms of self-harm, and this study defines self-harm broadly as an 'intentional, self-effected, low lethality bodily harm…performed to reduce psychological stress" (Walsh, 2006, p. 4)". Inclusion criteria were selected with the intention of centering individual experiences with self-harm as the primary inclusionary criteria for participation. In addition, inclusion criteria and recruitment methods were aimed at obtaining a diverse sample by utilizing public domain internet databases accessed by a wide array of users. Purposive and snowball sampling methods were implemented to access a complex group of individuals who engaged in self-harm across races, genders, sexual orientations, and religious preferences.

Ethics and Safeguards

Participant involvement in this study was kept confidential. Confidentiality was assured in that consent letters were kept separate from notes and transcripts. Upon signing the informed consent, each participant was assigned a coded number which was placed on all further

materials. Audio recorded digital files and subsequent transcripts were kept password protected. During the interview process, participants were cautioned to avoid using their names and identifying information. Interviews were conducted in private locations and individuals doing Skype interviews were cautioned to maintain privacy around their identity and location during interviews. All research materials including transcriptions, analyses, and consent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. This study will not include any information in any report that is published that would make it possible to identify participants. Quotes that were selected and appear in this study do not contain identifying information.

Both while gathering informed consent from potential participants, and again during the interview process, participants were informed of the risks and benefits of participating in this study. Risks of participating in this study included potentially becoming uncomfortable while exploring their experiences with self-harm and talking about self-harm in therapy. At the same time, participants involved in this study could have appreciated the opportunity to talk about their experiences engaging in therapy and telling their story related to experiences of self-harm. The larger benefits of participation included contributing to research surrounding therapeutic engagement and positive treatment outcomes with individuals who engage in self-harm. Participants were reminded of their right to withdraw from the study at any point during the interview process and were provided a referral and resource list for additional support along with informed consent materials. Referral lists included resources pertaining to info guides, referrals to treatment, self-harm support groups, and hotlines.

Data Collection

The data collection process was guided by an interpretive phenomenological analysis (IPA) approach (Smith, 2004; Smith, Flowers, & Larkin, 2009), a research method that aims at understanding how people construct meaning socially and symbolically. As this study was developed partly in interest in the symbolic meaning behind communicating about self-harming behaviors, a methods approach that was grounded in similar theory was intended to support the nuance and subjective nature of the research question being asked. IPA studies aim to generate in depth understandings of participant experiences and therefore trend toward smaller sample sizes. I interviewed twelve individuals based off selection criteria that enabled me to explore the specific phenomena addressed in my research question: communicating about experiences of self-harm within a therapeutic relationship. Individuals who were interviewed were all over the age of 18, identified as being in recovery from self-harm, were not presently self-harming and had completed a course of treatment centered on self-harming.

This study followed a semi-structured approach to interviewing. If at the end of the recruitment correspondence potential participants agreed to participate in an interview, a time and place was scheduled. Participants who lived outside the range of the interviewer's location in Western Massachusetts were given the option of participating in a Skype interview. For participants living within range of the interviewer's location, data collection occurred where it was most convenient for the participant. Participants received a copy of the informed consent by email prior to their interviews and were instructed to read it and contact the researcher prior to the meeting with any questions. Participants were also asked to bring the signed Informed Consent to in-person interviews, or return the Informed Consent by email prior to the interview if

participating in a Skype interview. Participants were encouraged to make a copy of the Informed Consent for their files.

Both in-person and Skype interviews lasted about 30-45 minutes. Participants were asked to speak about their experiences of talking about self-harm in therapy, identifying what aspects of therapy we're helpful to them, as well as what was difficult about engaging in therapy. Past research with self-harming populations has incorporated similar autobiographical approaches to interviewing, as this approach allows for in depth descriptions of the ways people make meaning around experiences of self-harm (Sutherland et al., 2014). Interviews in this study began with a brief review of the Informed Consent, including a caution to avoid using identifying information during the interview process, a reminder of potential risks discomforts of being in the study, the right to discontinue participation, and a reminder about the referral and resource list provided with the Informed Consent. Participants were offered an explanation of the study including a description of the research question: "This study will explore how individuals develop ways to communicate about experiences of self-harming in therapy." Participants were then asked to share their story about how they explored experiences with self-harm with a therapist.

The interview guide contained a number of prompts facilitating participant's exploration of exploring self-harm with a therapist, such as "Can you tell me about the time that you began therapy related to your experiences of self-harm?" "Do you have a way to describe how you developed communication about your self-harm while in therapy? What was this process like for you? What helped this process? What made talking about self-harming therapy challenging for you? Participants were also asked about the resources that were drawn upon during their recovery process from self-harm, "What resources have you drawn on to try to overcome experiences with self-harm? (meds, family, clinical support, specific types of interventions,

online support, peer support). How did you learn about/discover these resources?" Interview questions were framed to be open ended and subsequent follow-up questions throughout interviews were aimed at using the participant's own words to inquire more about certain aspects of participant experiences related to their experiences in therapy.

Interview questions, particularly questions about resources were developed with the understanding that experiences in therapy do not exist in a vacuum, and that inside and outside of the treatment environment, difficulties in communicating distress and intense affects, as well as asking for help may serve as precipitants to further acts of self-harm (McMain, Korman & Dimeff, 2001). Literature exploring the communicative functions of self-harm recognizes that self-harming acts may substitute for a speech that encompasses "the entire range of her experience-good and bad, traumatic and beneficial" (McLane, pg. 116). At the same time, it is also possible that through the recognition of one's own agency, and other mediums of expressing feelings that another more authentic voice emerges (McLane, 1996). This concept seemed critical to capture and highlight in this study, to better understand how personally defined resources intersect or are incorporated into the therapeutic process for the purposes of finding alternative ways to express the underlying emotions and meaning of self-harm.

Data Analysis

Data analysis first consisted of the transcription of individual interviews. While many methods exist for interview transcription, this study implemented a word for word transcription of interviews as best as possible for the purposes of reinforcing the social and symbolic meaning that came up around what participants found helpful or challenging while communicating around self-harm in therapy (Smith, 2004, Smith, Flowers, & Larkin, 2009). I, the researcher, then began to code for significant themes that came up as individual interview transcripts were read through

and interpreted. Data was simultaneously analyzed through intra and inter transcript analysis. While intra-transcript analysis encourages the understanding of what each participant is trying to express (Steinberg, 2015), inter-transcript analysis organizes data by the interview questions that participants responded to and search for similarities and differences to answers across respondents. This approach to organizing data encourages interpretation of themes arising from respondents as a group (Steinberg, 2015).

Data was first organized in this way by identifying participant responses to each of the interview questions and participant responses were copied into an Excel spreadsheet by the interview question or questions they fell under. Many segments of interview text were complex and could be ascribed to more than one interview question. For example, responses to the question "What resources have you drawn upon to try and overcome your experiences with self-harm? Where did you learn about these resources," might also have been identified by the participant as helpful or challenging in their experiences of communicating about self-harm in therapy. Following this initial organization of data, spreadsheets were printed out and highlighted to identify emerging themes, subjects and other expressions that appeared significant in individual responses to questions, and across interviews.

This process was facilitated by extensive note taking done to point out questions, summarize emerging statements, make comments on language as well as descriptive labels in interview transcriptions (Adams, Rodham & Gavin, 2005). Quotes that were collected offered positive and negative examples of direct evidence of the themes being noted throughout analysis. Collecting such evidence was intended to account for the quality of emerging themes regardless of their quantity (how often they emerge) and ensures emerging identified themes that can be upheld by supporting data with multiple excerpts from the transcripts (Steinberg, 2015). Finally,

data analysis consisted of connecting shared themes through the summarization of all interrelated concepts (primary and secondary themes), and their relationship to the master concept (Adams, Rodham & Gavin, 2005). In the next chapter, the study findings will be presented, followed by the discussion of these findings in the last chapter. In the next chapter, the study findings will be presented, followed by the discussion of these findings in the last chapter.

CHAPTER IV

Findings

Introduction

The purpose of this study was to explore how self-harming individuals develop ways to communicate in the early stages of the therapeutic encounter about their experiences of self-harm. This chapter documents the findings from twelve semi-structured interviews with individuals who identify as being in recovery from self-harm, regarding their experiences receiving treatment for self-harm. Participants were asked to share their experiences talking about self-harm in therapy, identifying what aspects of therapy were helpful to them, as well as what was difficult about engaging in therapy.

Interviews were centered around three broad areas of inquiry, with several questions for each area of inquiry. The three areas of inquiry are: beginning therapy related to experiences of self-harm, developing communication around self-harming experiences in therapy, and the resources individuals drew upon to overcome experiences with self-harm. Each section reflected numerous subthemes. The following sections will discuss these themes and offer examples from interviews to center what participants identified as meaningful aspects of their experiences.

This study also generated themes that were not related to the research question, such as what participants found helpful or challenging communicating about self-harm in relationships outside of the therapeutic encounter. This section focuses on reporting themes specifically related

to the research, and additional themes extracted from the interview process will be discussed in the following chapter. This chapter begins with an explanation of the demographic findings.

Demographic Data

Though demographic data was not explicitly collected during interviews, participants highlighted variable aspects of their identities throughout the interview process such as age, gender, age when treatment first began, length of time in treatment, number of treatment providers, treatment settings in relation to receiving services for self-harming experiences, as well as methods by which individuals self-harmed.

Participants ranged in age at the time of interview from early twenties to mid to late forties. Participants primarily identified as female or did not disclose gender identity during the interview process. Age when treatment for self-harming experiences began ranged from fourteen years old to 38 years old, and these numbers did not always reflect the time at which individuals identified they began self-harming.

An inclusion criteria for this study was that exploring experiences of self-harm was no longer a focus in therapy. However, some individuals were still receiving therapy at the time of interviews to address the ongoing impacts of depression, anxiety disorders, post-traumatic stress disorders. At the same time, some individuals identified no primary focus to be in therapy but continued relationships to support ongoing engagement in personal recovery and wellness. Others had discontinued treatment following cessation of self-harming behaviors, or because therapy was identified as no longer being helpful in their experience engaging in personal recovery.

Individuals who participated in this study often identified relationships with more than one treatment provider, as well as a range of experiences engaging with individual providers

and in outpatient/inpatient settings for the treatment of self-harm. Individuals also identified a range of methods and personal definitions for what self-harm meant to them. During recruitment, this study defined self-harm an "intentional, self-effected, low lethality bodily harm…performed to reduce psychological stress" (Walsh, 2006, p. 4). Experiences with cutting, hitting, scratching, eating disorders, substance use, and other methods were mentioned by participants in this study.

The following sections outlines the main themes that emerged during this study, in relation to the three larger areas of inquiry: the time individuals began therapy related to experiences of self-harm, how individuals identify developing communication around self-harming experiences in therapy, and the resources individuals drew upon to overcome experiences with self-harm.

Beginning Therapy Related to Self-Harming Experiences

Three main themes emerged in response to inquiries about beginning therapy related to self-harming experiences: *changing relationships with therapy over time, self-harm and emotion work, and qualities/responses of treatment providers.* The first section will explore participant responses to questions about the times individuals began therapy related to experiences of self-harm, and the idea behind beginning therapy. These responses highlight participants changing relationships with therapy over time. The second section will explore participant responses to inquiries regarding the time that experiences of self-harm first came up in therapy, highlighting the qualities/responses of treatment providers, as well as the emotion work done by clients that contributed to the exploration of self-harm in therapy.

Changing relationships with therapy over time. Participants identified a range of experiences that brought them to therapy in relation to self-harming experiences and changes to their relationships with therapy over time. It appears that self-harming experiences were often

going on for some time before individuals officially engaged in treatment for self-harm. As noted by *Participant #528:*

> Yeah so the first time I went to therapy for self-harm I was thirteen fourteen years old, I was in middle school, and it was a really particularly tough year, basically I was being bullied by girls in school. It wasn't the first time I had done any sort of self-harm behavior, the first time was about like twelve, like right before middle school. And the way my family treated that sort of instance was okay let's talk about it, okay you're good we're good you don't have to go to therapy.

Participants also mentioned while they had been in therapy at the same time they were self-harming, it took time for self-harm to become a central focus of therapy.

> I had been seeing a therapist for a while, I had been in therapy off and on for about ten years, and I had never talk about it. *Participant #910*

Several other participants mentioned similar experiences, particularly a number of participants sought treatment for experiences secondary to self-injury prior to having self-harm become a focus of their treatment. *Participant #606* spoke of learning about the therapeutic process and the resources available for treatment of self-harm at that time:

> I didn't really start therapy for like self-harm in particular. I started therapy just for depression and stress in general, and I wasn't sure how um…therapy really worked, I was kind of on my own…so I kind of went in and I didn't really know how to find resources, and I was on a limited income so I kind of went into therapy not knowing much about it and um, just kind of taking the first option I had which was to see an intern, um, because of the cost, and um, you know and that really wasn't a great experience you know, so I didn't go in necessarily focused on self-injury.

While some participants described their experiences of self-harming occurring prior to receiving treatment, beginning self-harm at the start of treatment was also noted. *Participant #702* noted the transition from emotional to more physical forms of self-harming while attending an outpatient treatment center:

So I was about 16 years old, um, I was currently in an outpatient treatment center getting help, uh, with issues dealing with mostly post-traumatic stress disorder and probably a month or two in another patient had entered and was large onto self-harm. And that was how I first kind of learned about it, it's very sad that's how I first kind of learned about it. I had always been self-harming not physically but mentally, and I then once I learned about this physical form of self-harm, um, it was, I was like let's try it out.

Another participant receiving individual treatment noted the duel timing of beginning to seek services and the development of self-injurious behaviors:

When I got to college I kind of starting self-injuring right at the same time I started seeing therapists, or psychiatrists on campus, so that was kind of a happy accident, like I don't really know which one came first or which one followed. *Participant #633*

Multiple participants noted the involvement of outside parties in their experiences leading up to engaging in therapy related to self-harm, such as parents, school personnel, friends, and romantic partners:

Um, it was…probably about five or six months, um. And it probably would have been longer than that, but in that time period I had, I was 18 and I had moved from my parents' house, and in with a friend. And at some point she found out that I was self-injuring and it freaked her out really badly. So she told me she didn't want to live with me because it

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like worried her, she said she didn't want to live with me if I weren't in therapy, so at that

point I did give the referral therapist a call. *Participant #606*

Participant #910 spoke of the transition from counselling for experiences secondary to self-

injury into more focused treatment:

Fortunately, with uh, a bunch of social worker friends, and a bunch of pastor friends, um,

I kind of did it for, by myself for a while. And I managed to get about a year of, um, no

injuring, um, and even with the friend support and that kind stuff it was very much alone.

Um, and um during this time I was seeing a therapist and seeing a psychiatrist, I never

told them a word of any of this. Um, about two years later I started dating a guy, and I

told him, and um, at that time, I had been re-injuring, but not to the point that I had been

to at that crisis point, and kind of told him, just to give him a heads up, I wasn't seeking

help, I just wanted him to have an explanation for some things. And, he went and did the

research and found *name of treatment provider*, um, and actually contacted them, and

got in contact… and communicated with her a couple of times before giving me her

contact information.

Involvement of outside parties was sometimes related to an increase in severity of self-injury.

Participant #971 speaks about the need for more focused resources for the treatment of self-harm

as their self-injury progressed:

It kind of got to a point during the therapy where my engagement in the self-injury

became kind of out of control and I felt like that therapist, since she didn't really have

background in studying that, or having much experience with that, I kind of felt like I

needed another resource. So she found a group for me called *names organization *. She

found them on the internet and told me about them, and told me that there was group

therapy for people engaging in that behavior…So we started, yeah, started going to that, group therapy. And it was helpful to an extent but things got worse for me in terms of self-injury. It just got more intense more frequent and I decided to do the, stay in the *names organization * but do the inpatient program where you lived in uh a psychiatric hospital for thirty days. Yeah so that was a month.

Participant #884 also acknowledged the role of outside parties in encouraging engaging in therapy as their overall well-being reached a low point:

So really started when I was in college, um and I, had kind of been going up and down and up and down, just like mood wise and general well-being wise and everything. And I just hit a really low point and a lot of my friends were like okay you need to, these things are happening, like you need to get some help, um, and this is something you can't handle without professional help, and so talked to them, talked to my parents and finally agreed to see the school counselor.

Participant #716 mentioned similar experiences of increased intensity of self-harm and the role of outside parties, highlighting the transition of their self-harm from a private act into a public one:

So then in college I basically had an episode where I cut myself too deeply, it wasn't just a scratch, so then I had to get stitches and it became a process thing. Then you know the urgent care made sure that I followed up with a psychologist at the college, but it was right before summer so they were all leaving, so then they referred me to a therapist in the community. So the thing about that episode was that it kind of freaked me out. Because I had always kind of been a light cutter, you know I didn't have any scars, I would mostly dig my fingernails into my skin so you couldn't really see much lasting

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impressions. You know people didn't question me on it because it was pretty… not

visible. So then when I had stitches I was like oh shit everyone thinks I had tried to

commit suicide or something which was very far from the truth. At that point I pretty

much stopped cold turkey, but then, so then I started seeing a therapist in the community

and she was extremely fantastic and supportive, and it's been like twenty years, so it's

really hard to remember back then.

Some unique responses came from participants who were under the age of 18 at the start of

treatment, highlighting the role of outside parties in having the deciding power in further

disclosure of self-harm and beginning treatment:

I was a foster kid and I was court ordered to be in therapy. *Participant #528*

And so yeah, a friend of mine who did notice told the guidance counselor, and the

guidance counselor talked to me and was like you know you can tell your parents or we

can tell your parents, and then my parents were like, of course at first very upset, sent me

to therapy. *Participant #699*

The next section will outline participant responses to inquiries regarding the time that

experiences of self-harm first came up in therapy, and explore two additional themes that

emerged throughout the interview process: *emotion work, and qualities/responses of treatment*

providers. Participant responses had a fair amount of overlap across these themes, as

qualities/responses of treatment providers often shaped the emotional work contributing to one's

ability or choice to disclose self-harm in therapy.

Self-harm, emotion work, and qualities/responses of treatment providers. Fewer participants

responded directly to the question: Was there a time that experience of self-harm first came up in

therapy? However, participants who did respond highlighted the emotional work that contributed

to their ability or choice to disclose self-harm in therapy, as well as the qualities and responses of treatment providers that shaped emotional experiences. *Participant #699* offered a portrait of how self-harm came up due in response to questions about medical history and comfort in exploring self-harm based on clinician responses:

> I guess, at this point I've seen five therapists *inaudible speech * and I think in part that's because they ask about medical history when you've been at therapy otherwise, and it's even come up at points that like, the last time I cut myself was about two years ago, and it like, even so there are pretty big gaps like, didn't' cut myself from fourteen to nineteen and then nineteen to twenty one, like that was a big gap, so there's been a lot of times where I haven't been actively cutting myself where it has to come up and be part of the conversation. To varying degrees of me feeling comfortable with that. Sometimes it depends on how the clinician has handled talking about it with me.

Participant #606 spoke about how not knowing how self-harm would be treated by a provider, led to hesitance around disclosing:

> So I was working with that therapist, and I think the reason I didn't bring it up was because, and I think this is kind of important. Because I didn't know that much about therapy, they tell you in the beginning that they're only required to share what you talk about if you're like thinking about hurting yourself? And I wasn't even clear on what that meant, so I kind of wanted to keep it a secret it, because I didn't know if self-injury would fall under the hurting myself category.

Participants also acknowledged that reactive responses from treatment providers including asking for too many details, or pushing the direction of treatment without checking in with the client, made talking about self-harm in the therapy difficult, and even potentially triggering:

The second person I saw when I started at college was, bordered on being helpful but also could be like, she was the first and only therapist who I would sit in her office and sometimes just immediately start crying, and part of that was that I knew she was really kind of a scary person. I mean we talked about my self-harm and she made me like very anxious to talk about my self-harm and to talk about different things going on in my life. Like the sort of thing where she, where I would be talking about things and she would interrupt and interject with a question and like, I kind of initially had to get over an immediate panic before being able to sit with her and talk about that, you know in relation to my self-harm. *Participant #699*

I called their hotline and, the first thing, I explained my situation, and the first thing they said was, "well, you need to go to an inpatient program," which was something like 4-6 hours away from my home. And I was like, well yeah, that's not happening. And I didn't feel I was that bad. Um, and I'm like, I'm just calling for a list of therapist, please, please just give me a therapist, quit pushing inpatient. And they said, well we don't have any therapists in your area, but we will sell you a book and an audio tape to give to your therapist. And I was like okay? Thanks but no thanks. Um, I got off the phone, and…cried. It was devastating because I felt I was reaching out to the one place that could help me. Um, and I self-harmed. It was a really devastating time. *Participant #910*

And, um, up until that point like her body language in all of our sessions looked kind of like bored in a way, like she would kind of slouch in her seat, and she would have her notepad on the floor by her feet. And as soon as I said yes she like jumped up, and grabbed a notepad and went in with all of these questions, and details, and things like

that, that was a little overwhelming. And then ironically like at our next session…again she was an intern, and I don't know who was supervising her but at our very next session she told me that she couldn't continue to see me. And she put it like this she said she didn't deal with people like me. And at that point she made a referral to another therapist. *Participant #606*

Conversely, several participants mentioned that their therapists' questions related to their self-harm, as well as clearness, calmness and directness in their role as the therapist were positively contributed to disclosure:

And um, I had really had been trying to keep it secret from everyone, um, and, um, my therapist was pretty attuned to me at that point. We had been seeing each other for about two and half years at that point, and um, she knew something was going on with me at that point. She, pretty clear, and she also knew that I was not someone who could lie if someone asked me a direct question about something and so I had mentioned self-injury in the past, and, I don't remember exactly what it was. *Participant #414*

But up to me I was very good at hiding it. I was never called into the guidance counselor's office, or like, it wasn't...I don't know, I never really, I didn't talk about it with anybody. I think my parent's thought it was a one off thing? Um, and I remember, and very classic teenager who cuts or whatever, I like, I wore like a ton of bracelets *laughs* and, I remember one time being in therapy, and talking about something completely different, and I just remember my therapist like straight up calling me out, like just being like I mean, "You wear a lot of bracelets, I'm not an idiot, you're clearly still, um, like cutting yourself" or whatever. I think that was like the first time anybody had actually

called me out because I was so good at hiding it and that's how I deal with a lot of my

problems. *Participant #710*

So, um, the way it kind of came up was about six months into like the therapeutic

relationship and um…I forgot what we were talking about but, she, I said something

about like I had punched a wall or something, and I said that's not something I would

typically do and I'm like, I wouldn't typically punch a wall because it would hurt, but in

that moment it didn't hurt because my emotions were so strong. And then she asked me if

I had ever hurt myself in other ways. And I'm not the type of person who can lie, like, um

if I'm asked a direct question, so…in that moment I said yes. *Participant #606*

This section has explored the first major area of research inquiry: participant experiences of first

beginning therapy for experiences of self-harm, and the themes of *changing relationships with*

therapy over time, self-harm and emotion work, and qualities/responses of treatment providers in

relation to first experiences in therapy. The following section will explore the presence of these

themes in relation to the second major area of research inquiry: developing communicating

around self-harming experience in therapy.

Developing Communication Around Self-Harming Experiences in Therapy

This section explores participant responses to questions about the specific processes by

which they developed communication around self-harm as therapy progressed, what was helpful

or challenging in those experiences, and the qualities/responses of treatment providers that

contributed to the development of communication around self-harm. Two main themes emerged

across this area of inquiry: *remission and recovery processes, and qualities/responses of*

treatment providers and relationships. The first section: *remission and recovery processes* will

explore participants' changing relationships with self-harm through time, while the second

section: *qualities/responses of treatment providers and relationships* will explore both the helpful and challenging qualities of participant experiences talking about self-harm in therapy.

Remission and recovery processes. Similar to descriptions of changing relationships with therapy over time, when asked to describe how they developed communication around self-harm in therapy, multiple participants spoke to how their engagement in self-harming behaviors decreased or shifted through time. For example, *Participant #528* mentioned a life cycle transition as offering closure to her self-harming behaviors and a shift in her relationship with therapy:

That was the, um, the birth of my daughter was the end of my behavior. Was the behavior. Prior to that. It was almost six months prior to finding out that I was having a child. I mean I have seen therapists since then, but just to talk about… I think when you have trauma as a kid it resurfaces in ways at different ages at different stages of life. And so I've spoken to different counselors since then, because she's no longer in practice.

Similarly, *Participants #699 and #606* spoke to their experiences exploring self-harm in therapy as self-harm took a less active role in their life:

And we did talk through this, and I think it honestly helped less that time because it wasn't, you know, I'm at the point where again self-harm is still a very strong part of my history, and it's not, but it's not something I think I immediately go to the same way that honestly I did even a year or two ago. Um, which I'm really thankful for, and I think part of that is like, I'm at a point in my life where things are still stressful, but like.. there's a degree of hope that I have now that I didn't necessarily have like a year or two ago because of certain circumstances in my life. And so, you know… there is a little part of me that like does question like does that mean that something, is something going to happen some day that is going to change that for me and become a part of the story again

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that I have to work through. You know I don't think that having that one really helpful relationship experience with a clinician is something, that's going to fundamentally change how I interact with self-harm, that's still, like behaviors are hard to unlearn. Um…I totally own up to the fact that it could be something in some degrees of remission like, a way of coping with things. *Participant #699*

And towards the end it got to the point where like I would leave. I, just naturally feel like progressed out of some of the self-injury behavior. Um, you know, like as a teenager and in my early twenties it was kind of like a daily thing, and it just kind of, feel like naturally tapered off, um in a way, but it was still like my, like when something major happened that was like my coping skill. And what would start to happen is I would leave her sessions and I would go home and cut because of like the sessions stressed me out so badly, and that was kind of the point where, again, like I was done like with therapy in general. *Participant #606*

Participant #414 mentioned being required to stop self-injuring in treatment as the beginning of a changed relationship with self-injury:

Eventually things did kind of get worse and I ended up in the hospital, um, and that was one of the things that helped me stop, self-injuring. And in some ways it wasn't the best way to get me to stop, it was kind of this punitive if you self-injure we're going to throw you out of this program, um, but it did help me stop doing sort of the major self-injury.

Participant #716 also acknowledged the role of having self-injury exposed through treatment in relation to the beginning of a changed engagement in self-injurious behaviors:

And then all of a sudden, maybe there might have also been a part of it where it was like before it was like completely an internal thing, like I was doing this to myself and it was

nobody else's business, and then as soon as I needed stitches I had to answer questions

and I had to talk to people about it. And I was like I don't want to talk to people about it,

this is like a personal thing, so if it's at a point where it's not a personal thing anymore, it

kind of lost its appeal.

Having self-injury exposed related to a larger theme of breaking isolation and shame around self-harm both inside and outside of therapy discussed by *Participant #414*:

Yeah and well I really didn't talk to most other people about the self-injury. It's really

something, and certainly not in the kind of detail I would talk to her about it with you

know? People, some of my close people knew it was happening but, you know, but that

was pretty much her urge you should let people know where you are. I mean obviously

no reason to give anyone details, but…um, again breaking that isolation and shame.

Participant #716 gave a description of how letting go of self-harm as part of their identity intersected with finding new outlets for emotional distress:

So I remember a big thing that we talked about and that I was working through, was up

until that time I saw the cutting as part of my identity, and so I had to figure out how to

let go of that part of my identity without feeling like I was letting go of part of myself. So

that was sort of the big realization that I had and that she really helped me with. So then it

was the process of letting go of that… So it was, when I was a teenager, it was definitely

that thing where you feel so much distress on the inside that you want a physical release

for it, and that was the only outlet, or the outlet that I came up for it. So over time I think,

um…certainly, you know, being able to make more choices, being able to have more

control over, you know where I am and what I'm doing and my job, it was gaining

independence helped, figuring out identity stuff helped.

The numerous ways participants described breaking isolation around self-harm, and the resources that contributed to these experiences will be discussed further in the final subtheme of this section. The next section will focus on the helpful and challenging qualities/responses of treatment providers and therapeutic relationships that participants encountered during their experiences talking about self-harm in therapy.

Qualities/responses of treatment providers and relationships. Participants were also asked to explore helped the process of talking about self-harm in therapy and what made talking about self-harm in therapy challenging. Participant responses to these questions and follow up questions related to what was specifically helpful or challenging exploring specific incidences and methods of self-harm were complex and extensive. While exploring each facet of participant responses surpasses the scope of the present research study, the main themes have been outlined below. Other areas of research inquiry left unexplored in the findings section will be summarized in the discussion under recommendations for future research.

Helpful qualities/responses of treatment providers and relationships. It appears that establishing long term relationships and continuity of care with treatment providers was significant in developing communication about self-harm in therapy.

> I mean I saw her from the time I was 14 until I was 21, so the approach was different. It wasn't consistent, because cognitively I was not in the same place at 14 versus 21. *Participant #528*

> It was just a matter of trust. It took her time to gain my trust. Um, and to just feel comfortable. Um, she had been, she actually, I ended up, the reason why I was hooked up with her was she was the social worker when I was in the hospital, um, so she was my social worker when I was in the hospital, and she happened to have her own practice, so we had already kind of established a relationship before I started seeing her outpatient, so

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that was kind of helpful as well. And I mean I just, over time, I knew I could call her if I

needed to. *Participant #528*

One of the really important things for me, was, they didn't usually let people do this, but

my therapist had set up so I could continue talking to her while I was there, so there was

this continuity of care. So she knew what was going on for me that whole time, so that

when I got out I was able to pick up my work with her, um, and it didn't feel like we had

to start over or anything. *Participant #414*

Participant #710 acknowledged the importance of getting comfortable in the context of

establishing relationships with their therapists:

> I got comfortable with her for like the first couple months of just talking about myself and
> getting to know each other and then it was just like, an understood thing.

> Her approach to it was like she let me get super comfortable, and then was like let's figure
> out why.

Establishing therapeutic confidentiality also appeared significant in getting comfortable

communicating about self-harm in therapy and having a trusting relationship with providers:

> (Referring to change over time) Where as now, I'm only seeing my therapist about once a

> month, so if I relapsed, it would take me a couple of weeks to tell him, but it would be the

> first thing I would tell him, and I know that. Because I trust him. I trust him a little bit

> more. And I also know he's not going to go to administration to get me kicked out,

> (Inaudible speech), yeah, that's a big part of it. *Participant #633*

Um, I had a really awesome therapist, so it wasn't really, even though I had to be there, it

wasn't really like I had to be there? I mean I didn't, you know what I mean? So it was

easy to talk to her it was like my safe place. Um, knowing that she didn't, that she

couldn't tell anybody what I said made it easier to talk to her. *Participant #528*

(Regarding disclosing self-harm in therapy) Um, and at first I didn't want to um, but we

managed to agree that that was gonna be kind of a point of safety with us. Um, and that

as long as I could tell her what was happening and she could determine, you know, as

someone on the outside as whether or not I needed any type of medical intervention, um,

then we could keep doing what we were doing. We, I think we were seeing each other a

couple times a week at that point. Um, and so it took me awhile to kind of trust that that

was going to be the case, but, I also think it was a huge relief, um, to have it not be a

secret? *Participant #414*

Unrelated to therapeutic confidentiality, one participants also highlighted the significance of trust

in their therapeutic relationships:

And, I think, building a relationship. I don't think, kind of, you can do any of the hard

work without trust and just the therapeutic relationship being there, and just I think in

general I'm very slow to do that. It takes a long time for me to trust people. And I think

my current therapist just had a lot of, and she still does, just a lot of patience, um,

surrounding that. Like knowing like, you know, I'm not just a very open person, I'm not,

like, I don't know what some of the words would be for it, but it takes me a really long

time for me to trust people. *Participant #606*

Another participant highlighted the concept of respect in regards to establishing a relationship

that allowed for communication about self-harm:

Yeah it was really helpful to have, I mean honestly just having the respect to no have to,

the relationship with the therapist is so vulnerable, and it's already, you're already sitting

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there verbal vomiting your problems at this person, and you're paying them to listen to you, but you're also kind of like are they judging me? *Participant #633*

Multiple participants noted the importance of their therapist's willingness to explore the underlying functions and meanings each individual ascribed to self-harm in therapy without essentializing why someone might self-injure:

> With my, my current doctor, um, like, like she was like "Alright, well why did you do that?" It's not like, you know, there's only one reason why someone does that. *Participant #710.*

> It was interesting because I think she was really helpful in, because I hadn't really gone to therapy when I was in high school, so my last therapeutic experience was with, um, the woman who I saw when I was in middle school which wasn't really awesome, so she was really curious about it, and what we started talking about was really my family relationships and dynamics, and she was making , she was one of the first people to start making the connections of like…"it's sounds like you had a pretty stressful home life. There might be, like do you think there's some relationship between this and that", and I don't think she ever really brought up explicitly the cry for help discourse.
> *Participant #699*

Therapist's willingness to explore the underlying functions and meanings each individual ascribed to self-harm in therapy also appeared significant in relation to avoiding ultimatums and reactive responses to self-injurious behavior.

> It was never being like "No you can't do this," but it was more like let's figure out why you're dealing with things this way. *Participant #710*

> And one of the things that was so different with my long-term therapist from college and on, was that there wasn't that reaction of this is outside the normal realm, or outside the,

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this is something to be feared. And the fact that she didn't do that, was key… And you

know those would be the times we would talk about can you keep yourself safe, and if

you can't what are we going to do? So she was always very clear about like…there needs

to be a plan, um, I don't want to punish you for this, and I need you to know this is

having an impact. You can't just keep hurting yourself without it impacting the people

who care about you, um, but it was never shaming. *Participant #414*

The treatment approaches and interventions involved in exploring self-harm in therapy were also

significant. For example, proper psychiatric assessment and diagnosis were noted by multiple

participants:

Also a big part since I've been seeing her is getting me properly diagnosed and properly

treated with medications, because, I had not been. Not even close. It wasn't until

probably until almost a year and a half after I had been seeing the therapist that I was

officially diagnosed with OCD. And it was actually through a psychiatrist that she

recommended. Um, she at the time was working with this psychiatrist, um so that she was

more aware of self-injury and um, basically trained her in the treatment of it.

Participant #910

He helped me get on meds, and he's been pretty good with me talking about it, and also
like understanding of the language I use to avoid admitting that I have slash had a problem
with self-injury. *Participant #633*

I remember the most significant part of that, part of it, you know there was so much other
stuff going on at that time too. I had undiagnosed learning disabilities and she pinpointed
them and told me to get tested. *Participant #716*

The use of worksheets, including behavior and injury logs, and other methods of finding

alternatives to self-harm also had a role in what some participants found helpful in facilitating

communication and recovery from self-harm:

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A lot of what they do and what she really worked on with me in the beginning, is, a lot of worksheets, um. The biggest one that probably made the biggest impact for me that I still use everyday, is what they call the alternatives. What is your alternative for self-injury? And, I remember our first, it was probably three or four sessions, where okay, for me what we did is she says "we need to break it down. We need to break it down." Homework. Church. Um, and I still have those lists. And she made me work really hard to get between fifteen and twenty alternatives for each place. Um, you know, it never, honestly, even with my training, it never occurred to me to do something else.

Participant #910

It definitely took some time, but I definitely responded to it and it's been really really helpful over the years. Um, I think it was, I think it was good for me in the position that I was to just be able to um, I don't know, to kind of have just like something to do and something to fill out, and it's like cut up in these little nice short like one sentence question and everything, and I don't have to elaborate and I don't have to create this huge long thing about what I'm feeling or whatever. It was very much like okay this is what I'm doing, this is what I'm feeling, this is what I need to do to avoid hurting myself.

Participant #884

Other aspects of treatment interventions connected to exploring alternative ways of coping that will be more specifically explored later on in the findings. The next section will outline what participants identified as being challenging qualities/responses of treatment providers and relationships in relation to communicating about self-harm in therapy.

Challenging qualities/responses of treatment providers and relationships. Participant responses to what made talking about self-harm in therapy challenging for them were extensive

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and at times reflected more focused responses to follow up questions pertaining to what was challenging communicating about specific acts/methods of self-harm in therapy, as well as what, if anything, participants wished their therapists had said or done differently in treatment. The responses outlined below aim to capture challenges in a range of treatment settings, including work in individual therapy, as well as outpatient and inpatient settings with programming focused on the treatment of self-injury.

It appears that reactive responses or ultimatums from therapists made talking about self-harm challenging in therapy. *Participant #710* notes:

…It wasn't like I was getting attacked, which is usually how I felt with my parents when they would bring it up, or with the first therapist that I saw when they were like, "So you're doing this thing and it's not cool," and I'm like, "Well no shit."

Participant #910 identified a similar discomfort when faced with the ultimatum of behavior cessation:

So, um, and then in the past year I have left that psychiatrist, um, because she, well she had changed. There were some medical issues, and then she said some insensitive things to me, such as, um, "You need to just stop self-harming. Just don't do it anymore." Or my favorite is, um, you know, "You just need to make the decision not to be OCD." So I was like, "Okay um, I'll just do that today. I'm not OCD anymore"

Participant #606 and #699 offered descriptions of why pushing for reducing self-harm behavior was not helpful in their experiences:

I think that so many people even in the professional arena, they're kind of scared of self-harm. So they hear it and then they want to like quote on quote like fix it, because they want it to end like as soon as possible, like that's what… sense I get about it. And that's

too much, it's almost too much pressure that can actually backfire. Um. So I just think having patience around it is kind of a huge component and *not* making it the focus, unless somebody wants to make it their focus. Like if somebody's coming in and saying oh I'm cutting myself and I don't know why, I want help to stop that then obviously that would be the focus. But when somebody's coming in with a lot of different issues and a lot of different feelings and depression in general, maybe the focus shouldn't be just stop cutting. *Participant #606*

And it's also sort of like, yeah, I mean how…if a clinician is coming from a perspective of reducing the behavior they're not going to be helpful if you do it once and come in and say I've cut myself. Where do you go from there? Because then it's like your word of I promise I'm not going to do that again, which isn't even a thing that's come up in therapy for me, but you know it's just that idea of like… having to be in a dialogue with yourself that doesn't even feel like the right dialogue to be in I guess? Um, but yeah like it has not always necessarily felt helpful. I guess for me it just hasn't really felt like that, doesn't make sense for like my meanings that I put on that element of how I've managed stress and managed depression and anxiety before. *Participant #699*

Conversely, other participants identified the difficulty of provider silence around self-harming behaviors during their time in treatment. One participant shared their experience of never being asked about self-harm during their time in inpatient treatment:

I mean I don't even recall anyone asking me in the hospital, "Do you cut?" and I mean I have scars on my wrists, I remember from a vertical and horizontal cut, but no one ever asked me. They, they, no one ever asked me. *Participant #528*

Participant #699 also spoke about provider silence around self-harming experiences, in the context of providers' lack of willingness to explore self-harm in therapy past a certain point:

> I think that a lot of times I've had therapists who kind of took that as an "Okay, we're done," and I don't even think it's necessarily like that they bought it, I think in the case of middle school, I think she kind of like, that's what she wanted me to say. So I gave her that and then we were done. And then I think other therapists saw it as maybe there was a little bit more of implicit agency there, like okay she's giving off this message, we can't work through this, we're done. Not in an obstinate way but like, okay…this is where we finish at.

Another theme that arose in response to what made talking about self-harm challenging in treatment related to treatment provider's premature diagnoses or assumptions being drawn from self-harming behaviors.

> I had a really hard time, like I wouldn't talk about my experiences with self-harm, um, when I was there, and especially because they, at least like the one doctor I talked to um, I mean she didn't really know me that well, but it was kind of, I remember she was like, you know, "because you have a past with it, um, and like a past with other behaviors" she was like " I think you're, uh, like borderline", blah blah blah, and I was like, I don't think I am, and my doctor who knows me pretty well doesn't either. So it felt like a lot of conclusions because I've had a history of self-harm. It was like oh you have a history of self-harm so you have to be on this list of having these issues and then go on to these meds, and I was like, but, I don't, I don't think I'm borderline, I will stand by that, not that's there's anything wrong with it, but that, the doctors would hear history of self-harm and jump to that conclusion. *Participant #710*

Like, um, it was definitely that mentally a little bit…um, where it was so much like you're just doing this for attention, and even my therapists were giving off that vibe, and there didn't seem to be a desire to actually figure out why I was self injuring, even if it had been attention seeking, which I don't think it was, but even if it had been attention seeking, there's still a reason why I'm looking for attention and that wasn't respected. *Participant #633*

The one session I do remember that I still think of as being really weird, was I…one day I think I said something about wanting to read The Bell Jar, and at that point in my life I was very into the book Running with Scissors, you know like I came from…a pretty dysfunctional family, I come from a family that has like a history of like depression, and there's always kind of been like a certain darkness that I always like, I have a pretty wicked sense of humor, I'm like a little crass sometimes, those kinds of worlds are very appealing to me and were at a very early age. And I made a comment about The Bell Jar being on my reading list, and like she said something to be about like "Yeah, you know you're, you really like dark and depressing things don't you? Like why is that?" And I remember just sort of feeling a little, not even just on the spot, but in hindsight like my things were weird? You know like really like, what's you being like that doing for me now? Like it's fine to ascertain something about why I cut myself because like…you know like, but that's…that's not why. It could be to some degree *inaudible speech * but I feel like there's almost a part of her that felt like I was trying to be, like make drama out of things, and it wasn't actually like I was a serious case to her, someone who was self-harming. *Participant #699*

One participant the significance of a loss of autonomy in treatment related to providers' assumptions about client judgement and needs related to self-harming behaviors:

Yeah, so I was in kind of a, so I spent like a week in a locked inpatient unit, and then I was in this sort of residential program. And they, it was a DBT based program, um, but not DBT in the way I've come to love it, but DBT in this "You don't really know what you're talking about, we're going to teach you how to think," kind of way sort of, is how it felt to me. Kind of like talk to the lowest common denominator, but it kind of assumed because we were all mentally ill we were also not very bright, um so it felt demeaning.

Participant #414

Another participant also acknowledged difficulty of not having autonomy in the treatment decisions being made during their time in inpatient:

One thing that I didn't like was a lot of times when I was in both inpatient and outpatient, um, my, I didn't like the way that my parents were brought into the situation. Obviously, I wanted them to come to group therapy because you know back then I was living with them, they were my main support. But the way that they were brought in, and the way that the group and family therapy sessions went, it was, I kind of felt like I was the little kid, you know, sitting in the middle of the couch, and they were having a conversation about me without me....And kind of talking about, in front of me what's best for me without, and I'm sure, I know they had intent to make it about me in my, and what I would like and how I feel, but sometimes I feel like the words that were used and the kind of style of the conversation, was that I was this little kid and they were talking about what to do with me. And that was difficult for me, because I knew that it was going to get

me out of inpatient, and that just made me feel even more buried, kind of, because I had

felt just kind of a loss of independence in my own mental health. *Participant #971*

Another theme that arose was the role of empathy and taking other's emotions in group therapy

settings. *Participant #710* explained:

> I don't think being around…sometimes it's nice to be around people who also have
>
> problems, but I know with myself I'm very empathetic and I take everybody's problems
>
> on, and she like quickly agreed that being in a group setting like that, like hearing other
>
> people's problems wasn't going to be beneficial to me, or hearing other people talk
>
> about…how they were dealing with like self-harm or what have you, like it wouldn't' be
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> beneficial. As much as I like to know that I'm not like alone, I also don't want to feel
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> like, I don't know, like my problems are less important just because like somebody's had
>
> like a way crazier experience.

Another participant discussed the risks of participating in group sessions with her individual

therapist:

> Um, my therapist and I decided kind of early on that I would not participate in group
>
> sessions, um, simply because my personality and my training? Because she said, um,
>
> *inaudible conversation* I told her I'd like to participate in a group, and she goes, "No
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> because you'd be mothering everybody," *laughs* "We're not putting you in the group."
>
> *Participant #910*

The above theme connected to a final theme that arose in response to participant challenges

communicating about more specific acts or methods of self-harm in treatment. This theme relates

to avoiding communication about self-harming experiences as a protective measure either for

self or others. *Participant #910* refers to ambivalence about the helpfulness of opening up about

self-harm in therapy and other life domains after a difficult experience disclosing to a friend:

> I'm at the point, and I'm seven years working on this, that you know, my, my scars are
>
> pretty mellow, and, you know, you really kind of need to look to see them. Um, but, if
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> someone would ask me about, okay, that's a weird scar, "Where's that from?" I would be
>
> very comfortable opening up and saying, you know, "This is who I am," but, on the other
>
> hand after that experience with my friend it's kind of like well am I better off, alone? It's,
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> I feel really a double edged sword and there may not be an answer, you know.

Participant #606 also notes a complicated relationship with disclosing self-harm in relation to

protecting the feelings of self and others:

> With the second therapist it was a little bit better, um, like she did want to know, you
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> know, some of the details surrounding it, and um, you know it was definitely
>
> uncomfortable to talk about, but I wasn't, I didn't have that feeling that I was scaring
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> anybody, or that I was hurting anybody by making them too stressed out or… Like
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> whatever, I'm just very sensitive to how I'm affecting other people and I didn't want, you
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> know, like I obviously didn't' want to be judged, but then I obviously didn't want to like,
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> kind of like traumatize them with too much of me if that makes sense. Um, but I also…I
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> didn't go into like…I wouldn't say I didn't lie about anything, but I didn't go into like
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> details, I admitted a lot of details, um, during the second therapist, when she asked
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> questions.

This section has explored what participants identified as the challenging qualities/responses of

treatment providers and within therapeutic relationships. This completes the findings for

inquiries related to developing communication around self-harming experiences in therapy**.** The

final portion of this chapter will explore findings pertaining to the resources that participants identified as being present in their experiences overcoming self-harm, and how these resources were incorporated by treatment providers and within therapeutic relationships.

Resources Drawn on to Overcome Experiences with Self-Harm

The final area of inquiry focused on the resources individuals drew upon to overcome experiences with self-harm. Often the resources identified by participants connected back to themes outlined in other areas of the findings chapter, such as what participants found helpful and challenging in therapy, and remission and recovery processes. This section focuses simply on representing the various resources that participants identified as being present in their experiences. Three main themes emerged in response to this area of inquiry: *creative and physical outlets for expression, treatment as a resource, and personal recovery processes.*

Creative and physical outlets for expression. The main theme that emerged through inquiry about resources participants drew upon to try and overcome experiences with self-harm were creative and physical outlets for expression. Participants identified a range of creative and physical outlets for expression that supplemented the emotional work done through self-harming behaviors as they began engaging in treatment. For example, *Participant #910* explains a unique form of art that was present in their recovery process:

> And I guess another resource that's kind of related to that, that I have started probably about three years ago, is, um, Zentangle?....Um, because, I want to say one of the problems in, not what leads to self-injury, but to kind of what I was saying before where my mind is just so busy, that I don't know what my body is doing, um, so practicing being present, is, is a tool that, you know, and it kind of started with the writing and

working on the impulse logs, and that kind of thing, and then through the Zentangle,

learning how to be present.

Another participant reflected on styles of art that capture their experiences with self-harm:

Well the most interesting thing, that I used to deal with it, was actually through art, and

not even normal art, I'm you're already in this field I guess, but I'm not sure how familiar

you are with abstract expressionism— Uh, Jackson Polluck is the person people know,

the splatter painter. This group of painters and other artists, um, explore the

subconscious. So when you see Jackson Polluck painting, it's paint splatterer right? But it

it's all about the paint, it's all about the movement of it. Um, so, instead of, and I find that

the movement of it is almost similar to the violence that I felt, to do upon myself.

Participant #272

It appeared significant that creative and physical resources have the power to transform internal

experiences that were being expressed through self-harming behaviors into other externalized

forms of expression:

So uh, I gravitated towards that kind of art and painting, and even photography in it's

own way, and especially, you know, imagined the canvas or me holding a pen or a

paintbrush, you know, doing that, you know, very quickly, so in that you know, paintings

and art almost as a form of violence, but taking the internal to the external. So that's the

way I handled it. *Participant #272*

I think that's a really big aspect of it, of like the creativity. You're still zoning out, but

rather than dissociating and hurting yourself, you're creating something. Or you can still

destroy something, but at least it's not your own body. I know that's very cliché but, I've

definitely noticed that it's very helpful to be like "these are my feelings!" and it's a picture, rather than "these are my feelings" my arms are going to hurt for the rest of my life. *Participant #633*

That was one of the things about the *names college * therapists, is I feel like they had this idea that self-injury was a cry for help, or equivalent to suicidality, where to me it was "fine, I'm not going to kill myself this time, I'll just hurt myself," it was like I'm stronger than killing myself, but I'm not stronger than hurting myself, so I will re-focus it to one tiny aspect of myself or my body, instead of completely destroying myself. And that's been a good part with the creativity, like drawing, and painting, and listening to music and all of that stuff, is yeah, it's still like the destruction and it's still the creation, it's just not on yourself. *Participant #633*

What I found for me, it was so odd, but it worked, for me I think the visual of seeing what I could control was helpful, so we had a wooden deck outside so taking a knife and stabbing the deck, or taking a bat to a tree and seeing that destruction. *Participant #702*

Other participants explored the significance of sensory driven alternatives in their experiences drawing upon resources to overcome self-harm:

I don't know if I have an exact like, like a really defined idea of why it helps I guess, I just know that like, I um… I think it's really grounding for me, like when I'm uh, experiencing a lot of anxiety or when I have a panic attack or something like that, like I get really shaky, like my muscles start clenching or unclenching, and I feel really out of control with my body I guess, um, and like I've felt that a lot when I was self-harming

and I think that my motive is that I've worked through this like disconnect I have with

my body, or have. But I think like in a way it is something that like allows me to kind of

connect with my body I guess, if that makes sense, or like, like, like I feel something

between my fingers or I move something with my hand or whatever, and not only do I

feel the object, but I feel my fingers moving as well, and like I can, like I have like one

small part of my body is under control, and like from that I can kind of stem out to like

my arm, and now I have control over this arm, and like this feels really nice so I'm gonna

like stroke it with my entire arm, and now I feel it going down both of my hands. So I

think it's a grounding thing more than anything if that makes sense. *Participant #884*

While several participants highlighted the significance of finding alternative coping skills,

particularly creative and physical outlets for expression, one participant offered their thoughts

about the risks of finding replacement coping mechanisms:

Um, I think through like doing research, and one of the most important things, and um,

for anybody to know is to watch out for like replacement coping mechanisms, um,

because that's kind of like this path I went down. Kind of purely by accident, um. I um,

when I really focused on um, not self-injuring I went to um, I was bulimic for quite a

while, um, and that again, like my cutting my down but then I was binging and purging a

lot. And then, you know, in an effort to like not binge and purge anymore like I stopped

purging but I was still binging. And it's just kind of like, and to me, it was like the lesser

of evils like in a way, but I think it's, I think it's important to look out for and to notice

especially when you don't have, like you mentioned like support from family and support

from friends, and when you don't have those things, and when all you have is one hour of

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therapy a week like it's really hard just to say…like…like oh I'm not going to do this

anymore without having something to replace it with. *Participant #606*

This idea leads into the next theme that emerged through inquiry about resources participants drew

upon to try and overcome experiences with self-harm: *treatment as a resource.*

Treatment as a resource. Along with the creative and physical resources that individuals

drew upon both inside and outside of therapy, another theme emerged that explored the role of

treatment as a resource. Firstly, it appeared significant that access to therapeutic treatment was

defined as a resource in it of itself for some participants:

Um, my first real reaching out though was, on the internet. I'm a social worker. I work

with a bunch of social workers. So we're really good at the research and finding the

resources, um, and the resource that I reached out to at the time was *name of treatment

provider *. *Participant #710*

I had one therapist that didn't have a background in self-injury and she did research for

me and found the (names program) which I'm very grateful for. I no longer, um, really

talk to anyone, or therapists from there, but it was very helpful at the time, and that had

the both group therapy and the um, and the group outpatient therapy, the inpatient

experience, and when I left I stayed with one of their therapists who is actually the

founder of *names program *. *Participant #971*

Uh, so I would definitely finding the right counselor that has the right approach that

works for you as well as just clicks with your personality, uh was a hundred times the

first answer, and finding a great psychiatrist that worked with me. *Participant #702*

Another participant also reflected on access to therapeutic treatment, and how conversations

about accessing treatment have changed over time:

> I, I don't know of any resources out in the community which is terrible because I live
>
> here, I should, but I think that the resources available when I was younger are different
>
> than what are available today. I also think that people are more open today talking about
>
> those things than they were 30 years ago. I mean I remember, to this day, I know I'll
>
> probably never forget this, but the first time I took an oath trying to kill myself, my father
>
> had me in the ER and said, "It's not her fault she and (names individual) had a fight" and
>
> I got home and the only conversation was everyone makes mistakes and goes to church.
>
> And that was all the conversation that happened, you know? I mean I think people are
>
> more conversant now about such things. *Participant #528*

One participant reflected on having to choose between accessing psychotherapy and other forms

of resources:

> I think a lot is like, you know and this was a few years ago, so like just having resources
>
> that don't cost so much money, it's like you'd have to choose, if you're paying for
>
> therapy weekly like out of pocket, you don't really have like, um, you know like if you
>
> wanted to do therapy and a group, you couldn't really do both because of cost, and being
>
> you know younger, or being in college, or all of these things that like, there a lot of
>
> barriers for different people for different reasons I'm sure, but it's not having all of the
>
> support or access that you need. *Participant #606*

The same participant spoke about their therapist's role in being present to provide support when

other resources were less accessible:

Um, for me I think a lot of it was having, having support, like having somebody

who…who wouldn't judge me, who would be able to support me, um. You know, I'm

naturally I'm like the caretaker, like I kind of do everything for everybody else, and then

kind of like nobody like really does anything for me, like. And partly that's my fault. I

don't talk about a lot of personal things. But one thing my current therapist did, and this

was a few years ago, she would just try and teach me how to ask for help when I needed

it, or how to ask for support when I needed it, and she would really focus on like, you

know I was able to email her or text her, or even call her, which I never did because I

don't really like the phone, but um. But she would let herself be available.

Participant #606

In addition to portraying access to therapeutic treatment as a resource, responses included

conceptualizations of the resources and tools incorporated into participants' experiences in

therapy. For example, the role of medication appeared significant in the responses of several

participants:

I took medication when I first started with her. Um, I've been on different meds, uh, as of

recently. Um, but I mean just like making sure I do that, um, and like I still, I definitely, I

see my, I mean cus she's like my, my therapist and my doctor, so I, I see her like now, it

was like every other week, um so just like having that person that I know like, um, is

there, she knows me so well. *Participant #710*

But I now have a new psychiatrist, um, who looked at all of the drugs I had been on in the

past and actually tried a brand new thing that was so incredible. There's a genetic test out

there where you can, where it helps you determine, it's not what will work and what

won't work, but it helps, you know, it's like this probably won't work, this may work,

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and this probably will work. And so for about a year now I've been on a medication that was determined by that test and it's been a whole new world. *Participant #910*

I was on a lot of medication too, which, uh, did not help me, I really hated it actually. I was on it for about a year when I started with the help and consent of my psychiatrist, helped me get off of all, over the course of about six or seven months. So that was a resource that I did not find helpful, but was a resource that I did use. *Participant #971*

Finally, participants spoke about the therapeutic approaches and subsequent tools/activities incorporated into their experiences in therapy.

We had different logs that we had to fill out, one was calling the negative thinking log, and you had to write down a negative thought for example um, you know the most basic thing is "I think I'm ugly," and then you had to write down your reasoning behind that thought. So "I think I'm ugly because my thighs jiggle when I walk," and then you had to challenge, you had to come up with a challenge to that. Something along the lines of, well this is how my body is, and my legs keep me strong, and I love them for that. So any time you had a negative thought about yourself, that was fueling your urge to engage in self-injury…you filled that out. *Participant #971*

I guess the…tool or resource that my therapist helped me with was helping me recognize, I mean they're not related directly to the self-harm, but she helped me recognize there were all of these places that I was really stuck, and in pain about, and helped me have the courage to address them, like getting tested for learning disabilities, which I was really resistant to at first, but she realized it might answer so many questions for me and it might provide relief. So I think it was around…you know, having specific treatment for

these things that were causing me a lot of distress, helped break that pattern and helped it

stay broken. *Participant #716*

And then I wish I could think of the specific mindfulness strategies that were used. She

even told me, but it was like this thing where she helped me talk to and name and

specifically describe my anxiety. And what was really interesting about that was that

what my anxiety ended up being was like a small child in like, like a small crying child

that was full of lightning. And I know it sounds super weird when I'm describing that but

there was something that was very important and meaningful in that. And I think that she

kind of was like someone to sort of name that I like characterized my anxiety as a child I

had to take care of, much in a way I've felt I've been in a position my whole life where

I've had to take care of other people. Um…and there was you know something that was

really liberating about that. And very self-soothing to be able to think of this pain that

I've been carrying around like carrying a child. *Participant #699*

In addition to the resources participants identified as being incorporated into their experiences in

therapy, participants spoke to the concept of personal recovery processes that were either

associated with or separate from work being done in therapy. The final section will focus on

these personal recovery processes.

Personal recovery processes. This final section pertaining to the resources participants

drew upon to overcome experiences with self-harm was a unique finding in that it looks outside

of the therapeutic relationship. Personal recovery processes arose throughout interviews as

participants identified the self or personal practices as resources for recovery. *Participant #272*

spoke about engaging with Cognitive Behavioral Therapy before learning about this approach in

therapy:

I realize that I already, before I discovered the name (referring to CBT), I was always

kind of practicing it in my own way. Um, I really like philosophy, and philosophy teaches

skepticism, and also to doubt yourself all the time. Uh, so I was already, uh and also into

Eastern philosophy which deals with very similar themes as far as consciousness going

with CBT, so , so basically I was already on that road of challenging my own perception

of it, and wondering, not necessarily trusting my own perception, um, but CBT kind of

gave it a reason and rules of how to do it.

Another participant spoke of a form of vocalization that they have found helpful in responding to

urges to self-harm:

I have noticed some vocals thereotopy is the word I would use for it, where, when I feel

an urge to self-injure, I might say "fuck me" or like some variation, or I might articulate

out loud "I want to die" or "I want to kill myself," but being able to hear it in my own

voice I can back track and say no you don't, you went to the hospital for this, you're on

meds. And I'm kind of able to talk myself out of it, rationalize I think is a better word,

rationalize my way out of the impulse, so that I'm not running to hurt myself.

Participant #633

One participant shared their experiences getting a tattoo in relation having closure with self-

harming experiences:

Um…I can't really see that I replaced it with anything. I did get a tattoo shortly after

getting stitches on my back, and it says "Skin." * Laughs* Because I was like it's another

way to put closure on it. You know labelling my skin in an obvious way, like my skin and

I have had a very tumultuous relationship with each other and I'm going to put closure on

it by being like, you know, giving you. I don't know it was just what I did. So um that

was another thing that I did that sort of provided closure with that. *Participant #716*

Participant #528 found that becoming a parent was significant in their experiences overcoming

self-harm:

> Oh absolutely, and becoming a mother.. Um, for me that was the turning point. Like I had to be a mom. I had to be present, I had to find different coping skills, and I did.

Two participants spoke about how their role in caregiving professions was significant in their

experiences overcoming self-harm:

> Another thing that you know I mentioned earlier was I was very interested getting into
>
> the field, and towards when I had gotten a little older and was still cutting occasionally,
>
> what really helped was I had started in a mentor program, and I really wanted to do well
>
> for this kid I was mentoring, because if I can't be a good um influence for her then you
>
> know what am I doing here? *Participant #702*

> At work I also take on a lot of the kids who have self-injurious behaviors because I know
>
> a little of what they're going through. I mean it's a little different when it's not just a kid
>
> who's self-injuring by cutting, but they're banging their heads or hitting themselves, and
>
> I can kind of help them out with that a little bit. I think just having that base
>
> understanding of being so overwhelmed that the only response you have is to hurt
>
> yourself, um, is a perspective that a lot of people in mental health don't have. Like, you
>
> can say that you understand it, but I think that it takes another level. Not necessarily that
>
> you have to experience it, but you have to like, think about it. *Participant #633*

Finally, Participant #971 spoke more broadly about their personal recovery process overcoming experiences with self-harm, which highlighted leaving therapy as a significant moment in their recovery process:

I think the most helpful thing, in my SI recovery has been me. I proudly credit myself with pulling myself out of that. Because I didn't, I didn't really get on the upswing until, I left therapy, honestly. Because it got to a point where we weren't really making any progress anymore, and they continued to push putting me back on medication, or me going back to inpatient, and I said enough is enough, which you know to my parents and to my therapist seemed like a terrible self-destructive decision, but it actually did the best thing in the world for me, because I feel great now, and um, and I've learned to take in my personal environment, uh, with more consciousness of myself and others, through, just practicing more mindfulness. It might sound cheesy but I started writing music, and that changed a lot for me, writing songs, really gave me an outlet for my feelings, because I was able to sing them instead of, you know, make a mark on my body. And um, finding uh, a career that I really liked, and um. Yeah probably, at the highest point I've ever been right now. I'm on a six-month backpacking trip by myself which everyone said you shouldn't do that, because you're suicidal, but I'm not feeling one bit that way. I definitely credit myself and my own practices of mindfulness for bringing me out of a really tough time in my life.

This section has outlined the personal recovery processes that participants identified as significant in their experiences overcoming self-harm, and concludes the findings for research inquiries regarding the resources participants drew upon to overcome experiences with self-harm. To conclude this chapter, the next section will summarize the main research findings in

response to the question: how do self-harming individuals develop ways to communicate in the early stages of the therapeutic encounter about their experiences of self-harm?

Summary of Primary Findings

This chapter outlined findings in response to the primary research question: how do self-harming individuals develop ways to communicate in the early stages of the therapeutic encounter about their experiences of self-harm? Primary findings from the first broad area of inquiry, beginning therapy related to experiences of self-harm, centered upon three main themes that emerged in response to research inquires: *changing relationships with therapy over time, self-harm and emotion work, and qualities/responses of treatment providers.*

The second broad area of inquiry explored in this study was developing communication around self-harming in therapy. This area of research inquiry resulted in three main themes: *remission and recovery processes, qualities/responses of treatment providers and therapeutic relationships, and resources drawn on to overcome experiences with self-harm.* Finally, participants responded to inquiry regarding the resources they drew upon to overcome experiences with self-harm, and explored *creative and physical outlets for expression, treatment as a resource, and personal recovery processes.* The next chapter will continue on to explore how findings of this study connect to previous literature exploring clinical treatment with self-harming individuals, and the ways in which findings reveal recommendations for further inquiry. Finally, I will explore the limitations of the present study and any implications of these findings for the field of social work practice.

CHAPTER V

Discussion

Introduction

This chapter will look at my findings in relation to previous literature focused on self-harm and the treatment of self-harm, and where my findings are consistent with those previous studies. I will then talk about themes that arose in my findings that add new understanding to pre-existing literature on how individuals develop communication around self-harm in therapy. Finally, I will discuss limitations of this study, and how the findings of this study may contribute to the field of social work practice with self-harming individuals, including recommendations for further study.

Discussion

The general framework used throughout data collection and development of this study reflected self-harm literature that explores self-harm as a form communication. Knowing that much of psychodynamic therapy occurs in the shared dialogue between the client and clinician, this study turned to the question: how do self-harming individuals develop ways to communicate in the early stages of the therapeutic encounter about their experiences of self-harm? The specific areas of inquiry in this study included: beginning therapy related to experiences of self-harm, developing communication around self-harming experiences in therapy, and the resources individuals drew upon to overcome experiences with self-harm.

Previous literature on self-harm suggests a longevity to self-harming experiences, with the behavior most often beginning in adolescence and persisting into adulthood (Nock, Teper & Hollander, 2007). This literature highlights the ways in which pre-disposing, precipitating and maintaining factors such as histories of abuse, as well as the need for punishment and the pain experienced from self-harming (Bunclark & Crowe, 2000) may contribute to the long-term nature of behaviors. Findings of this study suggest the importance of engaging with individuals in treatment around the temporal nature of self-harming experiences. Regardless of the length of time individuals had been self-harming, findings indicated changing relationships with self-harm itself over time, as well as feelings about therapeutic treatment at various points in the life cycle and the circumstances in which individuals engaged in treatment.

Connected to prior literature on the longevity of self-harm, findings indicate the importance of acknowledging the temporality of self-harm etiology, and a client's variable self-perception and relationship with pre-disposing, precipitating, and maintaining factors. Clinicians might include questions pertaining to the historical and present circumstances contributing to engaging in therapeutic treatment such who was involved in the decision to begin therapy, what have past experiences with providers been like, and is there information you would like to know about exploring self-harm in therapy? Such questions all have a place in building communication around self-harm in therapy, and encourage exploration of what the function of being in a therapeutic setting is across time for self-harming individuals.

Practitioners working from a Dialectical Behavioral Therapy model are already drawing upon such tenants, as DBT identifies that the first few sessions should be spent engaging with self-harming individuals around *commitment*, that is identifying motivational factors for being in treatment (Nock & Cha, 2009; Nock, Teper & Hollander, 2007). A thorough assessment is also

part of this process, sometimes including an individual's self-concept of their own level of risk, and willingness to contemplate change in the therapeutic setting (Nock, Teper & Hollander, 2007; Bunclark & Crowe, 2000). Nock & Cha (2009) identify importantly that clinicians should acknowledge that individuals use self-harm for a variety of reasons, and stress asking about unique factors that maintain self-harming behaviors and the contextual factors influencing client experiences.

Remission and recovery processes were central to participant's identifications of changing relationships with self-harm and their experiences in therapy across time. Literature on the role of assessment in early engagement with self-harming individuals through a DBT frame highlights that assessment is meant to begin the individual's process in holding autonomy in their recovery process by asking them to identify and maintain the terms of their personal safety while in treatment (Bunclark & Crowe, 2000). The DBT frame also acknowledges the communicative function that self-harm and thereby recovery from self-harm holds. Bunclark & Crowe (2000) note that the early stages of treatment generate and hold anxieties on a verbal level, exposing areas of the client's life in which their emotional experiences and experiences of self-injury have been silenced.

After collecting data my thoughts were taken in a similar direction around supporting individuals in developing tools to break isolation and shame around self-harming experiences as one aspect of their recovery. However, findings in this area, and later in response to research inquiries regarding the resources individuals drew upon to overcome experiences with self-harm, also indicated unique intrapersonal recovery processes and descriptions of recovery from self-harm experiences. That is, findings brought attention to limitations of therapy in facilitating recovery, particularly the limitations that therapeutic language have in accounting for what

recovery means to each individual. Literature exploring the communicative function of self-harm from a peer driven perspective (Chandler, 2012; 2013; 2014) is a growing body of research exploring the subjective nature of narrating the embodied experience of being in a scarred or harmed body, and thus the unique ways that self-harming individuals account for the recovered self.

Considering self-harm within Hochschild's (1979) frame of "emotion work" –the inseparable cognitive, bodily, and expressive forms of emotional communication (as cited by Chandler, 2012) challenges more traditional conceptions that conceptualize recovery as existing for an individual in a single place and time. Findings of this study support Chandler's (2013) explorations of "recovery by proxy" –the gradual processes through which managing difficult emotions through self-injury changed and shifted as individuals experienced changes in their life cycle and subsequently engaged in other emotional management techniques. These findings, and a growing understanding of recovery from self-harm as rooted in changing contexts stands counter to the behavior reduction or cessation focus implemented within many cognitive behavioral and DBT interventions, as well as in the realm of a clinician's own discomfort with working with ongoing self-harm and hold many implications for the future of social work practice with individuals who self-harm.

Recovery processes intersected with another main theme of this study's findings; qualities and responses treatment providers/relationships. Participant responses to inquiry regarding the times at which self-harm first came up in the therapeutic encounter highlighted the emotional work that contributed to their ability or choice to disclose self-harm in therapy. McMain, Korman & Dimeff's (2001) paper explores the use of Dialectical Behavioral Therapy in treating emotional dysregulation, identifies "within-session dysfunctional behaviors" –

complex ways of being and behaving that are often treated in tandem to the primary behavioral target of self-harm. My findings revealed discrepancies in the language participants used to describe the patterns of thinking that may come up around speaking about self-harm. Participants spoke to their own navigation of a complex range of emotions in the therapeutic encounter, expressing feelings about comfort, establishing safety, finding a sense of self-over time in the therapeutic encounter, emotional vulnerability, or the experience of feeling unable to control one's pain around disclosure.

Importantly, participant responses centered most on a range of qualities and responses of treatment providers that made talking about self-harm in therapy more accessible or difficult to them. Simply being asked about self-harm by a provider, as well as the importance of a therapist's clearness, calmness, and directness when exploring self-injury were positively contributed to disclosure. Participants also explored the triggering nature of reactive responses by providers, including a co-opting of therapy time with pre-mature interpretation, pushing for a higher level of care, and not going at the client's own pace around first exploring self-harm. While the *change* aspect of the DBT model places the focus of treatment on addressing target behaviors, results of my study hark on the importance of a relational framework, and incorporation of the clinician's subjectivity into the therapeutic encounter.

DBT's focus on change is countered by a balance with *acceptance*—a process through which clinicians are tasked with learning alongside the client show to tolerate the delicate nature of addressing self-harm in therapy, and developing patience before jumping to interpretation or behavior change too early in treatment (Nock, Teper & Hollander, 2007). The findings of this study connected the clinician's development of patience to client experiences --identifying the importance of getting comfortable, establishing confidentiality, and long term relationships with

providers.   The word "trust" came up more than once and this seemed connected to both a therapist's gentle curiosity about a client's self-harming experiences as well as an avoidance of reactive responses to self-harm from the clinician. Such findings support literature exploring the communicative function of self-harm; clinicians often miss "the main function of self-harm, that is to create an autobiographical narrative and a sense of self" (Motz, pg. 84).

On a similar note, findings indicated the importance of a clinician trusting the role of a client's own *voice,* and avoid placing the problem within the individual. Motz (2010) echoes this point in their work, reminding clinicians not to view self-harm "as simply the inability to verbalize" (pg. 84). McLane (1996), though conceptualizing self-harm as a pre-condition for language rather than an equal mode of expression, also supports the notion that self-harm communicates "the entire range of her experience-good and bad, traumatic and beneficial" (pg. 116) and through recognition of agency in the therapeutic work new voices coming into being. The final area of discussion pertains to the resources individuals drew upon to overcome experiences with self-harm, and contributed in some ways to what McLane (1996) identifies as a "recognition of agency"

Participant responses mainly focused on the creative and physical outlets they drew upon for expression, through art, music, or through physical actions that allowed for the body and mind to focus, release tension, and sometimes to see destruction without having to physically harming the self. I found this area of responding to be significant not only for the sensory aspects of many resources, which further supports the dialectic that the management of emotions involving a full system response (McMain, Korman & Dimeff, 2001), but because they represent less violent ways of articulating distress. Such expressions seem to capture the essence of some of the important questions posed in McLane's (1996) work about "the voice on the skin," --

"How can I get the pain to end, and when? Why do I hurt? Will it ever go away?" (pg. 108), that is creative and physical modes of expression provide a space for these questions to be answered along with the emotional work being done through self-harm.

Additionally, participants in this study spoke of treatment itself as a resource, both as something to be accessed along with other avenues of support, and of some therapists themselves as being a constant support in an otherwise changeable world of social and interpersonal reserves to draw from. Participants also spoke of the emotional, thought, and behavior logs—the physical resources themselves so present in DBT for self-injury and that a number of participants had encountered. When used thoughtfully and intentionally already touched upon in the above findings, it appears that these resources and tools have the powerful potential support alternative forms of communicating distressing emotions and the social context of the silencing forces in the self-harming individual's life (Nock, Teper, & Hollander, 2007; Motz, 2010).

Finally, the findings of this study importantly highlight the resources that individual drew upon to overcome experiences that were outside of the realm of the therapeutic relationship, defined here as "personal recovery processes." My attention in this area went to Chandler's (2012) paper on self-injury as embodied emotion work exploring the literature of Firth and Kitzinger (1998), and the functionality of emotion work and the pitfalls of considering emotion work as what they call an "analytic category." Rather, Fritz and Kitzinger (1998) conceptualize emotion work as a participant resource in addition to an analytic tool (as cited in Chandler, 2012). Signals of such participant resources arose throughout the study as participants identified the self or personal practices as resources for their unique experiences of recovering from self-harm.

Present findings support Chandler's (2012) conceptualization of this active and responsible nature of emotion work for individuals who are self-harming, with participants narrating the use of emotion work in both self-injurious acts themselves and a meaning of recovery from their experiences. Such narratives tend to bring a particular attention to socio-cultural concerns of individuals and thus resist victimizing narratives (Chandler, 2012). The focus of this study was the context in which changes of self-injury occurred, with a focus on the function of the therapeutic encounter. Not only did the personal recovery narratives present in this study outline the helpful and challenging aspects of engaging in psychotherapy to explore self-harming experiences, they captured the essence of the agency and voice many self-harming individuals have for accounting for their injuries and engaging in their own recovery processes around self-harm even outside of the therapeutic encounter.

Conclusion

This study was intended to respond to the question: how do self-harming individuals develop ways to communicate about their experiences of self-harming within the therapeutic encounter? Engaging individuals who self-harm in therapy poses a clinical challenge, as many individuals who self-harm have difficult verbally expressing painful emotions and experiences, including those that have contributed to self-harming behaviors and about self-harming acts themselves (Motz, 2010).

Limitations in this study arose when accessing the sample population, in that the language used in recruitment materials to define "in recovery" and "treatment" were left undefined and up to participant speculation. Though participants in this study confirmed that they were not presently self-harming before moving forward with the interview process, questions arose during the recruitment process about the length of time one needed to be self-

harm free. In addition, potential participants were interested to learn more about exclusion criteria left undefined in this study such as the length of time one needed to be in treatment, and the parameters of still presently being in treatment though not actively self-harming. Participants were offered an explanation of why certain terms were left undefined in this study, and I reiterated that the primary criterion for participant were that participants were over the age of 18 and not presently engaging in self-harming behaviors.

Because of the sensitive nature of the study, there was a risk that participants might become uncomfortable while engaged in the interview process. I was aware of parallels between the interview process and a participant's experiences communicating about self-harm while in therapy, and the communicative barriers that might arise while speaking about self-harming experiences in the context of the interview. Finally, attention to bias is critical in studies implementing an interpretive phenomenological approach, as many interpretations of what makes an observation salient during coding and analysis are highly subjective. Each researcher develops their own "significance filter" that reflects assumptions, beliefs, and values concerning the topic (Sutherland, Dawcyzk, Leon et al., 2014).

I also recognize my positionality as a White identified individual, and following completion of this study have reflected on the lack of voices of people of color and voices from the LGBTQ community in this study's sample size and findings. How do issues of race, class, gender, and sexual orientation intersect with access and quality of treatment for self-harm, the etiology of self-harming experiences, as well as the subjective experience off living in a self-harmed body? While I posted my recruitment flyer on two websites with large Twitter and social media followings, I wonder how little representation there is of queer and trans, and QTPOC individuals who self-harm in the media and even discussion in the field about how race and

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racism intersect with mental health in general. I also reflect on how I could have taken more steps to intentionally center these voices.

My investment in this topic stems from personal history as someone in recovery from self-harm. Primary concerns about my personal biases while developing this study and engaging in the data collection process related to the development of non-leading research questions. While completing the interview process I was aware of the importance of using participant language when responding with follow up questions. I also implemented the use of my own reflections, assumptions, procedures, and decisions to increase the dependability of the study and address biases throughout the interview and analysis process (Sutherland, Dawcyzk, Leon et al., 2014).

There are a number of implications of findings from this study for the field and clinical practice. The first is responding to a gap in self-harm research about specific interventions leading to better engagement or long term outcomes related to the communication challenges clients who self-harm often face (Ougrin & Latif, 2011; Sinclair & Green, 2005). In addition, this research will add to a growing body of work that explores the communicative function of self-harm, and the nuance of translating affective experiences that are expressed through self-harming acts into spoken word (Motz, 2010). As evidence based treatment and clinical trials studying the effectiveness of psychological treatments for self-injury are rare, many therapies tend to be catered to the individuals. Findings within this study stress the importance of attuning to the changing relationships an individual has with the etiology of their self-harming experiences at different points across time and how these factors intersect with how and under what circumstances an individual enters therapy for self-harm.

Additionally, findings bring an additional emphasis on the qualities and responses of treatment providers that allow for alliance building with clients and space for clients to develop communication around disclosure of self-harm. A growing understanding of self-harm as communication appears to capture the space between acceptance and behavior change, conceptualizing self-harm as "a means of self-creation and such acts are sometimes felt to be closer to affective states than words" (Motz, pg. 84). As such, the role of therapy is to foster a transition from gesture to language, so from the between of a client's own emotion work and the therapist's ability to hold an "empty space," a less violent voice may enter (McLane, 1996). Recommendations for further study include additional research establishing evidence based practice for clinical work with self-harming individuals, and an expansion of literature exploring the communicative functions of self-harm, recovering the self-injured body, and the subjective experiences of engaging in the emotion work of self-harm within a variety of socio-cultural contexts, including the clinical encounter itself.

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Appendix A: Moderator Outreach Correspondence

I engaged in outreach to the moderators of the following websites: sioutreach.org/ (Self-Injury Outreach & Support), twloha.com (To Write Love on Her Arms), mirror-mirror.org , themighty.com, recoveryourlife.com, selfinjury.com (S.A.F.E Alternatives), and selfinjuryfoundation.org. Initial contact email below.

Hello,

My name is Danielle Kowalski. I am a Master's of Clinical Social Work student at Smith College School for Social Work conducting a study for my degree requirements. I hope to interview 12 individuals who identify as being in recovery from self-harm and who have engaged in therapy for their self-harm. The central question of the study is how do individuals develop a way to communicate around their experiences of self-harm within the early stages of therapy?

Your website was chosen as a potential recruitment outlet following a search of websites with content focused on self-harm. Your website appears to be a site reaching individuals interested in content focused on recovery, psycho-education, and support services for individuals who have had experiences with self-harm.

Please feel free to be in contact to advise me on what steps I can take to advertise my study to potential participants on your website. I can supply additional recruitment and informational materials for your review per request.

Thank you for your consideration,

Danielle Kowalski

MSW Candidate '17

Smith College School for Social Work

Appendix B: Participant Recruitment Notice I

Hello,

I am a student writing my Master's in Clinical Social Work thesis at Smith College School for Social Work. This study will explore how individuals develop ways to communicate about experiences of self-harming in therapy. My goal is to fill in research gaps about how therapists can be most helpful working with individuals who self-harm, learning from individuals with lived experience about what was helpful and challenging to their ability to explore self-harm while in the early stages of therapy.

Are you interested in participating in my thesis? I am looking for participants who:

- Identify as being in recovery from self-harm
- Are not presently self-harming
- Have completed therapeutic treatment for experiences of self-harm
- Are over the age of 18

I have attached the recruitment flyer to this post for your consideration. Participants who agree to be in this study will engage in a 30-45 minute interview regarding their experiences of talking about self-harm in therapy. Interested individuals may contact the researcher for more information directly at dkowalski@smith.edu or xxx-xxx-xxxx.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Thank you for your consideration,
Danielle Kowalski

Appendix C: Participant Recruitment Notice II

Hello,

I am a student writing my Master's in Clinical Social Work thesis at Smith College School for Social Work. This study will explore how individuals develop ways to communicate about experiences of self-harming in therapy. My goal is to fill in research gaps about how therapists can be most helpful working with individuals who self-harm, learning from individuals with lived experience about what was helpful and challenging to their ability to explore self-harm while in the early stages of therapy.

Are you interested in participating in my thesis? Do you know anyone who may be interested in participating? I am looking for participants who:

- Identify as being in recovery from self-harm
- Are not presently self-harming
- Have completed therapeutic treatment for experiences of self-harm
- Are over the age of 18

I have attached the recruitment flyer to this post for your consideration. Participants who agree to be in this study will engage in a 30-45 minute interview regarding their experiences of talking about self-harm in therapy. Interested individuals may contact the researcher for more information directly at dkowalski@smith.edu or xxx-xxx-xxxx.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Thank you for your consideration,
Danielle Kowalski

Appendix D: Recruitment Script to Guide Purposive and Snowball Sampling

*Purposive sampling will use this script to outline contact with potential participants via email.

Thank you for responding to my request for participants. Before continuing can you please confirm you are over the age of 18?

Yes: Continue below

No: Thank you for contacting me to learn more about my study. Unfortunately, it is a requirement that participants in this study be over the age of 18 and therefore we cannot continue with the recruitment process. Thank you for your time.

EXPLANATION OF STUDY: I'd like to explain my study again and see if you are eligible to be involved. The goal of this study is to fill in research gaps about how therapists can be most helpful working with individuals who self-harm as well as to better understand how experiences of self-harm are communicated in therapy. I hope to interview individuals who have had lived experiences of self-harm to learn about what was helpful and challenging to their ability to explore self-harm while in the early stages of therapy. This will take place during a 30-45 minute semi-structured interview. If you agree to participate in the interview, you have the right to discontinue participation in this study at any point during the interview.

PARTICIPATION CRITERIA: To continue participating in this study one must identify as being in recovery from self-harm. Research on recovery from self-harm acknowledges that this is a sometimes complex, non-linear process and each person defines what recovery means to them. However, for the purposes of maintaining participant safety throughout the interview process, this study asks that participants are not presently self-harming. Finally, to participate in this study, one must have completed therapeutic treatment for experiences of self-harm.

At this time do you have questions about the above criteria or your eligibility to participate in this study?

At this time do you believe you meet the above criteria?

Yes: Continue below.

No: Thank you for contacting me to learn more about my study. Unfortunately, you do not meet criteria for participation at this time. Unless you have other questions would you like to end the call? Thank you for your time.

INFORMED CONSENT PROCESS. If following this explanation of the study you are interested in continuing, I will arrange to send the Informed Consent paperwork for you to look over. Along with consent for participation, you will also be asked to confirm or deny consent to be audio recorded during the interview portion of this study. You may contact me with any question following reading the Informed Consent and if interested in continuing with the study sign it at your leisure before the interview.

POTENTIAL BENEFITS AND RISKS OF PARTICIPATION: At this point I'd like to discuss some of the potential benefits and risks of participating in this study. Participants may appreciate the opportunity to talk about their experiences engaging in therapy and telling their story related to experiences of self-harm. At the same time, while participating in this study, you could potentially become uncomfortable while talking about some of their experiences with self-harm and talking about self-harm in therapy. If at any point in this study you feel uncomfortable and are looking for extra support you can contact a list of resources provided along with the Informed Consent forms. Referral lists will include resources pertaining to self-harm support groups, hotlines, and additional options for continued support.

Now that I've explained these criteria do you feel that you would like to continue with an interview?

> If yes: Thank you for agreeing to be a participant in my study. You have the option depending on your location to participate in a Skype or in-person interview. Do you have a preference on where we meet? Interviews in person can be held at a comfortable public space such as Smith College Library or Forbes Library.

> If no: Thank you for contacting me to learn more about my study. Unless you have other questions would you like to end the call? Thank you for your time.

I will arrange to send the Informed Consent forms for you to look over. Please read them and reach out if you have any questions.

> In-person interview: You can sign the Informed Consent at your leisure and bring it with you to the interview.

> Skype interview: You can sign the Informed Consent and return the paperwork to me prior to the date of our interview by postal mail or via email.

Thank you again for contacting me for with your interest about participating in this study. Once again, if you have further questions as we continue or as you review the Informed Consent please feel free to contact me.

Appendix E: Interview Guide

Title of Study: Engaging Individuals Who Self Harm in Psychodynamic Psychotherapy

Investigator(s): Danielle Kowalski dkowalski@smith.edu

……………………………………………………………………………….

Today we will be talking about your experiences with self-harm, particularly how you explored them in the early stages of work with a therapist. You will have space to explore your thoughts and we will engage in conversation while guided by central questions. Does this plan feel comfortable to you?

Can you tell me about the time that you began therapy related to your experiences of self-harm?

At what point in your self harming experiences did you first engage in therapy?

What was the idea behind beginning therapy?

Do you have a way to describe how you developed communication about your self harm while in therapy? What was this process like for you?

Was there a time that experiences of self-harm first came up in therapy?

What helped this process?

What made talking about self-harm in therapy challenging for you?

What resources have you drawn on to try to overcome experiences with self-harm? (meds, family, clinical support, specific types of interventions, online support, peer support). How did you learn about/discover these resources?

SMITH COLLEGE

2016-2017
Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA
....

Title of Study: Engaging Individuals Who Self Harm in Psychodynamic Psychotherapy

Investigator(s): Danielle Kowalski dkowalski@smith.edu

....

Introduction

You are being asked to be in a research study exploring how individuals develop ways to communicate about experiences of self-harming in therapy. You were selected as a possible participant through the recruitment process that aimed to distinguish individuals are over the age of 18, identify as being in recovery from self-harm, are not presently self-harming, and who have completed therapeutic treatment for experiences of self-harm. These criteria serve to develop a participant group that centers individual experiences with self-harm as the primary inclusionary criteria, versus other individual and social factors such as gender, socioeconomic status, race, religion, or family composition. We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

The purposes of this study are to learn about people's early experiences of talking about self-harm in therapy, and to increase understandings of how therapists can be most helpful working with individuals who self-harm. Though there are many forms of self-harm, this study defines self-harm broadly as an "intentional, self-effected, low lethality bodily harm…performed to reduce psychological stress" (Walsh, 2006, p. 4). This study is being conducted as a research requirement for my Master's in Social Work degree. Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures: If you agree to be in this study, you will be asked to do the following things:

First respond to the research's request for participants by confirming that you are over the age of 18.

Listen or correspond with the researcher via phone or email regarding a a description of the study, along with the potential benefits and risks of the study and other consent information.

Review Informed Consent materials received through postal mail or email and contact the researcher with additional questions prior to the interview.

Return a signed copy of the Informed Consent to the research prior to interview by postal mail/email, or bring a signed copy of the Informed Consent if participating in an in-person interview.

If you wish to participate in an interview, a time and place will be scheduled. You also have the option of participating in a Skype interview if you live outside of the researcher's primary location of Western Massachusetts.

The interview will consist of a semi-structured questionnaire prompting you to explore your experiences of talking about your self-harm in therapy. Interviews will last between 30-45 minutes.

At the end of interview session participants will be provided with a referral list for post interview/participation follow up support.

Risks/Discomforts of Being in this Study

While participating in this study participants may potentially become uncomfortable while exploring their experiences with self-harm and talking about self-harm in therapy.

Understanding the above risks, individuals agreeing to participant in this study self-identify as being "in recovery" from self-harming experiences to reduce the likelihood of distress during or following the interview session.

Understanding that each individual might experience this participation in this study differently, participants will be provided a referral list along with this Informed Consent document, and reminded of these resources at the close of the interview. Referral lists include resources pertaining to self-harm support groups, hotlines, and additional options for continued support.

Benefits of Being in the Study

Participants involved in this study may appreciate the opportunity to talk about their experiences engaging in therapy and telling their story related to experiences of self-harm.

The benefits to social work/society are: contributing to research surrounding therapeutic engagement and positive treatment outcomes with individuals who engage in self harm.

Confidentiality

Your participation will be kept confidential. Confidentiality is assured in that consent letters will be kept separate from notes and transcripts. Each participant will be assigned a coded number which will be placed on all materials. Audio recording digital files and subsequent transcripts will be password protected.

Participants are cautioned to avoid using their names or identifying information during interviews. Quotes will be selected that do not identify individuals. Interviews will be conducted in private locations. Individuals doing Skype interviews will be cautioned to maintain privacy during interviews.

All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. You may refuse to answer any question or withdraw from the study *at any time* (up to the date noted below) without effecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. If this is an interview and you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by April 15, 2017.

Right to Ask Questions and Report Concerns

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Danielle Kowalski at dkowalski@smith.edu or by telephone at xxx-xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep. You will also be given a list of referrals and access information if you experience emotional distress related to your participation in this study.

……………………………………………………………………………………………….

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

……………………………………………………………………………………………….

[if using audio or video recording, use next section for signatures:]

1. I agree to be **audio** taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be <u>audio taped</u>:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Work Cited in this Document :
Walsh, B. W. (2006). *Treating self-injury: A practical guide.* Guilford Press.

Appendix G: HSR Approval Letter

SMITH COLLEGE

School for Social Work
Smith College
Northampton,
Massachusetts 01063
T (413) 585-7950   F
(413) 585-7994

February 25, 2017

Dani Kowalski

Dear Dani,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Michael Murphy
Human Subjects Review Committee

CC: Elaine Kersten, Research Advisor

Appendix H: Referral List

REFERRAL AND RESOURCE LIST FOR ADDITIONAL SUPPORT

WEBSITES

- **http://sioutreach.org/** - Provides info guides about self harm, peer stories, and resources related to coping and recovery
- **http://www.selfinjury.com** -SAFE Alternatives is a nationally recognized treatment approach, professional network, and educational resource base, which is committed to helping people achieve an end to self-injurious behavior. You can find referrals for treatment by visiting their website or calling 800-366-8288
- **http://www.twloha.com/** - TWLOHA is a non-profit movement dedicated to presenting hope and finding help for those struggling with depression, addiction, self injury and suicide. TWLOHA exists to encourage, inform, inspire and also to invest directly into treatment and recovery
- **Yahoo group NoFEAR-S.A.F.E:** A support group for people who are serious about recovering. Access at **https://groups.yahoo.com/neo/groups/NoFEAR-SAFE_Approved/info**

ADDITIONAL PHONE NUMBERS

- S.A.F.E. Alternatives (Self-Abuse Finally Ends) Information Line: 1-800-DONT-CUT or 1-800-366-8288

- DOOR OF HOPE NATIONAL LINE: Call or text at 914.393.1904 OR 803.570.2061 Sunday, Tuesday and Thursday 8:30 - 10 pm est