Counsellors’ perspectives on self-harm and the role of the therapeutic relationship for working with clients who self-harm

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Abstract

Aims: To gain insight into counsellors’ experiences of and ideas about self-harm, and to develop understanding of relational depth when working with clients who self-harm. Method: A qualitative exploration of counsellors’ perspectives on working with people who self-harm. The research proposal gained approval from the University Ethics Committee. Data were collected from a sample of counsellors who have experience of working with people who self-harm (n=8) using tape-recorded interviews. Grounded Theory was used for analysis. Findings: Two major categories emerged from the findings: (i) the activity of self-harm; (ii) the therapeutic relationship with people who self-harm. These categories and sub-categories were integrated to form the core category. Implications: Counsellors have a valuable role to play in the lives of people who self-harm, by embodying confidentiality and so facilitating a sense of trust, by opening minds through acceptance, and by expanding knowledge through participation in research. Conclusions: In order to effectively accompany clients from a life of self-harm to a life of self-healing, counsellors must be aware of and responsive to the many concepts underpinning the emergent categories of the research.

Keywords: self-harm; self-injury; counsellor perspective; therapeutic relationship

Introduction

Self-harm is a widespread and controversial issue in contemporary society. Anderson and Standen (2007) suggest that it is the reason for 24,000 hospital admissions in England each year, while the Samaritans and Centre for Suicide Research estimate that self-harm affects one in 10 young people (Mental Health Foundation, 2006). While rates of self-harm are higher among 11–25 year olds (Mental Health Foundation, 2006), research indicates that people of all ages can engage in self-harming behaviour.

The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPS(NI), 2008) cites that self-harm is responsible for over 7000 hospital admissions per year in Northern Ireland, and that this figure has increased by 9% since 2000. These figures are based on reported incidents and therefore do not reveal the true scale of the problem, as self-harm is generally secretive behaviour (Mental Health Foundation, 2006; SANE, 2008; Turp, 2003). It is evident that self-harm is a significant public health issue throughout the UK, and that its occurrence may be escalating.

The popular media often depict self-harm in a stereotypical manner. The words can conjure up specific images, for example of ‘attention seeking’ young women cutting their arms with razor blades. The Mental Health Foundation purports a broader definition, which states that ‘Self-harm describes a wide range of things that people do to themselves in a deliberate and usually hidden way. In the vast majority of cases self-harm remains a secretive behaviour that can go on for a long time without being discovered’ (Mental Health Foundation, 2006, p. 5).

The literature strongly supports the idea that self-harm is usually a secretive behaviour (Fox & Hawton, 2004; Turp, 2003). The hidden nature of the behaviour challenges the view that individuals who self-harm are motivated by a desire to seek attention from or manipulate others. The Mental...
Health Foundation (2006, p. 21) states that ‘taking all the available research data together indicates a prevalence rate of between 1 in 12 and 1 in 15’ for self-harming behaviours such as cutting, burning, scalding or ingesting toxic substances. These figures suggest that self-harm is clearly a significant issue in the lives of young people.

**Definition**

**Self-harm**

Turp (2003) seeks to define self-harm in a way that reflects the multi-faceted nature of behaviour:

1. that results, whether by commission or omission, in avoidable physical harm to self,
2. that breaches the limits of acceptable behaviour, as they apply at the place and time of enactment, and hence elicits a strong emotional response (Turp, 2003, p. 36).

This definition captures the various dimensions of self-harm for both the individual and society. It can be an action or a non-action, causing harm by deed or by neglect. Self-harm is not confined to a particular gender, age group, culture or type of behaviour.

Research often suggests that self-harm is an issue that predominantly presents in adolescence (Mental Health Foundation, 2006), a result of personality disorders (Favazza, 1996), or the precursor to suicide (Hawton et al., 2006). Many qualitative studies on self-harm focus on clinical populations, i.e. those people who are known to health and/or psychiatric services (Huband & Tantam, 2004; Hume & Platt, 2007; Sinclair & Green, 2005). However many people who self-harm never present to formal health services (Ystgaard et al., 2009), and therefore do not fall into psychiatric/clinical statistics (Gratz, Conrad, & Roemer, 2002).

Turp (2007) presents a case study based on one of her clients who engaged in self-cutting. Turp (2007) uses object relations theory to facilitate understanding of the client’s dependence on and rejection of her abandoning mother and any maternal object or possible source of help. The therapeutic encounter in this case helped the client to feel that she could share her experiences and to identify her cutting was re-enforcing her endeavour to be overly self-reliant.

Harris’s (2000) small scale study, which explores letter writing of six women who self-harm, acknowledges that for many self-harm is a form of purgatory, ‘where cries for help go unheard, where the logic and rationality of one’s behaviour is constantly questioned, and where the only certainty is that the suffering will continue’ (p. 173). These qualitative studies, focusing on subjective experiences in an in-depth way, provide a powerful and articulate voice to people who self-harm in order to cope with their existence.

**Method**

The research hoped to explore counsellors’ perceptions of working with people who self-harm. Many researchers and practitioners who work with people who self-harm will appreciate that it is an emotive issue. In consideration of the sensitive nature of the subject area and the aims of the research project, an in-depth qualitative methodology was adopted. Initially, purposive sampling was used followed by snowball sampling (Strauss & Corbin, 1998).

**Participants**

Participants were accessed through the Northern Ireland Forum for Counsellors, a voluntary body of counsellors set up for support, networking opportunities and continuing professional development. An email was generated to counsellors within this body, which provided a brief overview of the research proposal and invited potential participants to contact the researcher by email or telephone. Two people
from the contact list responded and were willing to participate. These counsellors then recommended colleagues, and a snowball sampling technique was employed until the required sample size of eight counsellors was achieved. All of the counsellors worked within the Belfast area in Northern Ireland. A breakdown of the sample is provided in Table I.

Data collection and analysis

Eight semi-structured interviews were conducted with counsellors currently in practice; each interview lasting for approximately 45 minutes. Interviews were transcribed as soon as possible after completion. Data analysis was conducted using Strauss and Corbin’s (1998) grounded theory and involved open, axial and selective coding of categories. In keeping with one of the tenets of grounded theory, the interview guide was adjusted after each interview to incorporate additional themes, until theoretical saturation was attained.

Ethical considerations

The research proposal was assessed and the research given approval by the university’s Ethics Committee. British Association for Counselling and Psychotherapy (BACP) ethical guidelines for counsellors underpinned the research process (BACP, 2007). Specific ethical considerations included respect for the confidentiality of the individuals who participated in the study, and for those individuals and experiences they related. Confidentiality was assured and the interviews were conducted in a suitably safe environment. Participants were provided with a consent form and the assurance that their consent was ongoing. The interviewees were informed that there was a possibility of future publication. Pseudonyms were adopted for participants using an alphabetical system (Alice, Brenda, Ciara, Denise, Ellen, Francis, Gerard and Helen). Tapes and transcripts were locked away and computer documents were protected with passwords.

Findings and discussion

The interviews were conducted, transcribed and analysed by the principal researcher, which ensured immersion in the data; a requisite of grounded theory research. The researcher employed a manual method of coding to analyse the findings. The findings and discussion explore two emergent categories. They are counsellors’ perceptions of: (1) the activity of self-harm; and (2) the therapeutic relationship and self-harm. An overview of the categories is presented in Table II.

The activity of self-harm

In identifying counsellors’ individual experiences, the category depicts the unique nature of every act of self-harm and posits understanding within its own framework. Three major sub-categories surfaced within the activity of self-harm: people who self-harm; types of self-harm; and reasons for self-harm.

People who self-harm

The counsellors were in agreement that self-harm is a common issue that can affect people in any circumstance. The counsellors believed that self-harm might be more common among adolescents and young people. Yet the counsellors acknowledged other age groups who may be susceptible to self-harm: persons in their 20s and 30s, children of primary school age and older people. All of the counsellors had experience of working with both

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Cultural background</th>
<th>Counselling experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alice</td>
<td>Female</td>
<td>66</td>
<td>Northern Irish</td>
<td>20 years counselling experience, working in voluntary sector and private practice.</td>
</tr>
<tr>
<td>Brenda</td>
<td>Female</td>
<td>30</td>
<td>Northern Irish</td>
<td>Significant experience working with children and young people as well as three years formal counselling experience.</td>
</tr>
<tr>
<td>Ciara</td>
<td>Female</td>
<td>35</td>
<td>Northern Irish</td>
<td>Five years counselling experience in the voluntary sector.</td>
</tr>
<tr>
<td>Denise</td>
<td>Female</td>
<td>57</td>
<td>Northern Irish</td>
<td>20 years counselling experience in the voluntary sector.</td>
</tr>
<tr>
<td>Ellen</td>
<td>Female</td>
<td>48</td>
<td>Northern Irish</td>
<td>Seven years counselling experience in the voluntary sector.</td>
</tr>
<tr>
<td>Frances</td>
<td>Female</td>
<td>27</td>
<td>Northern Irish</td>
<td>Four years counselling experience in the voluntary sector.</td>
</tr>
<tr>
<td>Gerard</td>
<td>Male</td>
<td>58</td>
<td>Northern Irish</td>
<td>10 years counselling experience in the voluntary sector.</td>
</tr>
<tr>
<td>Helen</td>
<td>Female</td>
<td>29</td>
<td>Northern Irish</td>
<td>Four years counselling experience in the voluntary sector.</td>
</tr>
</tbody>
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Table II. Overview of categories.

<table>
<thead>
<tr>
<th>Core category</th>
<th>Categories</th>
<th>Sub-categories</th>
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<tr>
<td>the counselling role</td>
<td>The counselling therapeutic relationship and self-harm</td>
<td>The role of the counselling therapeutic relationship for clients who self-harm, The role of the counselling therapeutic relationship for counsellors working with self-harm, Counsellors’ skills and qualities for working with self-harm</td>
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men and women who self-harm. Only two counsellors suggested that females were more likely to self-harm, three agreed that both males and females were likely to self-harm, and one counsellor identified that males were more likely to self-harm. Interestingly the only male counsellor in the sample identified males as more likely to self-harm. Some of the counsellors suggested that the method of self-harm may differ between males and females:

**Brenda:** Men in my experience don’t self-harm as much as women especially with using blades. Men use alcohol, drugs, addiction to painkillers, serial womanising. Not with the cutting.

**Frances:** Sometimes men can find other ways of releasing tensions and upsets, are more likely to scream and shout or physically to hit someone and in those instances it would be the more dramatic that you would see, more visible.

These findings differ from those of Fox and Hawton (2004) who support the idea that self-harm is more common among adolescents. The findings concur with Gratz et al.’s (2002) study which denotes that ‘the extent of self-harm behaviour among men . . . the majority of researchers have concluded that this behaviour is more common among women than men’ (p. 10). The ways in which self-harming behaviours are identified will impact upon understanding about the population affected by self-harm. As such it is necessary to explore various behaviours that counsellors have identified as self-harming.

**Types of self-harm**

The counsellors related many types of behaviour that can be interpreted as self-harm. There were six concepts within this sub-category: deliberate and spontaneous; deliberate and ritualistic; repetitive or compulsive; socially acceptable/fashionable; carelessness with self and recklessness with self. The findings concur with Favazza (1996) who acknowledges eating disorders as a form of self-harm.

**Brenda:** Now one that’s becoming more common is eating disorders, either over or under, anorexia or bulimia.

The findings complement Turp’s (2003) conceptualisation of self-harm in demonstrating the broad spectrum of behaviours considered to be self-harming, from cutting to sexual risk-taking.

**Ciara:** Cutting, hair pulling, using rope on the arms, to burn the skin, pulling eyelashes out of the eyes.

**Alice:** Sleeping with somebody who they know has a sexually transmitted disease; that is self-harm.

The counsellors recognised that the means of self-harming behaviour can be influenced by the reasons for the self-harm.

**Reasons for self-harm**

Three concepts emerged from this sub-category. They were: the act of self-harm itself; individual psychology; and individual life experience. Findings illustrated that the act of self-harm can provide sensations of release, relief, escapism, purging, control or identity. The counsellors perceived that individual psychology could relate to the eros/thanasos conflict. This refers to the struggle between the life and death instincts, which Freud (1930) believed to be inherent in every individual. The counsellors’ perceptions of life experiences included trauma, physical abuse, sexual abuse, emotional abuse, depression, growing up, frustration and family
history of suicide. Some counsellors believed that self-harm may be the result of a combination of these concepts. The following narratives depict the complexity of the possible reasons for self-harm:

Alice: My own view is that some clients have so much mental and emotional pain that they self-harm to release that.

Denise: People by definition are born with that, we’ve all got it in us, the death thing and some people are more attuned to that thanatos principle than others.

Ciara: One person cut herself because of the abuse, because she felt dirty and wanted the dirt out, seeing the blood leave helped.

The findings would suggest that for some people who self-harm, blood continues to bear healing properties, albeit psychological healing. Favazza (1996) argues that blood has represented healing in cultural psyche for many years, citing the medical procedure of blood-letting as evidence. Schoppmann et al. (2007) relate a psychoanalytic interpretation of the life-bringing properties of the ‘dampness and warmth’ of blood, which may be reminiscent of life in utero. Menninger (1938) argued that self-harm was related to the eros/thanatos conflict. Contextualising the act of self-harm, not only culturally but individually in terms of the distressing life experiences that can predate the behaviour, could encourage a more open-minded tolerance in response to presentations of self-harm.

The therapeutic relationship and self-harm

The therapeutic relationship provides the environment within which individuals can cast off socially imposed constraints and progress psychologically as self-actualising individuals (Rogers, 1967). This category was refined to three sub-categories: the role of the therapeutic relationship for clients who self-harm; the role of the therapeutic relationship for counsellors working with self-harm; and counsellors’ skills and qualities for working with self-harm.

The role of the therapeutic relationship for clients who self-harm

The findings affirm the belief that the therapeutic relationship is central for counsellors working with clients who self-harm. This sub-category produced five concepts; time, confidentiality, acceptance, equality and sensitivity.

The counsellors acknowledged the need for time, in that clients will need time to establish trust in the therapist and in the therapeutic process. The concept of time is central in recognising the reality that many services are time-limited, and that funding can be precarious. Two counsellors stated emphatically that counselling services for people who self-harm should not be time-limited. As Frances articulated:

Frances: I think also to know that there’s someone there who isn’t rushing you, because defence mechanisms are there for a reason.

With regard to confidentiality, the counsellors recognised that the relationship must be a safe, neutral and confidential space for clients. Two counsellors highlighted that the relationship can be a painful experience for clients, while they learn to confront and talk about certain issues that may have been contained within them for a long time.

Brenda: Most of the wounds of self-harm go very deep . . . when you get to the core of the self-harm it’s terrifying . . . terrifying for the person even going there.

The concept of acceptance was evident from the findings, as the counsellors agreed that clients must feel that they are understood and that they are not being judged. They perceived that clients should experience the counsellor’s acceptance. Further, the relationship must be ongoing and reliable for clients.

Alice: That you don’t judge them or moralise . . . to be there for the client, to welcome the client into the therapeutic space.

Denise: It’s all about trust, it’s all about acceptance, it’s all about not judging.

The counsellors spoke of equality as important in the counselling relationship. Mearns and Thorne (2007) refer to an established inequity that can exist in therapy, ‘The counsellor is on familiar territory, the client is not’ (p. 156). Two counsellors in the current study stated that if anything, counsellors should be humbled by their position.

Ellen: The clients are the experts on their own lives.
Denise: You’ve [the counsellor] been given this great privilege to be told about this and you should never take that for granted.

The fifth concept, sensitivity, is integral as the counsellors related the sensitivity and gentleness with which clients must be held in the therapeutic relationship.

Denise: The therapeutic dance, the sensitivity, the gentleness that has to go on between the two people... it has to be held in some way, very, very gently.

The counsellors spoke of the value of a long-term, safe, non-judgmental, equal and sensitive therapeutic space in which clients can freely express their feelings and experiences. The findings suggest that the therapeutic relationship has a crucial role in facilitating psychological healing for clients who self-harm.

The role of the counselling therapeutic relationship for counsellors working with self-harm

Five concepts emerged within the role of the therapeutic relationship for counsellors: hope; trust; presence; openness; ‘being new’ with the client.

Hope echoed throughout the counsellors’ dialogues; hoping that they have done enough, hoping that the relationship would hold, hoping that clients would persevere. In the second concept, the counsellors identified a need for counsellors’ trust in their clients; trust in the therapeutic process and trust in themselves. In relation to the third concept, many of the counsellors acknowledged the need for a therapeutic presence for clients, and three counsellors talked of beyond presence, to being a witness to the client’s self-harm. The fourth concept refers to the counsellors’ recognition of the need to be open and transparent in the relationship. For two counsellors this included recognising personal and professional limitations.

Ciara: It’s not easy, when you’re working with someone who’s covered in marks, and if that’s going to mess you up through transference then you’re not the person to be in that room... It’s about recognising your limitations.

Denise: It’s important to be transparent in the work that you do because you’re dealing with a person that’s been really hurt.

All the counsellors identified a sense of ‘being new’ with the client. Clients may have experienced past hurt, abandonment, negative reactions to them, counsellors must transcend all those past experiences and be new for the client, treat them with the respect and acceptance that they have not experienced before.

Ciara: It’s about being there for them whenever no-one else has been.

Denise: The person has to some extent been rejected at many times in their lives and they don’t need another professional person to do that.

The findings indicate that the therapeutic relationship for self-harm is vital, complex, long-term and multi-dimensional. These findings advocate the centrality of the relationship as a unique entity supporting Rogers’ (1967) notion that the therapeutic relationship is fundamental to therapeutic outcomes for clients.

Counsellors’ skills and qualities for working with self-harm

This sub-category contained three concepts: establishing the therapeutic relationship, maintaining the therapeutic relationship and ending the therapeutic relationship.

Establishing the therapeutic relationship

The beginning of the therapeutic relationship can be a crucial time frame wherein the client determines whether or not the counsellor is appropriate for their needs. Observation skills, listening, establishing contracts, identifying client history, risk assessment and being person-centred were all identified by counsellors as crucial at the beginning of therapy.

Frances: I think it’s quite difficult for them to make the initial connection, really to be brave enough, so it’s about... letting that person know there is immediate support and that it’s going to continue.

Therapist qualities identified were empathy, trust, unconditional positive regard, acceptance, allowing time, creating a safe environment, not judging the client or their behaviour and allowing the client to determine the pace and content of therapy.

The counsellors in this study affirmed the importance of establishing a safe and respectful relationship, with qualities such as acceptance, congruence and empathy. Two counsellors related their views on using counselling contracts that ask clients not to self-harm while undergoing therapy. Both counsellors were strongly opposed to the notion of such contracts:

Alice: Is that to protect the counsellor rather than the client… if we ask this person to do this then we’re taking away the very act that helps them to continue living … so to deny them that opportunity might be to deny them of the one thing they have to help them at that particular time.

Ciara: Well you know, I really think that’s about the counsellor more than the client. People who self-harm, they need that behaviour, especially when they’re working through very painful issues. It’s their crutch, they need it.

These findings support the literature. McMyler and Pryjmachuk (2008) conducted a study on no-suicide contracts (NSCs). The researchers included self-harm under the topic of suicide, concluding that NSCs are problematic in terms of ‘the potential for coercion from the clinician for their own protection and the ethical implications of restricting a service-user’s choices when they may be already struggling for control’ (p. 512).

Maintaining the therapeutic relationship

The skills and qualities required for maintaining the therapeutic relationship were seen as personal, professional and ethical. Skills included: tapping into their own feelings; awareness of transference; therapeutically holding the client; awareness that client’s progress can be multidirectional; having practical awareness and experience of self-harm; continuing professional development; mirroring best professional practice; knowing when and how to refer on.

Alice: Empathy with their pain and trying if you like, to have the transference, picking up their pain, picking up their pain where it’s felt in the counsellor’s body, how do I feel when that client’s communicating with me.

Brenda: So it’s difficult to get to step two and then when you do get there, it’s difficult to keep them there. That’s probably the most difficult thing of all, maintaining it, containing it and keeping it all in … There’s the sheer fear that people feel when they do release, because they’ve contained everything for so long … You’re there to try and help them and be with them and hopefully they trust you enough at that stage to know that’s real.

Five of the counsellors recommended the use of creative techniques for clients during the therapeutic relationship, such as journaling or painting. These allow clients to determine their own progress and process their feelings about the therapy.

Ending the therapeutic relationship

The qualities and skills that counsellors need for ending the therapeutic relationship were seen as both personal and professional. The counsellors all imparted the idea that endings would be open, the counsellor must prepare the clients for the ending, and the client must be ready to end.

Gerard: It’s different for every person, but endings are something that I like the client to decide when they feel they want to — not when I tell them to.

The counsellors discussed teaching coping strategies, teaching clients to identify triggers for their self-harm, and one counsellor talked about safer self-harm.

Ciara: It’s finding ways of helping people to self-harm that are less dangerous. So for example with a client who was very bad with drugs and wasn’t ready to deal with coming off drugs, in therapy we looked at certain things, for example safer injecting, avoiding drug cocktails, things that would keep him safe … hopefully if he finds in time that
he is ready to deal with the drugs then he will come back, he knows I will be there.

Several of the counsellors concurred that when therapy ends, the self-harm may not have ended, but it may be diminished or the type of behaviour may have changed.

Many of the counsellors were personally reflective when discussing endings, and five of the counsellors openly conceded that endings can be difficult for them. They acknowledged that endings are an aspect of therapy that should be addressed in counselling training. The counsellors related that often with self-harm the relationship is long-term; emotional responses are the only human aspect to relationship closure. The findings nonetheless emphasised the importance of personal therapy and supervision for practising counsellors.

Limitations

The main limitation of the research is the focus solely on the experiences of practitioners. Suggestions for further research would include the development of qualitative studies from the perspectives of people who self-harm as well as practitioners. This would enhance research in the field for the purposes of education, development of evidence-based practice and continuing professional development.

There is a need for further research on the hidden population of self-harm; those people who never become known to formal statutory services. Counsellors provide a crucial role in accessing the hidden population because counsellors are more likely to be exposed to the silent voices at risk of self-harm. Variations in age, gender and cultural background of participants could have yielded different results, as self-harm might have been constructed differently within social or therapeutic parameters.

Conclusion

All counsellors who encounter self-harm in their professional and personal lives, have a pivotal role to play in improving the lives of people who self-harm. Counsellors’ insight to the breadth and depth of self-harm behaviour can foster understanding and acceptance, while also challenging negative attitudes. By raising awareness of the issue amongst counsellors, the study forges a small but important step towards achieving this aim.

References


**Biographies**

**Maggie Long** is a PhD student in the School of Sociology and Applied Social Studies at the University of Ulster (Magee Campus). The focus of her PhD study is self-harm. She is working towards counselling accreditation.

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