



'Sitting With Uncertainty'

A psychotherapeutic exploration of Adolescents who self-harm.

Tara Healy (10033289)

Supervised by: Dr. Grainne Donohue

**Thesis submitted in partial fulfilment of the requirements of the BA
counselling and psychotherapy, department of psychotherapy, Dublin
Business School, School of Arts.**

For the B.A. (Hons.) degree in Counselling and Psychotherapy

From Dublin Business School, School of Arts

Table of Contents

Declaration.....	i
List of Tables.....	ii
Acknowledgements.....	iii
Abstract.....	iv
Chapter 1: Introduction.....	1
1.1 An Irish Perspective.....	1
1.2 Theoretical Perspective.....	1
1.3 Transference.....	2
1.4 Aim of study.....	3
1.5 Conclusion.....	3
Chapter 2: Literary Review	4
2.1 Introduction.....	4
2.2 The Aetiology of Self-harm.....	4
2.3 Interpersonal Issues.....	5
2.4 The Therapeutic Response.....	7
2.5 Transference and Counter-transference.....	10
2.6 The use of Transference and Counter-transference in adolescents who self-harm.....	12
2.7 Conclusion.....	14
Chapter 3: Methodology	15

3.1 Introduction.....	15
3.2 Methodological Approach.....	15
3.3 Sampling.....	16
3.4 Data Collection.....	16
3.5 Research Strategy.....	17
3.6 Ethical Issues.....	18
3.7 Conclusion.....	18
Chapter 4: Findings.....	19
4.1 Introduction.....	19
4.2 The Counsellor’s capacity.....	20
4.3 Containment.....	23
4.4 The Management of Transference.....	25
4.5 Conclusion.....	28
Chapter 5: Discussion.....	29
5.1 Introduction.....	29
5.2 The Counsellor’s capacity.....	29
5.3 Containment.....	30
5.4 The Management of Transference.....	31
5.5 Conclusion.....	33
5.6 Limitations.....	33
5.7 Recommendations.....	34
References.....	35
Appendix A: Interview Schedule.....	41
Appendix B: Informed consent form.....	42

Declaration

I declare that this thesis is my own work, and it has not been submitted to any other University. I agree that the Library at Dublin Business School may lend or copy this thesis on request.

Signed: _____ Date: _____

Tara Healy

List of Tables

Table 1: Sample Demographics.....	16
Table 2: Thematic Map.....	19

Acknowledgements

To my husband Dav, without you this would not have been possible. Thank you for encouraging this journey and for your endless support, patience and love.

To my beautiful children Lola and Remi, you are my reason, my world, and I love you both with all my heart.

Thank you Mum for being my rock this past four years, you continue to give and for that I am truly grateful. You are my inspiration and I love you dearly.

Dad, Thank you for your endless support. You taught me the importance of learning and you encouraged me every step of the way. Thank you for believing in me.

I would like to express my thanks to all my wonderful classmates for sharing this journey. It was an honour to train with you guys and the experience of learning together has changed me forever.

Thank you Grainne Donohue my supervisor for your great advice and kind words of encouragement.

Thanks to all the participants for giving their time and sharing their work with me. It was an honour to get insight into the wonderful work you do.

Abstract

Self-harm is a pervasive symptom of emotional distress written on the body. It has become a common clinical presentation for Counsellors who work with Adolescents with many challenges attached to this type of work. The aim of this study is to explore counsellor's experience of working with adolescents who engage in self-harm whilst investigating the role of the therapeutic relationship, the therapeutic response to self-harm and the exploration of the use of transference as a therapeutic instrument. The sample chosen was five experienced counsellors from a multi-disciplinary team who all work directly with Adolescents who engage in self-harm. The process of thematic analysis was applied to the data, representing a qualitative method of research. Three subordinate themes emerged from the analysis 1) The counsellor's capacity 2) Containment 3) Transference. These themes were discussed extensively and the author gained insight into the challenges that counsellors experience in the therapeutic space, and their capacity to understand and tolerate the uncertainty that self-harm evokes, due to the provocative nature of such a presentation. Containment was found to be main function of the therapeutic relationship by providing a space to discard the nastiness of self-harm with the knowledge that it is safe and secure. It was evident that the counsellor's emotional reaction to self-harm was of significant importance in relation to managing the transference between the counsellor and the adolescent.

Chapter 1: Introduction

1.1 An Irish perspective

In the last few years self-harm has become more prevalent among adolescents in Ireland. The National Registry of deliberate self-harm Ireland was set up in 2012 and is based on data collected from hospital emergency departments as a result of self-harm in the Republic of Ireland. The most recent figures outlined in December 2015 and based on Emergency Department admissions, highlighted self-cutting as being in the top three methods of Deliberate Self-Harm (DSH). A study conducted in 2014 through the mental health and social research unit and supported by Pieta House, suggested that there are a substantial number of teenagers and children engaging in self harm in Ireland. The information to date suggests that people who seek help at Pieta House for DSH were less than 18 years old and one in 5 was 14 or younger. This piece of research will focus on adolescents who engage in Deliberate Self Harm practices.

1.2 Theoretical perspective

This thesis will define self-harm as 'a volitional act to harm one's body without an intention to die as a result of the behaviour' (White Kress et al, 2004, p.2) Self harm is an issue that appears to be complicated and there are many theories suggesting biological and environmental roots to such a behaviour (Bliss, 2010). It can be seen as a form of communication and an expression of the inability to manage internal distress (Adshead, 2010). For people who self-harm, the narrative of their scars is symbolic of their psychic pain. The act of cutting can replace and prevent thinking with the wish to communicate a message and demand a response from others (Motz, 2010). The body is said to be an 'outside expression of the self in which internal states can be imprinted and serve as a mirror to the mind, and then re-internalised' (Motz, 2010, p.4). The notion is that the act of cutting releases intolerable feelings in order to find a solution to the unbearable. Much of the theory around self-harm views 'object relating' as being significant in understanding self-harm behaviours; 'Object relating places relationships at the centre of what it is to be human' (Gomez, 1997, p.1). We are instinctively social creatures and the need for others is

Of primary importance. The quality of one's attachments in early life can affect one's relationships throughout their life (Venta & Sharp, 2014) and the internal working model. The therapeutic relationship has been identified as being central to Psychotherapy and there are many theories that endeavour to define this relationship. This research will use the description of the therapeutic relationship or alliance in terms of a collaboration, the creation of a relationship between therapist and client rooted in empathy, one that forms an affective bond (Gaston, 1990).

1.3 Transference

Contemporise theorists define transference as a mixture of the projection of past conflicts combined with real life, the therapeutic communication between therapist and client (Schafer, 1977). Transference was viewed by Saari (1986) as 'the projection of qualities of relationships from the past onto the therapeutic relationship' (P.193). Transference is recognised as a fundamental element in the therapeutic process one which is necessary to understand past conflicts by reliving them with the therapist, particularly challenging and complicated with people who self-harm. Walsh and Rosen (1988, p.16) ascertained that people who self-harm 'are sceptical of the continuity and longevity of the therapeutic relationship'. Those individuals believe others to be evasive, ruptured and cannot be depended upon. There is a very small body of research (Norton, 2011; Bliss, 2010) that identifies transference as an essential tool in treating individuals who engage in self-harm behaviours. The outcomes suggest the need to establish containment in the therapeutic relationship, the importance of developing empathy through the use of transference and counter transference (Norton,2011) and the recognition of the 'internal saboteur' (Bliss,2010) through the use of transference and counter transference.

1.4 Aim of study

The aim of this study is to investigate and present therapists experiences of the management of transference in adolescents who engage in self-harm. The research will examine:

1. The aetiology of Self-harm.
2. The Function of the therapeutic relationship.
3. Transference and Counter-transference as a therapeutic instrument.
4. Evidence of the use of transference and counter-transference in adolescents who self harm.

1.5 Conclusion

The literary review will focus on the evidence that suggests the self destructive parts of the self in individuals who self-harm. It will convey the significance of establishing a strong early relationship in therapy with individuals who self harm. There will be evidence given to suggest that transference is a useful therapeutic instrumental and finally, it will explore the outcomes of using transference with adolescents who self- harm.

Chapter 2: Literature review

2.1 Introduction

This thesis will explore the current research available in relation to adolescents who self-harm beginning with the aetiology of self-harm. Interpersonal relating and the quality of relationships will be discussed in order to develop a deeper understanding of the motives attached to self-harming behaviour. There will be a focus on the therapeutic response to self-harm with a particular emphasis on the therapeutic relationship. In addition to this, transference and its usefulness in working with adolescents involved in practicing self-injury will be examined.

2.2 The Aetiology of self-harm

A school-based case study conducted in 2013 reported that 9.1% of Irish adolescents had engaged in self-harm at some time. The most common self-harm method reported in this study was self-cutting and overdose (McMahon, 2013). Research conducted in 2016 with adolescents in a community in Northern Ireland suggested that there are numerous reasons why adolescent's self-harm, but the key factor appears to suggest 'intolerable psychological pain' (Rasmussen, 2016). This psychological pain can be reflected internally, taking place or existing in the mind, which is referred to as an 'Intrapersonal perspective'. Rasmussen's (2016) findings suggested intrapersonal motives as being the most likely cause in adolescents to self-harm. Research conducted by Klonsky and Muehlenkamp (2007) suggests that negative emotions and self-humiliation are characteristic in individuals who self-harm. These individuals may possess a self-critical attitude, with strong feelings of

displeasure towards themselves (Bliss, 2010). The private act of self-harm can suppress unwanted symptoms of anxiety and self criticism and the feeling of being numb. The pain experienced whilst cutting may replace the feeling of being numb and momentarily, the cutter can feel alive (Favazza, 1996). In her paper, 'The Internal Saboteur', Bliss (2010) said that adolescents often cut when they are angry with another who has left them and the anger is turned inward in response to feelings of dependency. The act of cutting might be an attack on the needy external part of themselves, which longs for connection and the 'internal saboteur' which hates feeling the longing and wants to destroy it (Bliss, 2010). It is like the cutting is a punishment for experiencing the desire for connection. Disconnection from self and others can result from childhood trauma and loss; Connors (1996a) suggested that this could cause a sense of numbness and dissociation, coupled with the inability to manage and communicate overwhelming feelings. Depersonalisation, defined in psychiatry as a state in which a person experiences an alteration in the perception or experience of the self and of reality can also be an extreme feature in adolescents who self-harm. (Favazza, (1996) and Waltzer (1968) both suggest that cutting can be very useful in ending an episode of depersonalisation.

2.3 Interpersonal motives

Another dimension, often referred to as Interpersonal, relating or communication between people can also be a motive in adolescents who engage in self –harm. Much literature suggests the quality of individuals close relationships as being connected to general well-being and health (Berscheid & Reis, 1998). For most children, their primary connection is with their parents and this can change during adolescence when friendships become

Increasingly important (Harris, 1995; Hunter & Youniss, 1982). There is research to indicate the influence that friendships have on adolescents in relation to their self-esteem and their ability to cope during this period of change (Hartup & Stevens, 1997). Repinski and Zook (2005) established that the quality of a close emotional connection in the parental/adolescent relationship supports the 'self-validation and self-enhancing feelings that can contribute to the development of adaptive self-regulatory abilities' (Lundh, 2009). A study conducted by Bjarehed (2009) in Sweden showed that an absence of positive feelings towards parents and a ruminative style of emotional regulation as a major factor in Adolescents who engage in self harm. There is a small body of evidence that found adolescent self-harm is motivated by a desire to manipulate others (Hawton et al, 1982; Schnvder, Vlach, Bichsel & Konrad, 1999). Favazza et al (1996) indicates that self harming behaviour endeavours to translate subjective experience externally and that this forms a way of regulating emotions and preserving the self. Self-harm can be a way of communicating inner pain outwardly, written on the body (Connors, 1996a). It appears to indicate an inability to self-regulate when internal pain is too much to bear. Klonsky (2007) Said that Deliberate self-harm can be a way to regulate negative emotions and can have the affect of short term relief. Pattinson & Kahan (1983) found that anger is characteristic of individuals who self-harm. A high degree of hostility and anger were found in Self-harming individuals compared to those who did not self-harm (Stanley, Frances, Mann, Winchel, 1992). According to Adshead (2010) Self-harm could be a 'somatic articulation of a rage and cruelty that cannot be spoken' and this could be directed at themselves in the practice of harming themselves. One patient cited in Favazza's book said 'Often I can feel the pressure build up internally until only self-mutilation can create a cathartic reaction' (Favazza, 1987)

Many people who cut themselves can have internalised anger, for not being good enough, not living up to their own or others expectations and for the current state of their lives (Favazza, p194). Fonagy and Target (1995) described self-harm as a violent act that individuals are driven to as a form of self expression, one which may have its roots in early attachment difficulties which can damage subjective states and mental processes (Bliss, 2010). Fonagy and Target (1998) underlined a high level of insecure attachments in individuals who self-harm and a deficit in mentalization Shuk-ching (2006) identified only 12.5% of secure attachments in a case controlled study of self-harming adults compared to 82.7% in the corresponding group. Associations between self-harm and enmeshed and disorganised attachment styles have been prevalent in further studies (Adam et al, 1996), and there is a correlation between dissociation in these attachment styles and individuals who self-harm (Adshead, 2010). Fonagy and Target (1998) suggested that the practice of self-harm can constitute a 'failure of mentalization in the mind which is insecure with respect to attachment' (p.48).

2.4 The Therapeutic Response

The therapeutic response to self-harm varies from behavioural interventions to psychotherapy and administrative therapies (Favazza, 1987). For the purposes of this piece of work, its focus will be on psychotherapeutic interventions. Rogers (1967) illustrated the importance of the therapeutic relationship in terms of being able to unleash 'socially imposed constraints' that move towards more self-actualisation. (Rogers, 1967) A study in Northern Ireland was conducted on counsellor's perspectives of self-harm and the role of

The therapeutic relationship for working with clients who self-harm (Long & Jenkins, 2010). This study, in line with Rogers (1967) findings emphasised the difficulties in working with clients who self-harm and it identified a number of qualities that therapists need to work with these clients. Trust, empathy, unconditional positive regard and a safe environment were listed as being important (Long & Jennings, 2010). Psychotherapists interviewed for this study suggested long-term, non-judgemental, safe, and emphatic place in which there is openness and free expression for the client (Long & Jennings, 2010). Walsh and Rosen (1988) reported that individuals who self harm

‘are sceptical of the continuity and longevity of the therapeutic relationship. To them other persons, including the therapist are just too elusive, partial and fragmented to be depended upon’

Sullivan (1953) mentions the significance of observing the self-system in adolescents who self-harm through the construct of therapy. He talks about typical development in infant’s and the importance of recognizing the self –systems to acknowledge whether the self is integrated or split off. The self-system is divided into three parts, the good-me, the bad-me and the not-me experience. This not- me experience is said to stem from extreme anxiety and can be called a dissociative state, a common experience for adolescents who self-harm (Sullivan, 1953). This not-me state can be overwhelming for someone who self –harms and it is through ‘interpersonal mediation’ (Bromberg, 1980a) that the self-structure system can be restructured. Adolescents who self-harm may try to establish and sustain a state of ‘good me’ (Norton, 2011) and this is visible in clients who search for continual approval whilst eluding conflict. Sullivan (1953) emphasises the importance of the therapist’s emotional reaction to clients who self-harm to allow them to facilitate ‘the new relationship into her

self-structure and personal meaning system' (Norton, 2011). For the purposes of this research, it may be beneficial to look at the concept of containment in relation to the therapeutic relationship. It originated and was developed from the theory of projective identification which involves a non-verbal communication between two people where one individual receives feelings or experiences from another. This projective identification permits a person to transmit unwanted feelings that may be unmanageable onto another (Gomez, p.39). Bion wrote 'I shall abstract for use as a model the idea of a container into which an object is projected and the object that can be projected into the container' (Bion, 1962, p.90). It has been said that the baby communicates with his/her mother as an empty container with space available for unmanageable distress in addition to the offer of an internalized mother who had the ability to tolerate such distress. The mother who provides the container can recognise her baby's distress and responds thoughtfully to the baby's internal experience initiating the first experience of understanding the 'human capacity for bearing pain' (Shuttleworth,1989:36). It could be suggested that the therapist becomes the container for the adolescent who self-harms or that the flow of blood that emerges after self-cutting may represent a surge of something that cannot be contained (Finlay, 2015). It was Bion's understanding that the capacity to process experiences lay in the capacity to engage in thought during distress as opposed to taking action and denial of feelings. This prospect lies in the 'responsive presence of a maternal figure' (Bion, 1962) who has that capacity to think which in turn is internalized by the infant. It could be suggested that the therapist takes the place of the mother in this instance by providing containment for the adolescent to manage their feelings.

2.5 Transference & Counter-transference

Transference was defined by Levy (2009) as 'a tendency in which representational aspects of important and formative relationships (such as with parents and siblings) can be both consciously experienced and/or ascribed to other relationships (Levy, 2009). Transference has been described 'as the projection of qualities of relationships from the past onto the therapeutic relationship' (Saari, 1986). Freud developed the concept of transference and he believed that patients brought past conflicts to therapy by re-enacting them with the therapist through transference (Freud, 1888). Freud said that it usually contains a distortion or cognitive bias (Nevy & Scala, 2012). His interpretation of the transference was a way of recognising distorted reality and a way of looking at his patient's perceptions (Wachtel, 1987). Freud (1915) emphasised the difficulty and complicated nature of transference and the importance of managing it; he said that clients can 'enact interpersonal patterns in therapy' (Nevy & Scala, 2012) and this represented past conflicts in a new way through the transference relationship. It was Freud's opinion towards the end of his life that the central component of therapeutic change was in fact 'the establishment, interpretation, and the resolution of transference' (Freud, 1937). Klein suggested that the client may act in a particular way that triggers the therapist into behaving in a similar way to the original attachment figure who is the source of the transference. Klein also said that the therapist is playing a part in reaction to the counter transference evoked by the behaviour of the client (Klein, 1952.) It was Fairbairn (1952c) who believed that psychopathology was rooted in the internalised bad objects and that the change was possible through the liberation of bad objects from the unconscious. He considered that transference was a vessel for releasing

the bad objects in treatment. Scharff and Scharff (1992) and Seinfeld (1990) shared this view. Contemporary psychotherapy views transference as incorporating real life with the projection of past conflicts, which in turn forms the therapeutic relationship (Schafer, 1977). It could be looked at the 'bridging of past and present, old and new, genuine and artificial, repetition and creation, the subjective world and the objective world' (Schafer, 1977, p.15). At the beginning of psychotherapy research, it showed that interpretations, through the use of transference may be harmful if used early in therapy and focus needs to be placed on the therapeutic alliance as a starting point in treatment (Levy & Scala, 2012). There is now evidence that proposes that low to moderate levels of interpretations through the use of transference can lead to 'structural change' (Hoglund et al, 2006, Clarkin et al, 2007). Counter transference can be explained as the therapist's response to the client's projections onto the therapist in connection to past conflicts (Norton, 2011). Racker (1988) defined it as that which 'arises out of the analyst's identification of himself with the analysand's (internal objects' (p. 137). Freud's belief was that it was a dangerous thing for the analyst to experience and that in that case, the analyst needed more analysis (Boyer, 1982). Racker believed that the analyst's feelings were relevant and not to be dismissed as this could develop into something to be worked with through the client (Racker, 1988.) Motz (2010) believed that the ability to work with counter transference requires the capacity of the therapist to tolerate intense feelings which can be experienced both in the mind and the body.

2.6 The Use of Transference and Countertransference in Adolescents Who Self- Harm

It was Freud's (Freud, 1912) belief that transference in therapy could be resistance and that working with this resistance was the starting point in therapy. It has been said that transference often occurs in adolescents who self harm and the therapeutic relationship can mirror that of the clients current relational schemas (Norton,2011) It is Saari's view that transference is very useful, to 'maintain the meaning system and the personal identify that underlines it' (Saari, 1986, p.197) He made the point that transference, which is a healthy thing exists in every relationship and adolescents who self-harm should work together with a therapist with a here and now focus as a way of understanding and interpreting past events throughout their life. Sullivan (2011) noted that the transference and countertransference reactions can be extremely intense in adolescents who engage in self-harm which may produce increased anxiety. The assumption is that transference and countertransference could hinder the therapeutic alliance or it might impart useful clinical material to be used in a benifical way in the therapeutic relationship. McGoldrick (1989) said that adolescents often identify themselves by the relationships they have with others and they might confuse individuality with closeness with a therapist. This could lead to enmeshment with the client being highly dependent on the therapist and the therapist responding by fixing or rescuing the client.

Norton (2011) believed that intimacy could be achieved therapeutically through interdependence rather than dependence. It is imperative for the therapist to be aware of

the adolescents' family history in order to work with the transference and countertransference (Norton, 2011). Relationship patterns in the client life can be repeated with the therapist therefore it is useful to know the family background. Bliss (2010) claimed that adolescents have difficulty in assimilating their own needs and there may be anxiety around the reliance on people, and self awareness that may induce fear in the treatment process. The therapist may be seen as a figure or an inspiring object in the transference, one who could provide hope, someone who could satisfy him/her emotionally. For the adolescent who engages in self-harm, the internal critic could attack the possibility of connection with the therapist which could be dismissed through the resistance in therapy. There may be denial for the need for assistance from the therapist and the therapist could in turn feel, 'the disowned parts of themselves that contain their feelings of rejection and need' (Bliss, p.233)

The therapist could be the hostile object who may have expressed hope but will now fail to fulfil these expectations. The therapist could feel rejected and powerless in the countertransference similar to the experience of the adolescent (Bliss, 2010.) Bliss (2010) believed that the therapist can experience the adolescents needs through the countertransference as the therapist 'is placed in a position of holding the wish for the relationship and the need for connection' (Bliss, p.233). It can be through the projection of feelings onto the therapist that may make the therapist feel powerless and dejected thus illustrating the recognition of the adolescent' unwanted internal experience. Racker (1957) coined the term 'concordant countertransference' which is 'when the therapist can identify with the client's self-representation' (Racker, 1957.) Therapists can experience feelings of

rejection and powerlessness in the countertransference they experience when many adolescents withdraw communication in sessions, miss appointments and act out during therapy, as a way of unloading their own feelings of rejection and helplessness onto the therapist. Connors (1996b) described the significance of, and the difficulties that therapists may relate to in the experience of countertransference:

‘Many professionals feel a sense of urgency when self-injury is disclosed, and thus abandon the more thoughtful, empathic, and empowering stance they might otherwise employ. Self injury can evoke potent and primitive counter-transferential reaction...it almost always elicits a sense of helplessness and may cause clinicians to question their competency’

2.7 Conclusion

Self-harming behaviour in adolescents has been examined under the headings of the aetiology of self-harm and the interpersonal motives attached to such behaviour. The evidence of the therapeutic response to self-harm was illustrated with the findings suggesting that the quality of the therapeutic relationship could facilitate healing for the adolescent under certain conditions. There was a review of the literature in relation to the use of transference and countertransference in working with adolescents engaging in self-harm, highlighting the need to explore this aspect of the therapeutic intervention in greater detail.

Chapter 3: Methodology

3.1 Purpose

This study aims to explore counsellor's experience of working with adolescents who engage in self-harm. It also hopes to investigate the management of transference in working with this population and the conditions of which may impact upon the therapeutic relationship.

The list below highlights the objectives in doing this study:

1. To present the counsellor's experience of the motivations for engaging in self-harm behaviour
2. To investigate the role of the therapeutic relationship for clients who self-harm
3. To highlight the therapeutic response to self-harm
4. To explore the use of transference as a therapeutic instrument.

3.2 Methodological Approach

This study will use qualitative research methods for investigation as it seeks to gather insight into particular phenomena through the therapist's experiences. McLeod (2003,p.48) described this approach as a study of real-world phenomena in an unobtrusive and open way regardless of what emerges in the data. It is suggested that the researcher does not make assumptions or theories in advance of the study being carried out. McLeod (2003, p.27)) defined qualitative research as 'a process of systematic inquiry in to the meanings which people employ to make sense of their experience and guide their actions'. The experiences of therapists through the work they do with adolescents will help to develop theory along with existing literature on the subject of self-harm. The qualitative design features are therefore to emphasise individual meaning and experience for this study and to focus on 'inductive analysis,' (McLeod, 2003) open-ended data, and reflective interpretation in this piece of work. The main objective is to investigate therapist's perception and experience of working with adolescents who engage in self-harm.

3.3 Sampling

Qualitative research requires a small group sample whereby the group of participants are preselected based on criteria relevant to a particular research question. The criteria chosen allow the focus on people who are most likely to experience, know about, or have insights into the research topic. (McLeod, 2003) Five working counsellors who have experience of working with adolescents will be selected. The counsellors were chosen by making contact with a multidisciplinary team who specialise in working with adolescents. See the table below:

Counsellor	Orientation	Pseudonym
Counsellor A	Social worker	CA
Counsellor B	Psychologist	CB
Counsellor C	Psychotherapist	CC
Counsellor D	Social worker	CD
Counsellor E	Psychotherapist	CE

Table 1: Sample Demographics

3.4 Data collection: Semi-structured interviewing

Semi-structured interviews are used in research as an informal and flexible approach to interviewing. The researcher formulates set questions and recruits the participants whilst collecting and recording the data (McLeod, 2003). This form of interview was used in this study, using face to face questioning that will be taped and transcribed verbatim. Each interview took approximately 30-50 minutes and the following subjects were discussed:

1. Personal details and background information.
2. The orientation and framework of the counsellor.
3. The counsellor's view on the prevalence of self-harm in adolescents.
4. The counsellor's experience of the reasons for self-harm in adolescents.
5. What therapeutic response is used with adolescents who self-harm
6. The challenges in working with self-harming adolescents.
7. The function/role of the therapeutic relationship for clients who self-harm.
8. The skills needed to work with clients who self-harm.
9. Counsellor's experience of the most effective tools needed for this work.
10. The counsellor's practice of self-care.

3.5 Research strategy: Thematic Analysis

The author was interested in exploring the views and perspective of the selected participants in order to gain insight to their lived experience. It was decided that qualitative analysis was the most suitable method for this purpose. Thematic analysis was applied to anticipate themes or topics that may emerge from the interview data. This form of analysis endeavours to extract data that is varied and detailed in content. Braun & Clarke (2006, p.52) described thematic analysis as 'a method for identifying, analysing, and reporting patterns (themes) within data'. It is a way of recording and arranging data with the focus on highlighting themes or patterns in an inductive or 'bottom up' way. In this inductive approach, themes are clearly recognised and linked to the data (Patton, 1990). The data will be balanced with equal importance given to each item. This method of analysis enables the data to be coded rather than trying to get it to fit into an existing coding frame. The codes will then be arranged into possible themes, representing the data collected. The themes will be defined and named in terms of specific concepts that aim to highlight and represent the responses from the participants within each theme.

3.6 Ethical Issues

The participants taking part in the research were fully informed of the nature of the study and the procedures involved, the aims of the study were highlighted. They were also informed of any potential risks in participating. (Mc Leod, 2003) Informed consent states that consent is of a voluntary capacity and participants are within their rights to withdraw from the study at any point and they have the right to decide what to disclose during the interview. A written document indicating all these points was sent by email to the participants prior to the interview (see appendix A and B) with the understanding that any questions regarding the research or the document presented would be responded to. (Mc Leod, 2003) Methods to ensure confidentiality were taken to ensure that the participant's identities will not be revealed. The names of all participants were concealed and replaced with pseudonyms on all documents used in the research. This did not interfere with the data collection or content of the material in any way. All the data collected from the interviews both written and tape recorded has been securely stored on the researcher's personal computer which can only be accessed with a confidential password known only to the researcher.

3.7 Conclusion

The purpose of this chapter was to illustrate the research methodology being used by the author to explore counsellor's experience of working with adolescents who engage in self-harm. An explanation of the methodology approach chosen in the form of qualitative research was given to the reader as well as an overview of the sample selection process for participants under the sampling heading. The author highlighted the form of data collection, outlining the details of interview style best suited to this research. Finally, thematic analysis was chosen as being most suitable to interpret the data and ethical considerations and Belmont principles were reviewed.

Chapter 4: Findings

4.1 Introduction

This chapter will outline and discuss the findings from the semi-structured interviews conducted with five of the selected participants. A multidisciplinary team of counsellors consisting of two psychotherapists, two social workers, and a psychologist were selected to share their experience of working in a centre with adolescents who engage in self-harm. This multidisciplinary team working has been the model of working in adolescents mental health services for many years now (Mental health commission, 2006). Throughout this chapter the five participants will be referred to as counsellor's CA, CB, CC, CD, and CE respectively. The data used will be coded numerically directly from the transcriptions for example: CB: 3 would indicate the third piece of script being used from the interview with counsellor B. In using thematic analysis, the author has identified three themes found within the data and they are presented below.

Theme 1: The Counsellor's Capacity	Theme 2: Containment	Theme 3: The management of transference
---	---------------------------------------	--

Table 2: Thematic Map

4.2 The counsellor's capacity

There appeared to be a consensus by all counsellors that adolescents engage in self-harm as a form of emotional regulation. The participants described the intensity of emotion as something restricted or constrained with almost an explosive energy to it. It appeared to suggest the difficulty for counsellors to work with the intensity of emotion presented in the therapeutic space. There was a sense that the counsellor's had to develop the capacity to attempt to understand and manage the distress experienced by the young person.

Counsellor A described the emotions as being restrained and the intensity of self as being difficult to tolerate.

CA: *"I think it's kind of a build-up of emotion, it's a real pent up kind of pressure cooker feeling, that leads to it, in my experience or when I am working with teens and they are describing it, It's like their level of tolerance for being able to sit with whatever they are feeling it is just completely gone, as for what led to that, I don't know"*

Counsellor B expressed a similar experience.

CB: *"and then there's the component of kind of bottled up stress in the attempt to verbalise it or express it or communicate it."*

Counsellor D highlighted emotional dis-regulation and the inability to tolerate intense feelings. There was an emphasis on how difficult it can be for a teen to sit with their emotional distress without having the ability to manage their feelings.

TD: *" I think that a large part of it is around emotional regulation, I think it's about that piece, the emotional dis-regulation, so whatever is going on for them that they cannot tolerate and they find it very difficult to manage that, so there can be the precipitating factors and it can be anything, it can be bullying or it can be whatever is happening in the family but I think it is , there is something about the really finding it difficult to emotionally regulate and difficult to tolerate for example the anxiety, and difficult to tolerate the levels of distress and not have another mechanism. I think that behind that actually it is that the young person has no way of regulating the level of distress so that is an attempt to regulate, obviously its functional but it is an attempt to regulate"*

Counsellor E described the palpable nature of physical pain compared to the hidden nature of emotional pain that is more difficult to identify or articulate without the resources to do so.

CE: *“it is a response to emotional pain and emotional distress, I think the reasons will vary across young people but I think there’s definitely an element of affect regulation in there, one way young people have described to me, sometimes it’s easier to deal with physical pain than emotional pain, it makes it more tangible, it makes more sense to feel distressed about physical pain or something that you can see as opposed to something that is going on for you in your psyche in your emotional world that maybe you haven’t developed the skills to make sense of yet as a teen”*

Two of the counsellor’s believed that self-harming behaviour can be a reflection of internal distress and that self-harm may have an intrapersonal perspective that represents internal pain;

CC: *“it’s kind of internalized, it’s inward, whereas I suppose with other people they would be acting out. There’s something about a person internalizing or I suppose whatever is going on for them, they have a sense that they are not managing or it’s not going to get better, it’s not that kind of troublesome outward behaviour that people respond to, its this quiet, nearly private, and there’s something about it being more inward looking”*

Counsellor E highlights distressing thoughts as a possible trigger for engaging in self-harm

CE: *“I think for other people it could be a way of distracting them from their pain or you know distressing thoughts or rumination of a very distressing set of circumstances that they might find themselves in”*

Considering the provocative nature of self-harm and the weight of pressure that it can exert upon those surrounded by it, the therapeutic space can be filled with extreme tension. The participants interviewed for this piece of research alluded to the fact that sharing their anxieties and distress in their teams permitted their capacity to understand and sit with those who engage in self-harm. Four of the counsellor’s talked about how they work in teams of two with one counsellor working one to one with the teen, and the other working with the parents/carers. Throughout the interviews there was a sense that this work is particularly challenging and anxiety provoking and that the counsellors manage by releasing the distress they are holding by sharing it with their partners. There was an emphasis on the supportive nature of this way of working and the understanding that without the space to alleviate or release the pressure of holding such distress, it may be extremely difficult to work.

CA: *"I think the way we work here in teams of two is hugely beneficial, because I would tend to have the opportunity to talk to a colleague before I leave work if something is on my mind, and that can usually be enough for me to leave it"*

There is a suggestion by counsellor A that self-harming behaviour induces anxiety is counsellors;

CA: *"I think with self-harm there is a level of anxiety that can arise in parents and in staff"*

The response from one counsellor suggested her ability to manage the anxiety and distress in the therapeutic space is increased through the relationship she has with her colleagues. It is almost like her level of tolerance for sitting with such intense pain is greater with the knowledge that she is can release what she is holding by sharing it with her partner.

CC: *"one of the biggest supports I find is actually the way the structure is in (centre) it is actually that peer, that partner who knows you so well , and I was talking before, and I had a team meeting about it and its nearly like a marriage, it's the closest relationship particularly because I work in just two centres so I've two partners and its nearly like that , you have to put time and effort into getting to know the other person, maybe having a sociable aspect but knowing their body language, just nearly knowing maybe what's going on for them, what they are thinking, where they are going with something when you are in the room with them, but outside the room them knowing I can go, that this is very much for my support I can go to my partner within two to three minutes of a client leaving and kind of let go of a lot of it, and then if it's still around we have structures for supervision, I have external supervision, so I have an awful lot of supports."*

The impossibility of working alone highlights the difficulty that counsellors experience with this type of work and that counsellors can tolerate more with the support from colleagues.

CC: *"I don't know how you could do an awful lot of the work without the supports , I really feel that it allows me to hold maybe an awful lot more because I know that I am held, and it's very rare to walk out the door holding something, because there is so many layers in it for you, and I think just that relationship with your partner really makes a difference, it's amazing really, it really does and you know them so well, and you know how they work, I suppose we are there for each other and it goes both ways, so it does make a massive difference"*

CD: *"we are really lucky in (centre) because we are very accessible to each other so say for example say post session or something like that there's something that is really, that I'm holding onto I can use my colleagues to kind of help me"*

Counsellor E articulated a similar response;

CE: "we work in teams of two which is a really, has a very supportive element to it so if there is something going on about, if something is staying with you and you need to give it a bit more attention and so talk about it and using supervision"

There was a sense from the author that Counsellor B was experiencing difficulty around sitting with the uncertainty of self-harm and worked in a very solution focused and cognitive way as opposed to an longer term, more in depth psychotherapeutic way.

4.3 Containment

This section of the findings is dedicated to containment, as the findings suggested it was a significant function of the therapeutic relationship. It is as if the counsellor is holding something for the teen, something that they are unable to manage, whilst permitting the expression of emotion in a safe environment. It appears to suggest the holding of young person's projections of feelings of an unbearable nature and the counsellor's response of returning these feelings to a more manageable and contained way. There is a sense that the counsellor's role is to absorb the teen's feelings, process them, and return these in a more palatable and less destructive format.

The unpredictability of self-harm is underlined here with the understanding that it can take time to unravel and decipher and that sitting with the un-certainty of it whilst holding the hope that it may get better is a way of containment.

CA: "holding the hope for the teen that we will figure this out, it might take a while, I think there's a bit of sitting with the uncertainty of it because, I think it takes a while to figure it out and I think that, what I am trying to say about the young person coming back and saying, it's actually gotten worse and i'm still doing it, and they can be still doing it but also saying that, in their day they are feeling better, I suppose it is really about trying to hold the hope that it is actually progress but it's not maybe in the way that a parent might want to see it"

Through the process of therapy, the counsellor is acting as the container taking in the nastiness and anguish of it from the client so that they can re-represent it and make more sense of it.

CA: *“ So trust is crucial and building that relationship along with the holding, being able to contain it for them, and sitting with the uncertainty of it, and the nastiness of it and the kinda distress of it, I don’t want to do this but i’m doing it, those kind of things.”*

Another counsellor implied that the therapeutic container can be seen here as the creation of a space to let go and struggle, a place to acknowledge what they are experiencing and pass it over, to manage the unmanageable. It is as if letting go of control of something that has been very painful to endure when released, can be a very liberating experience.

CD: *“ it’s in the room and they come in, and if I link it in with the anxiety that they come in with and having disclosed, and having got passed that point and they don’t know what to do so they are wanting to hand it over, so this is the transference piece for me, so their wanting to hand it over and their wanting me to manage it and make it ok, and massage it and whatever else you need to do around self-harm, so for me the work is actually allowing a space initially where they can do that and they can hand it over and then gradually to begin the work with them, beginning to be able to take it on themselves”*

And;

“Its allowing the space for not being in control, and for not managing, it is the container, it is that, but actually moving towards the building up of the ability to control, so I very often particularly after disclosure and maybe three to four sessions in , what my experience is young people come in and they just, their dying to come in for their counselling and they can’t wait, and their like this, see the way i’m describing, they are bouncing, on edge, and they come in, and they want to throw it out, and throw it out and dump, and that gives them release”

Counsellor C alludes to the container piece whilst also noting the importance of remaining steady.

CC: *“I think it is the container piece and the steady piece, for me that is the function of the relationship, and then and obviously you’ve got a multitude of stuff that comes up within that”*

There is a suggestion from another counsellor that bringing it into the room lessens the isolation by sharing it with the counsellor which puts a boundary around it

CE: *“I think containing is a really good word for it, that sense of holding, it’s ok and that maybe you delve into it with the counsellor or whatever it is and then there is a sense that you can leave it there and they will hold it and then you don’t have to get into it in your own thoughts you don’t have to go there outside you can come back in you know there’s like a boundary around it that feels contained”*

Counsellor C brought attention to the importance of containing the parental anxiety when working with self-harm so that it doesn't spill over into the work being done with the adolescent.

CC "Sometimes though if i'm working with the parents and my partner is working with the adolescent, it's up to me to contain the anxiety that the parents have and to help them to understand what is going on, but if i'm working with the adolescents then my partner kind of stop gates the parents anxiety from coming in so by the time i'm hearing what's going on, its filtered or calmed or eased"

There was a sense from counsellor B that the nature of the work was overwhelming and anxiety inducing and that sometimes it all got a bit too much. Perhaps some of the anxiety and tension experienced in the work spilled over and it appeared to suggest a difficulty with containment. The author wondered if the counsellor was being pulled into a parallel process periodically and there may have been a sense of dissociation, therefore it was not being contained.

4.4 The management of transference

The importance of the transference relationship in working with teens became evident during the interview process, therefore it warranted its own theme. The parental response to self-harm may be reactive and judgemental. Therefore, clients may bring their conflicts with parents into the therapeutic space and re-enact these conflicts through the transference. There was a clear focus on the therapeutic relationship in terms of the response to self-harm and the importance of creating a non-judgmental, non-reactive environment.

One counsellor talks about the therapeutic relationship as a secure base that provides a non-reactive response free of judgment.

CE: "just seeing the relationship as that safe space where it can be talked about without somebody having a very worried or anxious response, without feeling that you're going to be told on or you're going to be ridiculed, so I suppose one of the things the therapeutic relationship can offer is that non-reactive non-judgmental place to talk"

The typical negative response to self-harm is mentioned by counsellor A whilst noting that a different reaction is needed.

CA: *“Sometimes their experience is that their parents are cross about it or schools have reacted negatively about it because of the risk of it so, if it’s a space where they can actually talk about it, where they’re not getting that same kind of reaction”*

The transference piece is illustrated here as the handing over of the self-harm to the counsellor in order for it to be massaged and managed for the adolescent

CD: *“It’s in the room and they come in and if I link it in with the anxiety that they come in with it having disclosed and having got passed that point and they don’t know what to do so they are wanting to hand it over right, so this is the transference piece for me, so they are wanting to hand it over and their wanting to , for them wanting me to manage it and make it ok and massage it and whatever else you need to do around self-harm, so for me the work is actually allowing a space initially where they can do that and they can hand it over and then gradually to begin the work with them beginning to be able to take it on themselves”*

The ability of the counsellor to play different roles for the adolescent could be seen as a way of managing the transference

TD: *“I think you have many different roles right, so sometimes your role is a parent, that’s my belief and sometimes I find when you’re working with families, where there is self-harm and you have to be so careful in this as well but where there is self-harm and where the parent is not available to do that, the work, it’s like your kind of at some early point in the process you are providing that parent holding”*

TD: *“I think for me as a therapist, that I need to be willing to be in a number of different roles, and within those roles they have a lot of different things they want to figure out, so they can either be kind on a particular day and they can be fighting like blazes on a particular day”*

One way of managing the transference is by recognising the counter-transference that can be evoked in the counsellor as discussed by counsellor E

CE: *“I suppose for myself I’m always watchful and mindful of my own internal responses, say a young person had been working on their self-harm and they had been working on lots of other things and say something happened and they went back to their behaviour and you might feel a little bit of disappointment, or how did that happen and I think that’s ok once you can notice it and it’s about going back to the teens perspective and hearing what went on for them and their meaning, it’s their journey it’s not mine, it’s not anybody else so to bring it back to them”*

Four counsellor's said that the emotional reaction and the ability to remain steady and not to over-react was a central component in the transference relationship

CB: *" An important function is not to over-react, not to try to rescue immediately, not to try to shift the person immediately, to invite the person to try to describe, and to understand what's going on, the skills that are required, to attempt to stay calm and to attempt not to jump to conclusions or to make any assumptions about it, to invite whoever is engaging in the activity to try and help you understand it, they might struggle to understand it, but it's their understanding is more the key really, and to I suppose after that stuff is done , the type of skills are really just about trying to accompany the person to whatever new space they want to get into"*

The typical reaction of panic is discussed here and the importance of not getting involved in it.

CC: *"it is actually to not get into that panic state that comes up" So there's an awful lot of guilt and I suppose there's the trappings that you can really get caught into or if the self-harm is particularly visible or if is quite deep, people would tend to panic"*

And;

CC: *"parents are anxious, friends are anxious, and to not get hooked up into that and to very much to stay out of that, and to stay, I suppose that for me would be the biggest thing for me, not to go there, so it is anxiety provoking, it does seem to bring up a lot of fear in people and what you are saying is, you have to step out of that and look objectively really, yeah and just see it as part of them"*

And;

CE: *"Being non-reactive is very important because clients and young people are amazing at what they can pick up on they will pick up on if you are starting to react or if you are looking kind of worried"*

Counsellor D talked about the drama that adolescents elicit and the importance of being curious around the drama in the interaction;

CD: *"It is the skill of remaining steady, and the other skill in terms of working with, and it isn't just with self-harm but it's in a general way with adolescents is actually, really kind of being interested in drama but not too bothered by it, but I think that is a skill because young people who self-harm is full of drama"*

4.5 Conclusion

This chapter covered discussion in relation to the data assimilated from the semi-structured interviews which took place with counsellors who worked specifically with adolescents. The findings outlined the emergence of three themes obtained from the data. Data emerged that highlighted the importance for counsellors to manage their own anxiety around self-harm due to the provocative nature of such a presentation. The data indicated that the counsellor's capacity for understanding and sitting with the un-certainty of self-harm is increased when their own anxiety and distress is shared and contained by colleagues in their practice. The data highlighted the function of the therapeutic relationship is that of a container. The counsellor provides a safe space to facilitate freedom of expression whilst absorbing the unbearable feelings for the adolescent. The container holds the projected feelings and re-represents them in a more manageable way when the adolescent is ready to work with them. The counsellor's response to self-harm was deemed significant in terms of the non-reactive stance they employ in their relationship with the adolescent. This way of being illustrated a central component of the transference relationship.

Chapter 5: Discussion

5.1 Introduction

The purpose of engaging in this research was to explore counsellor's experiences of working with adolescents who self-harm, with a particular interest in the management of transference. Thematic analysis was selected as the method used when looking at the data collected with the five participants interviewed, all of whom worked directly with adolescents. The counsellor's experiences were explored and three themes emerged within the findings. All of the participants shared their individual views and meanings around the work they do and the findings suggested the complex and difficult nature of working with adolescents who self-harm.

5.2 The counsellor's capacity

The counsellor's capacity emerged as a result of the way the participants described the explosive energy and intensity of emotion that is felt in working with adolescents who self-harm. The counsellors all agreed that difficulty with self-regulation contributes hugely to self-harm. Counsellor A used the analogy of a 'pressure cooker' feeling to describe the intensity of it and the difficulty in tolerating that intensity. It can be the build-up of an internal pressure and the cathartic reaction can only be reached through self-mutilation (Favazza, 1987). Elements of emotional dis-regulation and the inability to tolerate or manage intense feelings became apparent as shared by counsellor D and the suggestion is that engaging in deliberate self-harm can regulate one's emotions and offer short term relief (Klonsky, 2007). Counsellor E compared physical pain that is tangible to the hidden nature of emotional pain that is difficult to understand and articulate. It can be a way to communicate inner pain outwardly; written on the body (Connors, 1996a). Self-harming behaviour could be as a representation of internal distress with a strong interpersonal perspective to it. Counsellor E described the inward looking nature of self-harm as opposed to the outward behaviour of acting out and the psychological pain that can exist in the mind (Rasmussen,2016) Indeed counsellor E added distressing thoughts as a factor to be considered as a way to distract the adolescent from the psychological pain. Self-criticism

was spoken about by counsellor E in relation to not feeling good enough or feeling less than peers and this self-critical attitude can have strong feelings of displeasure towards themselves (Muehlenkamp,2007).

The act of cutting is said to be a form of self-punishment, the result of anger turned inward (Bliss, 2010). Counsellor E described the self-hatred that can exist within female adolescents particularly, who have etched derogatory words about themselves onto their bodies, it is an attack on the self (Bliss, 2010). Issues around body image emerged from one of the counsellors who talked about self-loathing that can exist which could be 'a somatic articulation of a rage and cruelty that cannot be spoken' (Ashead, 2010, p7). This rage may be directed at themselves through the engagement with self-harm. Acknowledging the provocative nature of self-harm and the anxiety that can exist in the therapeutic space, it became apparent that counsellors who work with this population had to develop the capacity to understand it and sit with it. All of the participants interviewed highlighted the importance of peer support and supervision as a way to increase their capacity to work in this challenging environment but there is no current research that substantiates this. Counsellor C shared her feelings around the impossibility of working with self-harm on her own and the release that she feels when she shares her experience with peers. There is a sense that the anxiety around self-harm can spill over onto the therapist and that they also feel the need to be held or contained.

5.3 Containment

Four participants identified the second theme of containment with regard to working with adolescents who self-harm. They all agreed that it is the role of the counsellor to attempt to manage the adolescent's un-manageable feelings, by acting as a container for those feelings. Counsellor A described how she holds the hope that things will improve for the teen, and this is communicated non-verbally through projective identification, passing feelings from the adolescent over to the counsellor (Gomez, 1997, p.39) Counsellor A added that she viewed the transfer of unwanted feelings from her clients to her as a release, suggesting the transmission a success. This release or letting go can have a certain amount of freedom attached to it and when counsellor D talked about this, she gave the analogy of

the disposal of something unwanted, and the sense of relief afterwards. At this point the counsellor suggested that her position entailed the management of the adolescent's feelings and the creation of the space to facilitate this process as well as the returning of the feelings back to the teen in a more palatable way. Wilfred Bion's (1962) theory of containment describes how a mother can receive unwelcome, perhaps overwhelming projections from a baby that are then processed by the mother and returned to the baby in a more pleasing way (Finlay, 2015). This is the same process that can occur in the therapeutic encounter with the therapist representing the container, ingesting the adolescent's thoughts and feelings and returning them to a more acceptable format. Containment and the ability to hold came across as being the main function of the therapeutic relationship by counsellor C as well as the ability to remain steady. Bion went one step further when he talked about the mother's containing function as helping the baby to develop the capacity to self-regulate. The suggestion was made that when the baby internalises a feeling of being contained and feels the mother's emotional availability, this encourages the development of the baby's own capacity to self-regulate eventually (Finlay, 2015). It was said by counsellor E that sharing the self-harm with a counsellor can reduce the isolation, and that thoughts can become less intense when shared in terms of putting a boundary around them or containing them. Bion described the growth that can develop in terms of the dynamic between the baby and the mother through containment attributing benefit for both the baby and the mother and in this case the therapist and the adolescent (Bion, 1967, pgs90-1)

5.4 The management of transference

All participants spoke extensively about the importance of the therapist's emotional reaction to self-harm. Very often the parental response is reactive, filled with worry and anxiety, and counsellor E spoke about the significance of providing a therapeutic space that allows for open expression without fear of an over-reactive response or judgement. Giving permission to a teen to experience this environment can facilitate a new self-concept or personal meaning system (Norton, 2011). Counsellor A shared her experience of working with adolescents and noted the intensity of the transference through the negative reaction

they expect to be met with, this suggests a mirroring of relational schemas for the adolescent (Norton, 2011). The importance of managing the transference was illustrated by counsellor D as she described the adolescent's desire to hand over the self-harm so that she could work with it in the therapeutic space. Freud highlighted the complexity of transference and the importance of managing it, he believed that patterns of an interpersonal nature were repeated in therapy and that the transference relationship might represent past conflicts in a new way (Nevy and Scala, 2012). It became clear from talking to counsellor C that anxiety and panic can be evoked in parents and other significant people in the adolescents life when self-harm is presented and the importance of remaining steady in the response to it as it could lead to dependency on the counsellor if she/he responded by attempting to fix or rescue the client (McGoldrick, 1989). Another way that counsellor D alluded to the management of the transference was by assuming different roles in the relationship with the adolescent. The willingness of the counsellor to position themselves as a parent or a friend in order for the adolescent to figure out different things was highlighted by counsellor C as relationship patterns in the adolescent's life can be replicated with the counsellor (Norton, 2011). This suggested that when the adolescent's feelings are projected onto the counsellor, this can identify the adolescents' unwanted internal experience through the transference (Racker, 1957). Research suggested that the counsellor can experience the needs of the adolescent through the counter-transference, when the counsellor is placed in a position of holding a wish for the relationship (Bliss, 2010, p.233) Counsellor E discussed the awareness she has of her internal responses to self-harming behaviour and the importance of recognising what she is experiencing in the therapeutic space. Melanie Klein said that there is a possibility that a client may act in a way that triggers a counsellor to mirror the original attachment figure who could be the source of the transference. Klein went on to suggest that the counsellor can play a role as a reaction to the counter-transference aroused by the client's behaviour (Klein, 1952) The role of the 'good' mother could be adopted in the counter-transference, in an attempt to respond differently to the parental response, a way of protecting the client. Although this could aid the development of a caring therapeutic relationship, it also has the potential to

create an unconscious desire to rescue the client in being the good mother. (Norton, 2011, p.101) It was Connors (1996b, 213-214) who described the sense of urgency that self-harm can evoke in counsellors who experience it, coupled with the sense of helplessness can be experienced in the counter-transference, and feelings of rejection may be evoked during periods of silences or missed appointments, as 'adolescents can attempt to deposit their own feelings of rejection and helplessness onto their therapist' (Bliss, 2010, p.233)

5.5 Conclusion

Self-harm is a maladaptive way of coping and it has the potential to become entrenched if left without any intervention. It is a communication that has many different meanings to different people therefore it is complicated by nature and difficult to define. Self-injury has the potential to evoke anxiety and a sense of urgency when it is disclosed and sometimes it can elicit a sense of helplessness in clinicians who encounter it. This research found that counsellors had to develop the capacity to attempt to understand and manage the distress that young people who engage in self-harm often experience, whilst also recognising the challenge of this particular work in relation to intensity of what they encounter. All the participants attributed their ability to work with self-harm to the support system they have in their colleagues and that without this container, the tolerance may be somewhat lessened. It is clear that the therapeutic relationship's main function for self-harm is that of the container. It holds the space for the adolescent to struggle and to dump, a place where they can discard the nastiness of self-harm with the knowledge that it is a safe and secure. The importance of managing the transference was clear from the participants interviewed for this research as the 'therapeutic relationship can mirror that of the adolescents current relational schemas' (Norton, 2011, p.97) Adolescents can expect a similar negative response from their counsellor to their parents therefore it is imperative that the counsellor creates a non-reactive, non-judgmental environment for the teen to engage in. The findings in this research have documented the importance of looking at self-harm as part of the adolescent therefore the task of the counsellor to work with the individual and not the self-harm.

5.6 Limitations

Given the exploratory nature of this research there are limitations attached. One such limitation was that all the participants involved, practice in the same centre therefore it is hard to generalize given that it is only one centre's experience of managing this demographic. Another limitation is that given the fact that participants receive peer support, they may be more able to manage the work than participants working in private practice without this support. The selection of participants were from a multidisciplinary team therefore the orientation and approaches varied between each interviewee.

5.7 Recommendations

It is recommended that further research be carried out with a wider sample of counsellors practicing individually through private practice. The author would also see a gap for developing more research around the topic of containment and working with self-harm in private practice.

- Adam, M. Sheldon-Keller, M. West, M. (1996) Attachment organisation and history of suicidal behaviour in adolescence. *Journal of consulting and clinical psychology* 64: 264-272
- Adshead, G. (2010) Written on the body: Deliberate self-harm as communication: *Psychoanalytic Psychotherapy*; Jun 2010, vol.24 Issue 2.
- Berscheid, E. & Reis, H.T. (1998) Attraction and close relationships. In D. T. Gilbert, S.T. Fiske & G Lindzey (Eds.) *The handbook of social psychology* (4th ed., vol 2pp, 193-281) New York: McGraw-Hill
- Bion, W.R (1962) A theory of thinking. In *second thoughts*. New York: Aronson
- Bliss,S. (2010) The internal Saboteur: Contributions of W.R.D. Fairbairn in understanding and treating self-harming adolescents. *Journal of social practice* vol. 24, no 2.pp227-237
- Bjarehed, J. &Lundh, L.G. (2008) Deliberate self-harm in 14 year old adolescents. How frequent is it, and how is it associated with psychopathology, relationship variables, and styles of emotional regulation? *Cognitive Behaviour Therapy*, 37,26-37
- Boyer, L.B. (1982) *Analytic Experiences in work with Regressed patients*, publisher unknown.
- Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2) p. 77-101.
- Bromberg, P.M. (1980a) 'Empathy, anxiety and reality – a view from the bridge. *Contemporary psychoanalysis*, vol. 16. Pp. 223-236.
- Connors, R. (1996a) Self injury in trauma survivors: Functions and meanings. *American Journal of Orthopsychiatry*, 66, 197-206.

Crabtree, LH. (1967) A Psychotherapeutic encounter with a self mutilating patient. *Psychiatry* 30:91-100.

Fairbairn, W.R.D. (1952c) The repression and the return of bad objects. *Psychoanalytic studies of the personality*, Routledge, London: pp59-81.

Finlay, L (2015) *Relational integrative psychotherapy: process and theory in practice*, Chichester, Sussex: Wiley.

Fonagy, R.J. Target, R.J. (1995) *Towards understanding Violence: The use of the body and the role of the father. A psychoanalytic understanding of violence and suicide* ed. Perelberg, R. J. London: Routledge, 1999 Reprinted (IJP.076.0487A

Freud, S. (1888) Hysteria in J Strachey (Ed), *The standard edition of the complete psychological works of Sigmund Freud* (pp.41-57) London, England: Hogarth Press, Inc.

Freud, S. (1915) Observation on transference-love. In S.J Ellman (Ed.), *Freud's technique paper: A contemporary perspective* (pp.65-80) Northvale, NJ: Jason Aronson Inc.

Freud, S. (1937) Analysis terminable and interminable. *The international Journal of Psychoanalysis*, 18,373-405.

Gaston, L. (1990) The concept of the alliance and its role in Psychotherapy: Theroretical and empirical considerations. *Psychotherapy*, 27, 143-153.

Gomez, L. (1997) *An introduction to object relations*. London: Free association books.

Harris, J.R. (1995) Where is the child's environment? A group of socialization theory of development. *Psychological review*, 102,458-489.

Hunter, F.T. &Youniss, J. (1982) Changes in the functions of three relations during adolescence. *Development Psychology*, 18, 806-811.

Klein, M. (1952) The origins of transference. *The international Journal of Psychoanalysis*. 26, 11-33.

Hartup, W.W. & Stevens, N. (1997) Friendships and adaptation in the life course. *Psychological Bulletin*, 121, 355-370.

Hawton, K., Cole, D., O'Grady, J., & Osborn, M. (1982).Motivational aspects of deliberate **self** poisoning in **adolescents**. *British Journal of Psychiatry*, 141, 286–291.

Hoglend, P. (1993) Transference interpretations and long-term change after dynamic psychotherapy of brief to moderate length. *American Journal of Psychotherapy*, 47,494-507.

Klonsky, E.d.&Muehlenkamp, J.J (2007) 'Self injury: a research review for the practitioner', *Journal of Clinical Psychology: In session*, vol 63, no. 11, pp. 1045-1056

Kwawer, J.S. (1980) some interpersonal aspects of self mutilation in a borderline patient. *L AMAcad Psychoanalysis* 8:203-216.

Levy, N. & Scala, J.W. (2012) Transference, transference interpretations, and transference – focused psychotherapies. *Department of Psychology, Pennsylvania State University*, Vol 49, no 3. 391-403

Long, M. & Jennings, M. (2010) Counsellors' perspectives on self-harm and the role of the therapeutic relationship for working with clients who self-harm. *Counselling and Psychotherapy Research*, 10(3): 192-200.

Mental health commission, 2006. Multidisciplinary team working: From Theory to Practice. Retrieved March 30, 2017 from <http://www.mhcirl.ie/File/discusspapmultiteam.pdf>

McLeod, J. (2003) *Doing Counselling Research*. 2ⁿ Edition. London: Sage Publications.

Motz, A. (2010) Self harm as a sign of hope. *Psychoanalytic psychotherapy*. Vol 24 issue 2, p81-92

Nelson, S.H., Grunebaum, H. (1971) A follow-up study of wrist slashers. *Am J Psychiatry*. 127:1345-1349, 1971

Norton, C.L. (2011) Developing empathy: A case study exploring transference and countertransference with adolescent females who self-injure: *Journal of social work practice* vol.25, no1, pp.95-107

Patton, M.Q. (1990) *Qualitative Evaluation and Research Methods*, 2nd Edition. New York: Sage Publications.

Rasmussen, S. (2016) Why do adolescents self harm. *Crisis: The Journal of Crisis Intervention and Suicide prevention*, vol 37(3), pp. 176-183.

Repinski, D. J. & Zook, J.M. (2005) Three measures of closeness in adolescents relationships with parents and friends: variations and developmental significance. *Personal relationships*, 12, 79-102.

Rogers, C. (1967) *Onbecomming a person*. London, UK: Constable.

Racker, H. (1988) *The meaning and uses of counter transference: Essential papers on counter transference*, ed. B. Wolstein, New York university press: New York.

Racker, H. (1957) The meanings and uses of counter transference. *Psychoanalytic quarterly*, vol.26, pp.303-357.

Saari, C. (1986) *Clinical social work treatment: How does it work?* Gardner Press, Inc: New York

Schafer, R. (1977) *The interpretation of transference and conditions for loving*, Psychoanalytic Association, vol.25, pp.335-362.

Scharff, J.S & Scharff, D. (1992) *A primer of object relations therapy*, Aronson, Northvale.

Seinfeld, J. (1990) *The bad object: Handling the negative therapeutic reaction in Psychotherapy*, Aronson, Northvale. Shuttleworth, J. (1989) *Psychoanalytic theory and infant development*. In *Closely Observed Infants* (Eds. L. Miller, Michael Rustin, Margaret Rustin and J. Shuttleworth). London: Duckworth.

Scoliers, G., Portzky, G., Madge, N., Hewitt, A., Hawton, K., de Wilde, E. J., & van Heeringen, K. (2009). Reasons for **adolescent deliberate self-harm**: A cry of pain and/or a cry for help? Findings from the Child & **Adolescent Self-Harm** in Europe (CASE) Study. *Social Psychiatry and Psychiatric Epidemiology*, 44, 601–607.

Sullivan, H.S. (1953) *Beginnings of the self-system: The interpersonal theory of Psychiatry*. WW Norton & Co.: New York.

Venta, A., & Sharp, C. (2014) Attachment organisation in suicide prevention research: Preliminary findings and future directions a sample of inpatient adolescents. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 35, (1) 60-66.

Walsh, B.W., & Rosen, P.M. (1988) *Self-mutilation: theory, research and treatment*. New York: The Guilford Press.

Waltzer, cH. Depersonalization and self-destruction. *Am J Psychiatry* 125:399-401,1968

White Kress, V.E, Gibson, D.M. & Reynolds, C. A. (2004) 'Adolescents who self-injure: implications and strategies for school counsellors' professional school counselling. Available at: www.parenting.cit.cornell.edu, accessed 10.12.16.

Appendix 1: Interview Schedule

1. Can you tell me how you got into working as a Psychologist/Social worker?
2. What drew you to working with adolescents?
3. Would you please tell me about the work you are involved in?
4. How prevalent is self-harm within this population?
5. In your professional opinion, for what reason do adolescents self harm?
6. How do you work with young people who self-harm?
7. Can you name the challenges in working with adolescents who self harm?
8. How do you manage these challenges?
9. What is the function/role of the therapeutic relationship for clients who self-harm?
10. What skills do you feel are needed to work with this population?
11. What self-care if any do you use to look after yourself?

Appendix 2: Information form

Information form

My name is Tara Healy and I am currently undertaking a BA in Counselling and Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which is concerned with exploring your experience of working with adolescents who self-harm. I will be exploring the views of people like yourself, all of whom work with within this field.

What is involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, in having experience in working with adolescents. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than 20-30 minutes to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Anonymity

All the information obtained from you during the research will be anonymous. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate file. All data stored will be de-identified. Audio recordings and transcripts will be made of the interview and these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it's my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in the research. I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any of the records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) _____

Signature _____

Date _____

