Research Paper

A Silent Cry

By Cheryl Murphy

This article is a qualitative exploration of the lived experiences of clients who disclose self-harming behaviours to their therapist

Introduction

Persons engaging in Non-Suicidal Self-Injury (NSSI) may be slow in asking for help, often because of a perceived stigma attached to the engagement of such behaviours. The National Suicide Research Foundation (NSRF) released statistics for presentations to hospital for 2018, for self-harm in Ireland, stating 12,588 cases were reported. With an increase of 8% of admissions since 2014 (NSRF, 2019) there is a compelling argument for therapists to be equipped with the knowledge and training to support individuals presenting with self-harming behaviours.

There seems, however, to be a gap in research, in relation to client's experiences when they disclose self-harm, in a therapeutic setting. Understanding client's perspectives may provide richer, more robust feedback to help educate therapists in working more effectively with clients who self-harm. As a practicing therapist, reflecting on the number of adult clients disclosing NSSI, makes me question if the statistics are a true reflection of the number of individuals engaging in NSSI, as these are solely focused on hospital admissions.

Review of Literature

Self-harm is an intentional act of damaging one's own body tissue, regardless of suicidal resolve (Saraff & Pepper, 2014; Burke et al., 2018). Self-injury can be seen in a variety of behaviours involving cutting, inflicting burns, self-hitting, hair pulling, excessive skin picking and interfering with wound healing (Sheedy et al., 2019). Given the identifiable behaviours associated with self-harm, it is understandable one may confuse NSSI with suicidal attempts. However, NSSI is usually embarked upon in the absence of suicidal resolve (Whitlock et al., 2015). What it does indicate however, is the intensity of the core anguish that, if left unattended, can cause unforeseen levels of dangerous self-injury or indeed mortality (Whitlock et al., 2015).

Research indicates self-harm is used to cope and regulate dysregulated emotional states (Shallcross, 2013; Wester & McKibben, 2016). NSSI is employed to induce physical pain to distract from psychological pain, or to diminish an experienced sense of numbness (Lloyd et al., 2018).

NSSI and Suicide

Self-harm is a universal public health concern linked to psychological suffering, and while distinct from suicide, it can indicate a higher risk of suicidal ideation or completion (Gardner et al., 2020; Ferrey, et al., 2016). Research indicates conflicting opinions of the relationship between NSSI and suicide. Duarte et al. (2020) argue NSSI should be considered a protective act, in contradiction to suicidal tendencies (Nock, 2009; Castellvi et al., 2017). Nock (2009) and Castellvi et al. (2017) specify that permitting the act of harmful compulsions into a confined area, helps individuals construct an impression of having self-control over fatality. Moreover, Nock (2009) and Duarte et al. (2020) say NSSI is employed to diminish suicidal ideation, which suggests there is no clear link between NSSI and intentionally completing suicide.

Disclosing NSSI

The secretive nature of self-harm is evidenced in 40-60% of university students never revealing their NSSI (Gayfer, 2020). The social stigma attached to NSSI may contribute to reluctance in disclosure (Gayfer, 2020). Socially stigmatised acts tend to induce feelings of shame and rejection, coupled with anxieties around judgement (Corrigan & Rao, 2012; Gayfer, 2020). Despite the high rates of NSSI, individuals who self-harm are habitually disinclined to reach out to support services or helping organisations (Burke et al., 2018).

Persons who engage in NSSI tend to exhibit poorer competencies in communication (Nock, 2009). This is attributed to the absence of emotive language or, possibly, alexithymia (Cerutti, et al., 2014). Alexithymia is a personality trait with inability to regulate and communicate feelings in a typically adaptive way, and difficulties in deciphering and describing emotions. This leads to the limited probability of these individuals seeking help (Burke et al., 2018; Yilmaz, 2019).

The historical propensity in conducting research with psychiatric populations has led to a distorted empirical evidence base by constructing countless assumptions. These assumptions hold inadequate weight of NSSI in the broader population (Long et al., 2016) As a Humanistic Integrative therapist I question the validity of such studies (Skegg et al., 2004; Jacobson et al., 2008) in overemphasising self-harm as a product of a "disorder", leading to missed opportunities to explore NSSI thoroughly, in the wider population.

Treatment Planning

Evidence suggests some helping professions may find the treatment of NSSI difficult. The National Collaborating Centre for Mental Health UK (2012) (NCCMH) highlight that therapeutic engagement is vital for impacted individuals. However, there is uncertainty about the effectiveness of psychosocial interventions. The main interventions employed are Cognitive Behavioural Therapy (CBT) or Behavioural Therapy (BT) (Shallcross, 2013). These therapeutic orientations require client self-motivation and desire to change behaviour. Therapists may assume clients want to stop self-injuring, however, Shallcross (2013) indicates many are reluctant to stop believing this coping mechanism works. Hence, the sole use of CBT techniques may be ineffective. Additionally, asking clients to cease self-injuring can cause isolation and prevent them from verbalising future instances (Shallcross, 2013).

About this Study

This research explored the experiences of clients who had disclosed self-harming behaviours to their therapists. The objectives for this research were for clients:

- To verbalise their experiences of disclosing their self-harming behaviours to their therapist.
- To explore the different ways that therapists responded to their disclosure.
- To define the impact of the therapist's response on them, and thereafter the therapeutic relationship.
- To describe what were helpful and less helpful behaviours in the therapist.

Methodology

Interpretative Phenomenological Analysis (IPA) was employed to explore, in detail, how clients perceived their experiences in therapy. Phenomenological in nature, the essence of IPA aspires to understand and portray the experiences of individuals as they contend with, live and engage in given circumstances (Smith & Osborne, 2003).

Due to the COVID-19 pandemic, access to participants was through a designated online self-harm support group, where participants self-selected. The participants consisted of six females and two males, aged 22 to 33 with a mean age of 26.8 years, who had disclosed self-harm to their therapist. Table. 1 "*Participant Demographics*" below displays the population sample.

Procedures for Data Collection and Data Analysis

Participants were requested to complete a semi-structured questionnaire with closed and open-ended questions. SurveyMonkey

Table 1: *Participant Demographics*

Name	Gender	Age
Kelly	Female	23
Nina	Female	33
Diane	Female	29
Finch	Male	27
Phoenix	Female	30
Roxy	Female	28
Paul	Male	22
Ellie	Female	23

**Participants were invited to provide a pseudonym to protect their identity and adhere to research ethics.*

was used as a data-collecting tool. All respondents were provided with an information sheet and were required to sign a consent form.

Ethical Considerations

As you can see from the "Participant Demographics" table, confidentiality was adhered to. It was imperative that participants be protected from harm. Inevitably there was a risk factor in participating in this study. Due to the sensitive nature of the topic, participants who believed they were lacking in support, and/or processing deep emotional work were requested not to take part.

Findings and Discussion

The findings impart the respondents lived experiences of disclosing self-harm to their therapists. Key themes that arose are presented through the narrative of the participants, with their words displayed in italics. The analysis elicited the metaphor of a Jack-in-the-Box and the painting Fig 1. *Jack-in-the-box* (painting created by author) symbolises the secretive nature of NSSI and the unspoken complex emotions attached to self-harming behaviours. The hands represent the therapists holding capacity and the vulnerability of the client in this.

Imagine Jack, squashed down and hiding in inside the safety of his box. Jack knows he is going to reveal himself, but he can't see what awaits him. Jack is frightened, fearful and feeling alone. He is worried that in sharing his deep secret he will be made "feel like a monster" (Roxy). Jack wonders how he will express himself and if he has the words to match his emotions, which he struggles in deciphering. He is concerned how his therapist will react and is uncertain if they will understand. When Jack springs out and is seen, how will the therapist respond? Will the therapist's response frighten Jack back into hiding in his box, or will he feel safety in the holding of his therapist?

Figure 1: *Jack-in-the-Box*

A Reflection of Clients' Lived Experiences

The overarching themes that arose were; visibility and invisibility, power and disempowerment, and feelings prior, during and after disclosure. Each of these themes inter-linked to form sub-themes:

- the positive and negative consequences of being seen/unseen
- effects of the quality of the therapeutic relationship and responses
- the perceived lack of understanding of self-harm, by therapists
- the importance of a trusting safe space

"…it was my darkest secret" (Kelly)-Unseen

Consistent with previous research (Wester & McKibben, 2016; Abrams & Gordon, 2003), the findings depicted the secretive nature of self-harm, with participants expressing reluctance in disclosing and difficulty in verbalising their self-harm. Kelly had borne her "secret" for "a long time", conveying self-protection in building "walls around" her "determined nobody would knock through them". Nina experienced a profound "struggle with putting words" to her emotions and "didn't really understand" what triggered her self-injury. Diane felt ready to disclose however, she had to "write it down, as it was too difficult to verbalise". This indicates alexithymia might be part of some respondents' presentation. Considering trauma in childhood is typically common in individuals

with alexithymia, a trauma informed approach would be useful when working with this client base. Hence, longer term therapies, rather than solution focused therapies may be more effective.

Before disclosing, Finch told of his "fear" of being put "under lock and key" or "being put on medication". The therapist's reaction determined whether the participants continued hiding their NSSI, or alternatively whether they actively investigated healthier coping strategies, coupled with exploring the origins of their self-harming behaviours. Respondents indicated that a supportive environment, feeling "validated" (Phoenix) and "reassured" (Diane) by their therapist, encouraged exploration of various aspects of their NSSI. Kelly conveyed a sense of ease and being "comforted in the care" shown, where Ellie felt "safe to talk" about her self-harm when there was a sense of "trust" (Finch, Nina). Respondents reflected on how this deepened the therapeutic bond.

"For the first time I felt I wasn't alone." (Nina) -Seen

When respondents felt seen as a whole, they felt connected. Therapy was regarded most valuable when therapists recognised NSSI "doesn't define" the client (Kelly, Nina, Diane). Promoting client autonomy and a willingness to listen, suggests an approach to working with NSSI that is based on co-creating an effective therapeutic relationship, rather than techniques. To achieve this, practitioners need to appreciate the unique meaning the individual attributes to their NSSI, with Finch expressing "it's important for therapists to have a broad knowledge of the reasons a person may self-harm." When therapists journeyed alongside their client, this reinforced a sense of solidification and solidarity in the therapeutic relationship. Ellie felt "we were in this together" which helped her reduce her self-injurying. Long et al. (2016) suggest that therapists are more supportive when they are prepared to accept self-harm as a meaningful attempt to manage distress, rather than pathologise it as a psychological abnormality.

This research evidenced that barriers to disclosing were interpersonal, due to fear of the therapists' response, rather than an intrapsychic conflict

"…brushed under the carpet" (Roxy)

Respondents felt invisibility in visibility when their therapist response was unproductive. They revealed the complexities they experienced after disclosing NSSI, and how unconstructive responses stimulated further invisibility of their NSSI. Not being met, or adequately supported would lead clients to deny their reality. Kelly felt her therapist "just didn't get it" and Roxy would put "on a mask" and/or withdraw from therapy. A direct challenge from Kelly's therapist to stop self-harming, subjected her to feeling "ashamed and guilty" when she relapsed, preventing her in disclosing future incidents. Wester and McKibben (2016), propose that individuals engaging in NSSI to manage their stresses often turn to maladaptive coping tactics, namely self-reproach, substance abuse and denial. When clients feel shamed, they can internalise a skewed view of self-hatred, believing they are immoral or fundamentally flawed (Garisch et al., 2017). Therapists need to be attuned to and actively help in managing shame with this client base.

This research evidenced that barriers to disclosing were interpersonal, due to fear of the therapists' response, rather than an intrapsychic conflict. This research reflects the conclusions of previous research that social stigma was present (Lloyd et al., 2018). This theme relates to participants' perspectives on strategies to therapy, which emphasises cessation of self-harm. Additionally, when self-harm was minimised, respondents felt it was "brushed under the carpet" (Roxy), and they would regress into their secretive ways.

"…things didn't seem as daunting" (Nina)

In order to encourage the clients to own their own power, therapists should consider the needs of their clients rather than their own assumptions of what is favourable. Participants' felt that exploring the geneses of their behaviour was helpful in activating their own power, helping Nina in "figuring out what had caused" her "to begin hurting" herself. Nina felt able to tell her therapist when she relapsed as "he didn't ever tell" her to "just stop." Finch expressed the strength in the relationship with his therapist, whom he "trusted entirely," enabling Finch to take his own power, and consider "various strategies to stop" his "habits."

Considering trust in the therapeutic relationship, the focus typically rests on the client trusting the therapist. However, respondents highlighted the fact that reciprocal trust provided them with a sense of empowerment. Furthermore, Nina felt valued when her therapist regarded her as "a capable person" and not as someone who "needed to be fixed." As self-harm tends to be a repetitive act (Bennardi et al., 2016), therapists need to anticipate the possibility of relapse. Discussing this possibility with clients is important in the early stages of therapy.

"…too broken to be fixed" (Ellie)
Disempowerment
Evidence of disempowerment was displayed by Kelly's therapist asking her not to cut in-between sessions. When participants felt exposed unwillingly, they felt disempowered with Ellie adding she felt her therapist was not "equipped with the knowledge and training" needed to work with persons who self-harm. When respondents (Paul) felt a "shocked" reaction from therapists, they were left with a sense of no one understands. Roxy was left feeling "horrified" and "made out to be a monster," on top of not having the "choice" of self-disclosure. Paul also said that he felt "angry" that he "had to tell someone." It seems removing clients' choice and coercing a premature disclosure takes away their power. Ellie was referred to another therapist, leaving her feeling that she was "weird, too much of a problem and too broken to be fixed." This compounded Ellie's feelings of helplessness and ultimately "escalated the cutting."

"…you're not alone" (Diane)
Support
All respondents communicated the importance of hearing from their therapist that they were not alone. Most respondents expressed the need to consider what had led them to self-harming behaviours and wanted their therapist to help them "find the trigger" (Roxy). Participants said they would like therapists to say that self-harm does not define them; it is only part of who they are (Kelly, Diane & Nina). Respondents also felt the use of phenomenological questions was helpful.

"it's just for attention" (Diane)
Unsupportive Interventions
Throughout the participants responses there were consistent commonalities on what proved the most unhelpful. Roxy and Phoenix felt hearing self-harm was a "cry for help or doing it for attention" was unsupportive. It is also contradictory to the secretive nature of NSSI that respondents had expressed. Linking self-harm to suicidal tendencies was another unhelpful intervention. This would indicate the participants viewed self-harm and suicidal ideation as separate entities. This is important information for therapists to understand while working with and assessing clients who present with NSSI. While both are distinct in their intent, it is also essential that practitioners do assess how they may interrelate as there is an increased risk of unintentional suicide (Garisch et al., 2017), particularly where substance abuse is present.

Linking self-harm to suicidal tendencies was another unhelpful intervention

The Importance of the Therapeutic Relationship
There is little empirical evidence about treatment of NSSI however, studies (Levitt et al., 2006; McAndrew & Warne, 2014; Garisch et al., 2017) illustrate that clients place importance on the therapeutic qualities of the therapist. They suggest the relationship is a key factor in facilitating change which was evident in the present study. In line with previous studies (Long et al., 2016), most participants expressed the importance of making sense of their experiences with self-injury. Furthermore, Garisch et al. (2017) state that by validating your client's "experiences as understandable within the context of their experience" (p. 101), encourages the probability of disclosure and promotes self-acceptance.

This would suggest a humanistic approach would be more beneficial then the traditionally employed approaches of Cognitive Behavioural Therapy (CBT) and Behavioural Therapy (BT). Scholl, Ray and Brady-Amoon (2013) propose that a humanistic approach is deeply relational, with relational depth being a state of profound connection and contact, co-created between two people (Mearns & Cooper, 2005). The humanistic approach to therapy encapsulates the essence of the relationship being at the core of healing. I believe we are *fellow travellers* (Yalom, 2010) with our clients, and moreover including them in research, allows them to have their voices heard, thus empowering them and enlightening us as therapists.

Ultimately, this research shows the importance of hearing the voices of clients and listening to their lived experiences. This offers the prospective of a more enriched therapeutic experience. Based on the literature and the voices of the respondents in this research, Table 2: *"Hearing the Clients Voice"* is offered to provide guidance, derived directly from individuals engaging in NSSI, and offers some resources for therapists, health practitioners and others working in the field of mental health. Offered alongside are alternatives that may be helpful. Included in the table are the voices of respondents, and what they have expressed as being important to hear from therapists. Having this knowledge may assist us as therapists in building a supportive and and trusting relationship with our clients who struggle with their silent cry.

The Use of Safety Contracts
Evidenced in this study, there were negative consequences when clients were asked to refrain from self-injury. Washburn et al., (2012)

suggest that safety contracts or contracts agreeing not to engage in NSSI have no empirical support (Lewis, 2007; Garisch et al., 2017) and may be counterproductive, leaving the client feeling isolated and misunderstood. Garisch et al., (2017) suggest contracts are more likely to be used to ease practitioners' anxieties rather than generating therapeutic change. Special attention is advised with regards to introducing 'no harm contracts' with consideration given to what purpose it is serving, and whose needs are being met.

Table 2: *Hearing the Clients Voices*

What NOT to Say- The Clients Voice	Suggested Alternatives- The Therapists Voice	What Respondents' Felt would be Important to Hear
Will you not cut before we meet? (Nina)	What would it be like for you if you did self-injure before we met again? Do you imagine you could share that with me?	I don't expect you to just stop but I am concerned for your safety so what can we do to manage your cutting in a safe way? What do you think may help? (Kelly)
Why would you hurt yourself? (Kelly)	How is it for you to tell me you hurt yourself?	Thank you for telling me that, I'm proud of your honesty. (Finch)
Can I see your cuts? (Kelly)	Are you taking care of your cuts/burns? Opening a discussion around risk of sepsis	Do they need medical attention? (Ellie) If they ask to see your cuts maybe explain why, I thought she didn't believe me. It also felt too exposing. (Nina)
Do you feel ashamed? (Kelly)	I'm noticing... (Body language, facial expressions etc.) What's happening for you right now?	Your self-harm does not define you; you are still you. (Diane)
You know self-harm is linked to suicide? (Nina)	Do you ever have suicidal thoughts?	It's ok that it happened you had a bad moment and couldn't talk to anyone. (Paul)
Do you think it does any good? (Finch)	What is it like for you when you self-injure?	How can I help you? (Diane)
Why do you do it? (Paul)	Do you know what triggers your need to self-injure? Is it typically impulsive or compulsive?	How can I help ease that pain you are feeling? (Phoenix)
Do you enjoy it? (Finch)	When you self-injure, what need does it serve?	It is just your way of trying to cope (Ellie)
Why didn't you tell someone? (Nina)	Is this the first time you've spoken about it?	Thank you for being brave enough to tell me this and I will support you. (Nina) You don't need to be alone in this. (Kelly) I am here for you. (Kelly)

Limitations

As a Humanistic Integrative Therapist, I feel this research would have benefitted more with the use of interviews. As it was conducted online with the use of a questionnaire, there was no opportunity to probe for elaboration or clarification, which may have yielded more fruitful insights and a greater depth of understanding.

Conclusion

This research represents a preliminary step toward developing an in-depth understanding of clients' lived experiences in disclosing NSSI in therapy. The therapeutic relationship is a significant factor in fostering clients' autonomy and empowerment. Respondents perceived therapy to be helpful when therapists were prepared to work with underlying issues, exploring the geneses of their behaviours, rather than focusing on the cessation of self-harm. Practitioners need to look past the behaviour, connect with the client, and facilitate the necessary therapeutic requirements for cultivating a soothing reconnection with self, and others.

Cheryl Murphy

Cheryl Murphy is a pre-accredited member of the IACP and a member of the Psychological Society of Ireland. Cheryl is currently working as a Humanistic Integrative counsellor within two organisations, Kerry Rape and Sexual Abuse Centre and Listowel Family Resource Centre. This research was undertaken as part of B.Sc (Hons) Counselling and Psychotherapy in Cork Counselling Services Training Institute, under the supervision of Dr.Kate Kirk. Cheryl holds a B.Sc. (Hons.) Psychology Applied to IT, B.Sc. (Hons.) Counselling & Psychotherapy and M.Ed. Counselling in Education.

Contact details
email: cheryl7891@live.ie

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