Therapists' Experiences of Witnessing the Physical Manifestations of Self-Injury: An Interpretative Phenomenological Analysis.

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Psychotherapy (DPsych), is entirely my own work, and that I have exercised reasonable care to ensure that the work is original and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

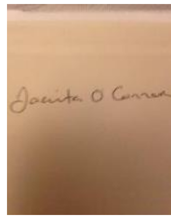
Signed: 

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Table of Contents

Acknowledgements 2
Table of Contents 3
List of Abbreviations 3
List of Tables 3
Abstract 4
Chapter 1: Introduction 5
Background and Rationale for the Study 5
Outline of Thesis 7
Researcher's Reflexive Comment- What Sparked my Interest? 8
Chapter 2: Literature Review 10
Introduction 10
Literature Search Strategy and Definitions of Self-Injury 10
Motivation, Meaning and Misconceptions 15
Self-Injury: A Growing Concern Across Genders 17
Attitudinal Barriers and the Risk of Suicide 21
Therapists Responses to Self-injury: Verbal and Non-Verbal 27
Conclusion 37
Chapter 3: Methodology 38
Introduction 38
Research Aims and Objectives 39
Researcher Positioning 42
Data Collection and the Semi-Structured Interview 44
Data Analysis Methods and Stages 46
Sampling, Method, Size, and Data Sources 50
Participants 53
Inclusion Criteria 54
Exclusion criteria: 55
Chapter 4: Findings 63
Introduction 63
Superordinate Theme 1: Feeling Shocked 64
Subordinate Theme I: Struggling to Hold Face 67

Subordinate Theme II: When your Stomach Turns 70
Subordinate Theme III: Keeping a Lid on It 77
Subordinate Theme IV: Carved in my Mind 78
Superordinate Theme 2: Sitting at the Edge of your Seat 83
Subordinate Theme I: You Need to be on Top of your Clinical Skills 84
Subordinate Theme II: Shouldering Responsibility 102
Subordinate Theme III: Feeling Inspired 105
Subordinate Theme IV: Protecting the Self 107
Conclusion 111
Chapter 5: Discussion 109
Introduction 109
Concealing your Inner World 109
Not as Plain as the Nose on your Face 114
The Push-Pull Struggle 118
Fear and Anxiety 128
Chapter 6: Conclusions 139
Introduction 139
Implications and Recommendations for Practice 139
Theoretical Transferability 142
Strengths and Limitations of the Current Study 142
Recommendations for Future Research 145
Review of the Aims of the Research Study 147
A Reflexive Journal Entry 152
References 154
Appendices 180
Appendix A: Interview Schedule 180
Appendix B: A sample of (Anna's transcript) demonstrating the first stage of analysis. 181
Appendix C: Developing Emergent Themes. 183
Appendix D: Recruitment Flyer/Advertisement with IACP and IAHIP. 190
Appendix E: Plain Language Statement 191
Appendix F: Ethical Approval 194
Appendix G: Informed Consent Form 195
Appendix K: Information about the Debriefing Protocols/Schedule 196

List of Abbreviations

SI	Self-injury
SH	Self-harm
CSA	Childhood sexual abuse
SPD	Skin Picking Disorder
IPA	Interpretive Phenomenological Analysis.
EBE	Experts by Experience

List of Tables

Table 1	National Self-Harm Registry 2018 Annual Report (Published 2019)
Table 2	Master table of superordinate theme one
Table 3	Participant Demographics and Profile
Table 4:	Superordinate and subordinate themes:

Abstract

Jacinta O'Connor

Therapists' Experiences of Witnessing the Physical Manifestations of Self-Injury: An Interpretative Phenomenological Analysis

A precise account of the prevalence of self-injury (S.I) is unachievable as many incidences remain unreported. However, its high prevalence suggests that psychotherapists will encounter S.I in their practice and benefit from an increased understanding of the strong emotions that can emerge when *seeing* and *hearing* explicit accounts of S.I. This Interpretative Phenomenological Analysis (I.P.A) study explored the lived experiences of therapists who have witnessed the physical manifestations of S.I with specific regard as to how witnessing the injuries impacted upon them both personally and professionally.

The study concerned itself with what aspects of these presentations were most challenging for therapists and the supports they drew upon to sustain them in their therapeutic practice. It utilised in-depth one-to-one interviews with nine psychotherapists. Two superordinate themes emerged: 'Feeling Shocked' and 'Sitting on the Edge of your Seat'.

Theme 1 outlines the therapist's initial sense of shock, disbelief and revulsion at the sight of the injuries. They grappled to manage this inner conflict/tension and struggled to conceal this response from their clients, believing that clients would perceive their reactions as a judgement. 'Sitting on the Edge of your Seat' highlights the fears, concerns and heightened sense of responsibility experienced by the participants. They were concerned that their clients may complete suicide or die accidently from their S.I and feared that they could be held accountable for any fatal outcome. The embodied, challenging and sensed aspects of self-injury are rarely discussed from the perspective of the therapist and this study highlights the challenges experienced by therapists as they witness the physical manifestations of S.I.

Chapter 1: Introduction

This chapter briefly outlines the background of the study and the reasons for undertaking the research project. The methodology and methods used- along with the research aim and objectives- are presented in summary form. An outline of the succeeding chapters is provided alongside a reflexive commentary discussing my particular interest in this topic.

Background and Rationale for the Study

Prevalence rates of self-injury are notably high and a global health concern, (Edmondson, Brennan, & House, 2018; Hawton, Saunders, KE, O'Connor, & RC, 2012; Lilley et al., 2008; Victor & Klonsky, 2014). Approximately 17% of adolescents worldwide engage in S.I (Swannell & Sarah, 2014). According to Griffin, et al. (2019), recent statistics from the National Suicide Research Foundation (N.S.R.F) report that in 2018 there were 12,588 presentations at Irish hospitals involving 9,785 individuals engaging in S.I. Thus, the number of [1]self-injury presentations and the number of persons involved were higher than those recorded in 2017. The report demonstrates a 29% increase in the rates of self-injury in young people between the ages of 10-24 years between 2007 and 2018. In 2018, the rate of S.I in Ireland increased by 6%, following a period of stabilisation over the previous seven years, since 2010. Moreover, the increase observed in 2018 was evident across all ages and in both males and females. Furthermore, as only a small percentage of individuals

[1] The terms self-harm, self-injury and non-suicidal self-injury are used interchangeably.

engaging in self-injury present at hospitals, it is estimated that the actual rates could possibly be six times greater than the aforementioned (Griffin, et al., 2017).

In considering this prevalence, it is likely that most [2]therapists will encounter clients engaging in self-injury behaviour. Therefore, it is imperative that therapists acquire a greater understanding of S.I and gain a greater awareness of the emotive feelings that may emerge when working with such individuals. Training in psychotherapy/counselling does not fully prepare the therapist for such events; psychotherapy training focuses primarily on how to deal with mental and psychological distress, rather than on how to respond to the *physical* manifestation of self-injury. By focusing on therapists' responses/reactions to the physical presentation of S.I, therapists will be better prepared for the reactions/responses they may encounter as they witness the self-inflicted injuries of their clients. Furthermore, if therapists are unable to conceal their reactions/responses to the S.I presentations, this may well have an impact upon their clients. They may feel judged or it might even add to an increase of shame and degradation if such responses were interpreted as disapproving. This study aims to contribute to this body of research from the perspective of the psychotherapist.

Methodology

I.P.A research is idiographic and descriptive, examining the lived world of individuals and their detailed experiences recalled through a narrative.

[2] 'Therapist', 'counsellor'. Clinician' and practitioner are used interchangeably to describe psychotherapists.

According to Patton, “If you want to know how much people weigh, use a scale… If you want to know what their weight means to them, how it affects them, how they think about it, you need to ask them questions, find out about their experiences, and hear their stories” (Patton, 1990, p. 13). Similar sentiments are echoed by Smith (1996) who posits: “the aims of I.P.A is to explore the participant’s view of the world and to adopt- as far as is possible- an ‘insider’s perspective’ (p. 264). As a novice researcher, I valued the step-by-step approach that I.P.A offers and believed it would assist me through all aspects of the study.

Outline of Thesis

Chapter Two presents a review of the existing literature related to self-injury and contextualizes this within the field of psychotherapy. An exploration and discussion on the various definitions of S.I will also be addressed. In addition, this chapter discusses the ambiguous relationship between S.I and suicidal behaviour including the potential risk that S.I behaviour might indicate underlying suicidal thinking in the individual. Moreover, the literature will concern itself with the attitudinal barriers encountered by those who self-injure when they seek support. A brief discussion on the prevalence rates of S.I amongst males and females will be presented. Finally, this chapter concludes with a section on psychotherapists’ responses to S.I in the therapeutic space. Chapter Three justifies the use of I.P.A as the prime methodology to answer the research question. It outlines the three philosophical underpinnings of I.P.A: phenomenology, hermeneutics and idiography. This chapter also outlines the research design, including the processes of sampling, recruitment, data collection and analysis. Ethical considerations that

emerged during the study process are highlighted. Finally, validity criteria used to evaluate the quality of the study are also detailed.

Chapter Four presents the findings of this study, where the individual experiences of the participants are brought to life by including the use of direct quotes. A master table- representing the two superordinate themes and the relevant subordinate themes that emerged from data analysis- are described in further detail.

Chapter Five discusses the study findings in the context of the extant literature. It positions the findings within the literature in a way that offers new perspectives and insights on psychotherapists' experiences of witnessing the physical manifestations of S.I.

Chapter Six discusses the implications of the study findings for psychotherapy practice, supervision practice, training, policy and research. The study's strengths and limitations are considered while its quality is evaluated using Yardley's (2000) framework which Smith, Flowers, and Larkin (2009) recommend for I.P.A studies. The chapter concludes with a reflexive journal entry.

Researcher's Reflexive Comment- What Sparked my Interest?

My interest in this topic was borne out of my experiences of working as Chief Clinical Officer for 13 years, within a service that primarily focused on supporting clients engaging in self-harm and experiencing suicidal ideation. I supported many clients engaged in S.I

and whilst the majority did not expose their wounds, there were some whose wounds were clearly visible. I experienced a multitude of reactionary emotions, including sadness and compassion; there were however, times when my reaction was *physical*: an overwhelming sense of feeling weak. Furthermore, I discovered that while facilitating group supervision within the organisation, therapists expressed their sense of being misunderstood by their external supervisors and that S.I seemed to raise a lot of anxiety for their supervisors. They stated that their supervisors tended to lean toward the "risk of suicide" as opposed to facilitating the therapists in exploring the impact of S.I. It was also apparent that some of my colleagues experienced adverse reaction to witnessing wounds and/or hearing detailed accounts of S.I episodes.

Although it appears that much has been written on S.I, I found that the existing literature is primarily focused on the meaning/function behind S.I and the adverse negative response of staff working in *hospital* settings, and did not address the perspective of the psychotherapist/counsellor's experiences of witnessing S.I to any great extent. Therefore, I believe this area of research is important to provide an opportunity for therapists to share their individual experiences and make sense of them. The overall intention of this research is to contribute to the field of psychotherapy by informing and equipping therapists and supervisors alike on the S.I presentation and the responses that may be experienced as a result.

Chapter 2: Literature Review

"We turn to the body because it cannot be denied. We get old, we die, we disintegrate into dust, but our living bodies are proof of our here-and-now existence in a world that is too often numb and confusing". (Hewitt, 1997, pp. 20–21)

Introduction

In this Literature Review I will outline the various definitions of self-injury and will explore the ambiguous relationship between S.I and suicidal behaviour, as it appears the literature differs on whether S.I is a coping strategy or an indication of suicidal intent. The potential motivations, meanings and misconceptions behind S.I will be addressed and the attitudinal barriers experienced by clients which may prevent those in need of support from accessing services and/or remaining engaged with the therapeutic process. Furthermore, a brief discussion on the prevalence rates of S.I across genders and age will be discussed. Although there appears to be limited research available on the therapist's experiences of witnessing S.I, the literature review will focus on the emotive responses from the therapists and include the verbal and non-verbal communication/responses when faced with a client's self-inflicted injuries.

Literature Search Strategy and Definitions of Self-Injury

The literature search strategy included electronic searches of the main databases in order to identify all empirical studies in relation to self-injury and psychotherapy. The following

are the databases that were explored: PsycInfo, Medline, EMBASE Psychiatry, PubMed, and the British Nursing Index. The search was limited to papers and/or journals written in English, using primary search terms including “self-injury/psychotherapy”, “self-harm/psychotherapy”, “deliberate self-harm/psychotherapy”, “self-harm/counselling”, “self-harm counseling”, cutting/psychotherapy”, “self-mutilation”, “attempted suicide”, “self-injurious behaviour”, “self-poisoning”, “self-wounding”, “parasuicide” and “non suicidal self-injury”. The numbers of identified references were reduced by searching within the findings for any of the following terms: “counselling and psychotherapy”, and the resulting titles and abstracts were then inspected for relevance. As the literature accumulated, the references of included papers were searched to identify any additional studies that might be of further relevance.

Discussions of S.I have appeared in psychiatric literature since the second half of the nineteenth century, with some initial attempts to differentiate these acts from suicidal behaviour. Early “case notes, textbooks, and journals... refer to a wide variety of acts, ranging from the refusal of food to many attempted suicides” (Chaney, 2011, p. 280). Chaney (2011) also outlined, how the term self-mutilation was adopted in the 1860s and excluded behaviour like food refusal or anything deemed suicidal but included behaviours consistent with today's conceptualization of S.I, such as punching walls, head banging, cutting the body, or inserting objects into the skin. Self-mutilation appeared in the Surgeon General's Index Catalogue for the first time in 1910 and the associated discourse included selfishness, excessive religion, and sexual guilt (Chaney, 2011). In more recent literature numerous terms are used interchangeably to define the behaviour, such as, “self-injury”, “deliberate self-harm”, “self-harm, “non suicidal self-injury”, “parasuicide”, “self-

poisoning", "self-cutting", "carving", "overdose", parasuicide and "attempted suicide", however, the most frequently used terms are "self-injury" and/or "self-harm". For the purpose of this study, I have chosen to use the term self-injury (defined here as including both suicidal behavior and non-suicidal self-harm), whilst acknowledging that the participants' definition may differ, in line with the conflicting definitions reflected in the literature. Moreover, S.I methods that cause tissue-damage such as scratching, cutting, and stabbing have been viewed as more severe (Baer et al. 2020) as they are related to increased risk of suicide attempts (Hawton et al. 2010; Andrewes et al. 2019).

Self-injury first appeared in psychiatric writings in 1860, to date there is still no one agreed definition. This perhaps sheds light on the polarised viewpoints that many people have when it comes to the issue of S.I. Walsh, and Rosen (1988) view S.I as, "deliberate, non-life-threatening, self-effected bodily harm or disfigurement of a socially unacceptable manner" (p. 10). (Klonsky & Muehlenkamp, 2007; Nock, 2009) state that
Self- injury (S.I) is the direct, intentional destruction of one's own body tissue without the intent to die and according to the National Institute for Health and Care Excellence's (N.I.C.E's) S.I constitutes:

> […] any act of non-fatal self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting. Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself. (N.I.C.E, 2013)

The above definition is comprehensive and includes a broad spectrum of behaviours and excludes the use of words such as 'intentional' and 'deliberate' which is in line with the recommendations suggested by Kapur (2005). Notwithstanding this, the definition does not distinguish between the intention behind the act of S.I regardless of whether the hoped for outcome was life or death. The description of self-harming acts as 'deliberate' is no longer recommended because it has been argued that the extent to which the behaviour is deliberate or intentional is not always clear. The National Collaborating Centre for Mental Health and the Royal College of Psychiatrists have both dropped the prefix 'deliberate' from self-harm in response to the concerns raised by individuals engaging in S.I and the adverse attitudes they encounter when accessing services (Kapur, 2005). Moreover, it could be argued that the motivation behind this decision may be an attempt to reduce stigma as opposed to providing an accurate definition of S.I itself.

Research has shown that less than half of those who engage in S.I choose to disclose their behaviour (Martin, Swannell, Hazell, Harrison, & Taylor, 2010) often due to the fear of receiving negative and judgemental reactions/responses from others (Fortune, Sinclair, & Hawton, 2008a; Klineberg, Kelly, Stansfeld, & Bhui, 2013). Furthermore, Kapur's definition may indicate a cautious approach based on the ambiguous relationship S.I bears to suicide. Mangnall, and Yurkovich (2008) argue that despite agreement across disciplines regarding the significance of the phenomenon, there continues to be definitional ambiguity and lack of consensus regarding what S.I is and is not.

In exploring the many terms that are used to describe and define S.I, the following

presentations are not included, Trichotillomania, (T.T.M), hair pulling and dermatillomania/excoriation, Skin Picking Disorder (S.P.D). When clients engaging T.T.M or S.P.D present for therapy, therapists often group them under the umbrella of S.I, as does some of the literature. Stanley, Winchel, Molcho, Simeon, and Stanley (1992) propose that suicide, self-mutilation, and trichotillomania all represent points along a continuum of S.I. The Diagnostic and Statistical Manual of Mental Disorders (D.S.M-5) working group concluded that current evidence indicates that hair pulling, and skin picking are more closely related to Obsessive Compulsive Disorder (O.C.D) than to the other disorders, although there is a partial overlap with O.C.D. Furthermore, T.T.M and S.P.D do not fall under the category of S.I within the DSM-5, and S.I is documented under a new diagnostic category listed as "**V-codes**". The V-codes can be described as a condition in need of further study and a condition not attributable to a mental health disorder.

Despite the differentiation made between T.T.M and S.P.D in the DSM-5, Snorrason, Smári, and Ólafsson (2011) argue that skin-picking allows individuals to avoid experiencing aversive affective states and that the act of picking helps to regulate a person's negative emotions. They consider this a maladaptive coping method but a coping method nevertheless, a method that is continually reinforced due to the feelings of relief and/or gratification that result from skin picking episodes. The similarities of T.T.M and S.P.D with S.I becomes more apparent as the underlying motivation and meaning share many similarities.

Motivation, Meaning and Misconceptions

Inckle (2017) argues that S.I is to a large extent an embodied experience, resulting in a physical, psychological, and emotional response. Moreover, she suggests that people who engage in S.I are trying to communicate their distress to others and are asking for help or care. Klonsky (2009), suggest that people may also use S.I to obtain relief from a particular emotional state or overwhelming situation. Furthermore, Hjelmeland et al. (2002) propose that S.I does not simply follow from a direct wish to die. Understandably, it can be difficult for people to comprehend how an act as self-destructive as S.I can serve a positive purpose or have meaning for people who engage in this behaviour, therefore, it is not surprising that many misconceptions relate to S.I.

Warm et al. (2003) conducted a survey with 243 people who engaged in S.I. They included 34 male participants, 205 female and four participants who did not specify gender identity. The participants were asked to assess the accuracy of perceptions regarding S.I that exist in psychological and psychiatric literature. Most of the participants believed that S.I is a way of expressing emotional pain and anger and can be used as a means of staying in control.
The survey found that there was a consensus from participants that it was not just a "women's problem, a failed suicide attempt, a sign of madness or Munchausen's disease" (Warm, et al., 2003, p. 75). More importantly in respect of clinical interventions, there was overwhelming agreement that people who engage in S.I should not be forced to stop and should not be treated as psychiatric patients. The Survey by Warm, et al. (2003) gave voice to the individuals who engage in S.I and provided an opportunity to challenge some common misconceptions which often lead to negative attitudes and/or attitudinal barriers

to accessing services and/or treatment.

Parkes, and Freshwater (2012) found that eleven women included in their study gave different reasons for why they choose to hurt themselves and that they engaged in S.I in "an attempt to draw attention to their plight. This 'cry for help' should not be confused with mere 'attention-seeking' behaviour. On the contrary, these women wanted to communicate their desire to end the difficulties they were experiencing and for their 'pain to stop', albeit temporarily". Moreover, people who self-injure are considered 'attention-seeking' in the derogatory sense (Gratz, 2003; Klonsky, May, & Glenn, 2013). Hjelmeland, Knizek, and Nordvik (2002) and Warm et al (2003) concur with Parkes, and Freshwater (2012) suggesting that the immediate motivation for S.I can vary between individuals. Several women expressed that their primary reason for S.I was to release pent-up emotions and tension, or to communicate to others extreme feelings of unhappiness. This view is substantiated by the studies of Bockian (2002) and highlighted in the plight of one 38-year-old female participant engaging in S.I who expressed,

> I feel like a pressure cooker that's going to explode. Cutting and bleeding sufficiently is like letting out the steam. If I do this to my satisfaction, I feel immediate relief, as if injected with Valium or something. It helps stop the inner turmoil for a while (Bockain, 2002, p. 19).

Hu, Taylor, Li, and Glauert (2017) conducted a study examining the meanings and functions associated with S.I. Their study found that out of the 26 women who participated, 19 linked their S.I behaviour to their experience of Childhood Sexual Abuse

(C.S.A). They expressed that S.I provided a cleansing effect, related to their sense of "dirtiness" because of the CSA they experienced. Hayes, Follette, and Linehan (2004) reviewed existing theoretical and empirical literature on survivors of C.S.A, with specific emphasis placed on the impacts of C.S.A and the notion of resilience and coping strategies in the lives of CSA survivors. They highlight how survivors of multiple traumatic events during childhood are drawn to ineffective coping strategies or mechanisms including S.I. Parkes, and Freshwater (2012) suggest that the positive after-effects of self-injurious behaviour strongly reinforced its benefits for most of the individuals in their study. They propose that the activity releases chemical endorphins in the brain which aid the creation of euphoric feelings in the person, leaving them with temporary feelings of calm. Chakraborti, Arensman, and Leahy (2021) focused their qualitative study on participant's experiences and meaning of engaging in repeated episodes of S.I. All four participants- two male and two female- had a history of traumatic childhood events relating to physical, emotional and sexual abuse and often engaged in S.I to prevent flashbacks and other painful memories. In a number of clinical case studies, authors have highlighted how S.I may be understood as a way of coping with trauma (Gardner, 2001; Turp, 2003; Yakeley & Burbridge-James, 2018). Numerous studies have provided good insight into the motivation and meaning of S.I, with similar findings spanning the literature for over two decades as illustrated in this literature review. The review, however, found that the studies focused primarily on women, despite S.I being a growing problem across age and gender.

Self-Injury: A Growing Concern Across Genders

There is extensive evidence to suggest that S.I is a global widespread and growing mental

health concern, particularly among school-aged youth, adolescents and emerging adults (Chakraborti et al., 2021; Lewis & Heath, 2015; Swannell & Sarah, 2021). Numerous studies concluded that the incidence of repeated S.I is reasonably high among young adults who present to hospital emergency departments (Doyle et al., 2017; Murphy et al., 2019; National Suicide Research Foundation, 2019). Although the rates of S.I appear to be higher amongst women, Taylor, (2003) supports the view that most of the literature relating to S.I primarily focuses on women. Furthermore, Adamson and Braham (2011) argue that the current knowledge regarding S.I is primarily focused on women, in particular white women with a diagnosis of Borderline Personality Disorder (B.P.D). Chen and Chun (2019) propose that it is probable the literature focuses on females as they are perceived to be more likely than males to engage in S.I.

Ogrodniczuk, and Oliffe (2010), suggest that there is a reluctance amongst males to engage in help seeking behaviour and the studies of Galdas, Cheater, and Marshall (2005) postulates that men seek help for mental health issues less often than women. The Irish National Suicide Research Foundation, NSRF (2018) report which includes statistics on S.I found the male rate of S.I was 193 per 100,000, 7% higher than 2017. The female rate of S.I in 2018 was 229 per 100,000, 5% higher than 2017. Thus, the female rate S.I in 2018 was 7% higher than it was in 2007 whereas the male rate in 2018 was 19% higher than 2007. Furthermore, when considering prevalence rates amongst young people, Doyle, Treacey, and Sheridan (2015) found that only “a small minority of young people presented to hospital as a result of their last attempt to harm themselves (6.9%, n=7) or any previous attempt to harm themselves (11.8%, n=12)”,(p.489). It is fair to argue that the actual presentations recorded by the National Self-Harm Registry Ireland are merely the tip of the iceberg.

Table 1 below provides a summary of the changes in the number of presentations and persons since the National Self-Harm Registry Ireland reached near national coverage in 2002.

Table 1.

	PRESENTATIONS		PERSONS	
Year	Number	% Difference	Number	% Difference
2002	10,537	-	8,421	-
2003	11,204	+6%	8,805	+5%
2004	11,092	-1%	8,610	-2%
2005	10,789	-3%	8,594	-<1%
2006	10,688	-1%	8,218	-4%
2007	11,084	+4%	8,598	+5%
2008	11,700	+6%	9,218	+7%
2009	11,966	+2%	9,493	+3%
2010	12,337	+3%	9,887	+4%
2011	12,216	-1%	9,834	-<1%
2012	12,010	-2%	9,483	-4%
2013	11,126	+<1%	8,772	-8%
2014	11,189	+1%	8,708	-<1%
2015	11,445	+2%	8,791	+1%
2016	11.445	+2%	8,876	+1%
2017	11,620	+2%	9,114	+3%
2018	12,588	+8%	9,785	+7%

National Self-Harm Registry 2018 Annual Report (Published 2019).

Turner, Baglole, Chapman, and Gratz (2019) postulate that little is known about the day-to- day experiences of males who engage in S.I. However, Hjelmeland et al. (2002) included male and female participants in their study (41men and 48 women) showing virtually no gender differences with respect to the motivation and/or meaning to the functions that S.I provided.

Between January 1st and December 31st 2017, there were 223 episodes of SI recorded in Irish prisons, involving 138 individuals. Most prisoners were male (80%), 39% of the S.I episodes recorded by the prison did not require medical attention and therefore, are not included in the figures provided by N.S.R.F as they only document hospital presentations. These figures suggest an overall under reporting of S.I, however, considering 80% of the sample were male, it also highlights how the male population are not fully represented in the annual figures reported in Ireland. It appears that existing literature on S.I weighs heavily toward women whilst figures relating to men is primarily focused on the male prison population. An additional factor that must be considered is highlighted in a study by Cannon, and Umstead (2018) who highlight that men often engage in indirect forms of S.I, that are perceived to be stereotypical male behaviours, such as substance abuse, unsafe sexual behaviour and punching walls, as opposed to direct S.I behaviours, such as cutting and burning. However, in contrast, the Irish Prison Report (2017) reported ‘self-cutting’ and/or ‘scratching’ as the most prevalent form of SI representing 60% of recorded S.I episodes, and although most incidents of self-cutting were less severe, the report found that the risk of repetition was elevated. The scant literature addressing men and S.I is a cause

for concern and possibly fuels the assumption that S.I is primarily a women's problem. Where research is available, men are further stigmatised as research usually focuses on the prison population. It could be assumed that men who engage in S.I are more violent than men who do not. There appears to be insufficient evidence in existing literature to draw this conclusion and moreover, this view could possibly lead to additional attitudinal barriers for men in accessing mental health support services. Given the complexity of the S.I behaviour, it is not surprising that there are so many negative attitudes and/or attitudinal barriers in relation to S.I behaviour, especially in cases of repeated acts of S.I. While it could be expected that with enhanced understanding of the motivations, meanings and awareness of S.I, it might reduce attitudinal barriers; unfortunately, the existing literature does not appear to support this view.

Attitudinal Barriers and the Risk of Suicide

Saunders, Hawton, Fortune, and Farrell (2012) propose that, despite efforts to increase awareness and educate professionals on S.I behaviour, negative attitudes towards people who engage in S.I appears to remain consistent over time. Conflictingly, though reassuring, it is important to note that according to McCarthy and Gijbels (2010), following training of Emergency Department nursing staff, staff demonstrated greater empathy and confidence when managing patients who present with S.I.

Less than half of those who engage in S.I disclose their self-injurious behaviour, Park, Mahdy and Ammerman, (2021; 2020). Nielsen and Townsend, (2018) conducted a study which incorporated vignettes to ask adults how they would respond to a disclosure of S.I.

A total of 355 adult participants took part in the study. The majority of the sample were female (73.5%) and white (84.5%) (2.3% black, 7.0% Asian, 2.8% mixed background, 3.4% unspecified/other). Participants ranged in age from 18–67 years. Four participants (1.1%) did not specify their age. “The community sample was self-selected, with participants responding to poster, e-mail and word-of-mouth advertisements” (p.483).

Participants were not pre-screened for, nor excluded, on the basis of personal S.I history. Participants who engaged or had a history of S.I may have a greater understanding and degree of compassion and empathy towards the motivations that lead to S.I. Notwithstanding this, participants may have a negative perspective if they had difficult experiences of S.I, such as their own children or other family members engaging in S.I. Moreover, they may have worked as health professionals. If they shared such experiences their response may be influenced by these encounters and not represent the view of the general public who do not have personal experience of S.I. Notwithstanding this, one might question the motivation to partake in the study and query if their motivation was fuelled by personal experiences of perhaps their own S.I or S.I of people that are known to them. It is reasonable to expect that their opinions may vary based on these factors. Although this study is interesting in that it documents responses to the perceived motivation behind S.I, it may have been helpful to have screened participants for experience of S.I with either themselves or others, as opposed to asking what level of knowledge they had with respect to the issue. The majority of the sample (73.4%) had low to moderate familiarity with S.I. The findings demonstrated substantial differences in individual responses based on the assumed motivations of a person's S.I. Community samples specifically reported they were more likely to ignore the S.I if they perceived the S.I to be attention- seeking in nature. Moreover, rejection- related responses decreased

when the underlying motivation of the S.I was perceived to assist in 'regulating emotions' or as a means of 'self- punishment'. Furthermore, individuals were more willing to offer help when the perceived purpose of S.I was to escape or reduce negative emotions.

Duffin (2010) suggests that some professionals view people who engage in S.I as manipulative and attention-seeking. This can be particularly damaging when we consider that a trigger to S.I can be as a result of low self-worth and/or having suicide ideation. Therefore, being met with negative reactions from professionals can possibly make them feel worse and act as a barrier to seeking the necessary supports. Some studies have concluded that the perceptions of staff in the accident and emergency department towards patients who S.I were mostly negative (Mackay & Barrowclough, 2005; O'Connor & Glover, 2017). Moreover, it appears that there is an assumption that people who engage in S.I enjoy pain and/or should be punished for engaging in such behaviour, (Pembroke, 1994). Considering these attitudinal barriers and when factoring in the difficulty in witnessing the physical manifestations of S.I, it is hardly surprising that the actual prevalence rates of S.I go underreported.

Pembroke (1994) reported that in some cases people who present to hospital following episodes of S.I have their injuries stitched or attended to without pain relief, however, existing literature highlights that those individuals who engage in S.I have stated they did so to manage, avoid or release difficult emotions (Stänicke, 2021). It sounds paradoxical to say that hurting can be healing, but this is precisely what many people who cope through S.I are seeking and may do so in the hope of finding healing and relief from intolerable states of mind (Parkes & Freshwater, 2012). Therefore, being met with adverse negative attitudes when attending a hospital can result in the individual having a sense of been

punished for their S.I behaviour. Pembroke (1994) highlights the issue of punishment which was discussed at the ‘Looking at Self-Harm’ Conference held in 1989, where a speaker referred to extremely explicit presentations of S.I and the “outright physical abuse” suffered by the patient, in the form of “inadequate anaesthesia” when stitching self-inflicted wounds (p. 17) and that such behaviour is “common” in Accident and Emergency Departments (Pembroke, 1994, p. 3). The aspect of punishment was further supported by participants who shared their personal experiences of punishment meted out on them following S.I through self-poisoning. In more recent times, Williams et al., (2020) also reported that health professionals intentionally withheld particular treatments from patients, such as pain-relief medications, during the treatment of self-inflicted wounds (Owens et al., 2015; Anonymous, 2016). These actions were cited as being related to professionals assuming that these patients enjoyed pain (Anonymous, 2016) or that they were less-deserving of treatments (Owens et al., 2016). It appears that educating and raising better awareness and understanding of S.I behaviour in an effort to reduce attitudinal barriers, tends to focus solely on knowledge acquisition on specific conditions, albeit around emotive presentations, such as B.P.D and S.I, (Choi, DiNitto, Marti, & Choi, 2016). Perhaps a different approach to education is warranted if negative attitudes appear to have remained consistent over time. There is a growing body of evidence which suggests that involving people who have personal experience of living with mental health issues, including S.I and suicide ideation can create a positive impact in nursing education (Happell, et al., 2018

Haw, Hawton, Houston, and Townsend (2003) concur that conflicting findings have been reported regarding the relationship between the potential lethality of acts of S.I and suicidal

ideation or intent. Carroll, Metcalfe, and Gunnell (2014) suggest that approximately half of all people who complete suicide have previously engaged in an episode of S.I. However, many perceive S.I as a coping strategy albeit a potentially dangerous coping strategy. Much of the existing literature proposes that the desired outcome of S.I is to provide temporary relief with an aim to staying alive rather than dying. In contrast, Bergen, et al. (2012), report that S.I is the strongest predictor of future suicide, and McMahon, et al. (2014) also concur, noting the strong association between S.I and suicidal intention. A six-year follow-up study by Sinclair, Hawton, and Gray, (2010) reported that patients who engaged in S.I experienced higher overall levels of mortality and lower quality of life, although this study did not differentiate between people who were suicidal and those engaging in non-suicidal self-injury. Furthermore, individuals who engage in S.I might be ambivalent in their intent to die, with some episodes associated with more intent, and suicidal ideation might increase over the course of engaging in S.I. The conflicting views in the literature reviewed could lead to uncertainty for psychotherapists and other professionals supporting the client who presents with S.I. This raises the issue as to whether S.I should be viewed as a means of coping, therefore, aiming to replace the S.I with alternative healthier coping strategies, or does the therapist treat the client for suicidal ideation, which would require a crisis intervention approach to therapy? It appears the most appropriate response would be to ask specifically if there is any intent to die or previous suicide attempts and base the intervention on the client's actual presentation rather than drawing one's own conclusions.

There are assessment models which can assist in this process, for example a nine- item questionnaire: The Patient Health Questionnaire (P.HQ9) that was developed by Spitzer

and Brown, Williams, and Collins (2007). The questionnaire is limited to how people have being feeling over the last two weeks and asks if people “thought they would be better off dead or of hurting themselves in some way” P.HQ 9 (2007). This is the final question on the questionnaire, and it does not ask if there have been previous suicide attempts or if the person has a plan to die by suicide. The questionnaire due to its two-week limitation may miss vital information, as it has been reported that people who present to hospital as a result of S.I have increased risk of further S.I and completed suicide, (Bergen et al., 2012, Carroll, Metcalfe, & Gunnell, 2014; Hawton et al., 2015). Moreover, The C.A.M.S model has been investigated across various patient populations in both non-randomized comparison trials (Ellis et al., 2015; Ellis et al., 2017; Ellis, Rufino, & Allen, 2017) and randomized controlled trials (R.C.T), finding C.A.M.S to be an effective and in comparison to other models C.A.M.S is considered a superior treatment approach for reducing suicidal ideation (Comtois et al., 2011; Jobes & Joiner, 2019; Ryberg, Diep, Landrø, & Fosse, 2019) and suicidal behaviours (Andreasson et al., 2016). Notwithstanding this, whilst it is easy to be critical of the conflicting views of SI, and the risk assessment process, Morrissey, Doyle, and Higgins (2018) address the complex and ambiguous relationship between SI and suicide, noting that the line between S.I and suicidal ideation is often blurred. McMahon, et al. (2014) concur and suggest that people who have engaged in S.I are 100 times more likely to die by suicide than the general population. Despite the conflicting arguments of previous studies, it is worth holding this view to the forefront when working with S.I to ensure the safety of the client. McGough et al., (2021, p.66) examined mental health nurses’ perspectives on people who S.H; one of the fourteen participants expressed what she would find helpful when working with S.I:

What would be useful is … getting the perspective of the consumers… someone who has self-harmed to be able to talk about it…because in that way it becomes more real…I found [it] helpful to see the perspective and with mitigating risks from the consumer's perspective.

Happell et al., (2020) conducted a study of 51 students completing their nursing education in a number of universities across Europe. Some students signified they "considered "Experts by Experience", (E.B.E), EBE-led knowledge more credible than knowledge presented from other sources (e.g, nurse academics, text books) and therefore, believed it would be more influential over their knowledge, development and clinical practice" (Happell et al., 2020, p.815). The sharing of personal experiences provides students with an opportunity to view patients through a different lens, as multi- dimensional people rather than a one-dimensional set of diagnostic criteria (Eriksson 2013; Gidman 2013; Meehan & Glover 2007; Ridley et al. 2017).

Negative emotional responses when working with S.I, with one participant expressing how S.I is disfiguring and considers it repulsive to counsellors. These findings are in line with the results of a number of other studies, (Long and Jenkins 2010; Fox, 2011;Whitlock et al. 2009).

Therapists Responses to Self-injury: Verbal and Non-Verbal

Bunclark, and Crowe (2000) suggest that the therapeutic environment, "acts as a container

of anxiety" (p. 51), which may well stir up strong emotions for the therapist themselves. Furthermore, considering that S.I is often preceded by great difficulty in tolerating painful thoughts and feelings, confronting this barrier by beginning to explore experiences of bearing painful circumstances within the therapeutic environment, can prove to be a difficult task for client and therapist alike (Nock, Teper, & Hollander, 2007) The existing literature related to the emotional response to the physical manifestations of S.I focuses primarily on medical staff within a hospital environment. As part of their training, medical staff receive specialist training to manage their response to witnessing traumatic injury to the human body, including open wounds, cuts, burns and bruises. Yet despite the severity of these traumatic injuries, some research studies indicate that the S.I presentation can evoke an increased emotional response in medical staff. Park, Mahdy and Ammerman, (2021; 2020) noted how individuals who engaged in S.I behaviour sought help with the hope of being treated as normal, however, their experiences with mental health professionals widely varied; some reported positive experiences of feeling supported and others revealed feeling as if they were perceived as a medical 'case' rather than a person. (Breakwell et al., 2006; Gratz, 2003) suggests that S.I is often viewed as a manipulative and attention- seeking behaviour that elicits feelings of shame, anger and irritability towards those who S.I. In comparison, psychotherapists focus on addressing mental anguish and/or psychological distress, but do not receive any training to prepare them for witnessing the physical manifestation of S.I, which can evoke a strong emotional response including visible shock, horror, anxiety and disgust (Fleet, 2010; Nafisi & Stanley, 2007; Walsh, 2008). (Whisenhunt et al., 2014) conducted a grounded theory study examining the impact on counsellors when working with S.I. The study included nine females and three male counsellors. They found that in general the participants shared negative emotional

responses when working with S.I, with one participant expressing how S.I is disfiguring and considers it repulsive to counsellors. These findings are in line with the results of a number of other studies,(Long and Jenkins 2010; Fox, 2011;Whitlock et al. 2009). Williams, and Gilligan (2011) conducted a study investigating the impact of young people's S.I behaviour on social care staff in residential social care settings. While the study initially sought to understand the professional responses from staff, it became apparent that such was the emotional impact of these incidents, many of the staff interviewed found it necessary to report the impact that the experience had on their personal lives also. Although the participants were not psychotherapists it could be argued that they may experience similar emotional responses/reactions to that of therapists as they too, are not trained medical staff. One social care participant in Williams and Gilligan's (2011) study relayed how she had a particular fear of blood and- although she was a vegan- she went to the butchers to purchase red meat in the hope of desensitising herself and felt herself panic at the sight of blood which she believed escalated the situation. Other participants reported nightmares, difficulty sleeping and an overall sense of been 'shook up' after witnessing S.I.

Favazza (1989) suggests that psychotherapists can experience an array of negative emotional responses when working with S.I, including "helplessness, horror, guilt, fury, betrayal, disgust and sadness", (p. 143). Sanderson (2006) supports this view maintaining that clinicians can experience a range of negative emotional responses including "a sense of powerlessness and inadequacy" (p. 287). Sexton, (1999) highlights that a client's self-destructive behaviour can result in the therapist developing a sense of "cynicism, despair and loss of hope" (p. 396). Furthermore, Figley (1995), outlines that working with this client base

may lead to compassion fatigue, and in addition, Sexton (1999), suggests that working with such clients can result in vicarious trauma impacting the therapist, however, he also proposes that although some therapists fail to acknowledge their emotional response and/or the impact of their work, remaining cold and objective, they can still be effective practitioners.

Simpson (2006) postulates that a major difficulty that arises when attempting to develop a therapeutic rapport with people who engage in S.I is caused by the inability of both the therapist and the client to form a reasoned understanding of this form of distress. De Stefano and Atkins (2017) suggest that in the therapeutic sphere, the attachment to the therapist is the catalyst that fosters, among other things, emotion regulation. The "containment" of safety provided by an empathic, responsive therapist allows the client to express upsetting emotions and thoughts. These characteristics, refined and nurtured by the therapist along with intentional communication both verbally and non-verbally (in addition to the demonstration of warmth, interest and support) are what soothes the client and helps build the therapeutic relationship. Long and Jenkins (2010) interviewed eight counsellors who worked with S.I and their findings promote the importance of the relationship as a 'unique entity' supporting Rogers' (1967) notion that the therapeutic relationship is fundamental to therapeutic outcomes for clients" (p.192).

The 'squeamish factor' may also be a response for the therapist when confronted with S.I such as visible cuts or burns. However, it is also important to note that some therapists may not experience adverse physical or emotional responses when confronted with the physical

manifestations of S.I. Turp (1999) posits that if the therapist is not shocked or disgusted by the manifestations, it can bolster the therapeutic relationship. Nonetheless, this seems to be a tall order for therapists to aspire to and might indicate that the outcome of the therapeutic process may not be as positive in comparison to the therapist who reacts or finds open wound, weeping sores and blood distressing and/or difficult to tolerate. However, it appears that insufficient research exists to substantiate this viewpoint. In contrast, Yalçin, et al. (2015), outline that a potential challenge for even the most experienced clinician is the “squeamish factor”, particularly with Skin- Picking Disorder (S.P.D), as clients often present with newly opened sores, that are weeping and look painful. People with S.P.D often engage in what is described as “post picking behaviours”, and studies show that 32-35% will eat the skin afterward, Snorrason et al., (2011); Wilhelm (1999). Notwithstanding this, Turp (1999) appears to consider the fact that the client may already feel self-conscious, repulsed and ashamed by their own appearance and therefore, attuned to the verbal and nonverbal ways in which the therapist manifests their negative response and/or attitudes.

Although it is accepted as best practice that therapists attend regular supervision, it is particularly relevant when engaging with clients presenting with S.I behaviour, to receive supervisory support when managing emotional responses, and adverse reactions to the more difficult or explicit physical manifestations as S.I. Furthermore, the therapist’s supervisor must possess an ability to contain the therapist’s adverse emotional response which can include a strong sense of shame and/or sense of failure as a clinician brought about by the difficult nature of the work. According to Morrissey (2015) “working with people who engage in self-harming behaviour”, and/or extreme S.I can result in the

therapist "being exposed to a range of intense and extreme emotions; thus, practitioners need to pay attention to their own well-being not only for the sake of themselves but also for the people they work with and their colleagues" (p. 40).

Elliott, Watson, Goldman, and Greenberg (2004) postulate that non-verbal charismatic communication is distinct from such constructs as empathy, congruence and positive regard. However, this study does not suggest that charismatic communication is required in response to the physical manifestations of S.I, but places emphasis on the importance of the non-verbal communication in the therapy room and its implications for the therapeutic relationship. Antonakis et al. (2011) posits that charismatic personalities possess the ability to articulate themselves through voice characteristics, body movements, and facial expressions that are considered to inspire others. Furthermore, non-verbal communication can be easier to sense than it is to define, and our non-verbal communication can speak volumes. Roter, Frankel, Hall, and Sluyter (2006) note that there is a significant amount of literature and several well-established tools for measuring non-verbal sensitivity. The ability to judge another's emotional expression is one of the defining facets of the concept of emotional intelligence. Most measures of non-verbal sensitivity assess accuracy in the recognition of emotions as expressed by others; such sensitivity is known broadly as a human decoding skill. We define non-verbal behaviour to include a variety of communicative behaviours that do not carry linguistic content. Roter et al., 2006, p. 28 propose that this includes:

> Facial expressivity, smiling, eye contact, head nodding, hand gestures, postural positions (open or closed body posture and forward to backward body lean);

> characteristics such as speech rate, loudness, pitch, pauses, and speech dysfluencies; and dialogic behaviours such as interruptions. Nonverbal behaviour is widely recognized as conveying affective and emotional information. (Roter, et al., 2006, p. 28).

More poignantly, Roter, et al. (2006) suggest that "it is the largely untapped healing power of the emotional connection between patients and physicians" (p.28), assuming that the non-verbal communication is positive in nature.

It is accepted that effective practice depends to a great extent on the quality of the therapeutic relationship and the communication therein. According to McLeod (2013) who examined the literature concerning what clients describe as both helpful and unhelpful in the therapeutic process. McLeod (2013) concludes that there is sufficient evidence expressing that the relationship factor of therapy was more important than the use of therapeutic techniques or approaches. Morrissey (2015) shares a similar view and suggests like any "therapeutic/helping relationship, a genuine respectful relationship that is collaborative, compassionate and supportive is essential for working with someone who hurts themselves" (p. 38). However, O'Donovan, and Gijbels (2006) report that medical staff, viewed working with people who engage in S.I as both challenging and frustrating. One participant stated that this frustration arose when they were treating an individual who had stopped self-injuring for a while but relapsed. The sense of being challenged and frustrated when treating individuals engaged in S.I can impact negatively on the connection between clinician and client and communicated unconsciously nonverbally. Furthermore, according to Snorrason, et al. (2011); and Wilhelm (1999), individuals

diagnosed with SPD often engage in what is described as “post picking behaviours” and studies show that 32-35% will eat the skin afterward. One can appreciate the strong emotions encountered whilst working with this form of S.I and the risk of adverse nonverbal reaction.

Existing literature highlights that many people who engage in S.I are dealing with loss and rejection issues (Banks, 2006; Shaw, 2000, and Trepal, 2010). Long (2018) posits that in addition to issues of loss and rejection, people who S.I are subjected to moral and physical stigma. Moral- on the basis of perceived mental ill health and the physical- due to visible wounds and scars on their body (Goffman, 1963). The creation of a trusting therapeutic alliance with transparent communication both verbal and non-verbal is therefore, immensely valuable. The experience of a secure and trusting relationship between client and therapist can be corrective and fruitful (Muehlenkamp, 2006), and Trepal (2010) suggests that the formation of a connection with the therapist can serve as a model of a healthy relationship, and it may promote and enhance a client’s relationship with others.

It is clear that real connection is required for successful therapy and this is based on the genuine and authentic feelings of client and therapist towards one another- feelings that differentiate a real connection from a transference relationship. Moreover, according to Murphy, Cramer, and Joseph (2012) the process of therapy involves mutual experience of the core conditions identified by Rogers (1995): empathy, acceptance, unconditional positive regard and congruence. However, it appears that the S.I presentation can challenge these conditions within the therapeutic relationship. Hence, the need for reflective practice which can be facilitated through the form of supervision.

Turp (1999) a psychodynamic psychotherapist, writes about her personal experience of working with clients engaged in S.I and states that, “more than once, I have felt my own ability to maintain a therapeutic presence pushed to the limits by a client who self-harms” (p. 311). According to Turp (1999) we need to develop and communicate a better understanding of the needs of practitioners who encounter S.I; many do not have the support which would encourage a practice of thoughtfulness. Supportive supervision and training which help clinicians to make sense of the self-injurious behaviour they witness is also vital. “Until there are changes in thinking in some quarters, clients will continue to present for counselling or psychotherapy with a legacy of dismissive or punitive responses and a consequent reluctance to confide in us about their self-harming behaviour” (Turp, 1999, p. 311)

If the concept of S.I is difficult for clinicians/therapists to understand and they find it difficult to tolerate the physical manifestations of S.I, the impact on the therapeutic relationship when struggling to contain the non-verbal reaction must be considered. Furthermore, the ability to empathise, accept and remain non-judgemental- which ultimately is the core condition of therapy- may be considerably reduced in this case. Klonsky, and Muehlenkamp (2007) propose that “the key to effectively treating self-injury will lie in the clinician’s ability to form an empathic, non-judgmental relationship with the client” (p. 1053). Long, and Jenkins (2010) propose that research affirms the belief that the therapeutic relationship is central for therapists working with clients who engage in S.I and there is extensive literature pertaining to S.I with specific emphasis placed on the meaning and function of S.I. However, there is a paucity of literature relating primarily to

the physical manifestations of S.I within therapy and how this impacts upon non-verbal communication within the therapeutic relationship.

It appears that existing literature on S.I fails to address the important issue on whether therapists should comment on fresh wounds, and that how they communicate either verbally or non-verbally might affect the therapeutic relationship. Existing literature does not sufficiently identify whether clients would see this enquiry as caring or obtrusive. Notwithstanding this, Burke, Ammerman, Hamilton, Stange, and Piccirillo (2020) found that some people who S.I have "positive beliefs about their scars, including that they represent their physical and emotional strength and serve as sources of hope and pride" (p.314). Jagger, and Sterner (2016) devote a subsection of their article to this topic and propose that approaching the topic of excoriation should be done in a sensitive and respectful manner so that the therapeutic alliance is preserved. Furthermore, Burke et al., (2020) conducted a study involving 505 participants. 42% were female and 76% were white. Some participants had more than 50 scars on their body from SI. Moreover, the study found that "79.5% (*n* = 221) endorsed concealing their scarring from others and 63.7% (*n* = 177) endorsed concealing their scarring from themselves at least sometimes. Furthermore, a majority, 62.6% (*n* = 174) endorsed concealing their scarring from themselves *and* others at least sometimes, 16.9% (*n* = 47) endorsed concealing their scarring only from others (and not themselves), at least sometimes, and only 1.01% (*n* = 3) endorsed only concealing their scarring from themselves (and not others)" (p.316). This is an interesting study and coincides with (Burke et al. (2020) who note that scar concealment from others is highly common. However, one of the limitations of the study is that it did not address if people who S.I take offense to professionals acknowledging

their scars, or if they perceive it as caring or obtrusive.

Conclusion

Having examined the literature, this review concludes that there is a considerable amount of research based on S.I in general, that places emphasis on the meanings, functions and motivations behind S.I and the relationship S.I bears to suicide. However, there appears to be a paucity of research specifically related to the impact that witnessing the S.I presentation has on the therapist. This is surprising given the prevalence of S.I as outlined in the literature included in this study. Moreover, when this issue is addressed within research studies it tends to feature only as a subsection of what is considered a more important issue.

The literature reviewed offers therapists an improved knowledge and understanding of S.I and the physical manifestations of psychological distress that may present in therapy. Fleet and Mintz (2013) highlight that working with clients who engage in S.I has a significant impact on the therapist. Having worked for over 13 years as a psychotherapist primarily with clients presenting with S.I, it became apparent over time that further in-depth research needs to be devoted to deeper exploration of the S.I presentation and the risk of adverse impact on the therapist and client. Therefore, this study has sought to focus on the experiences of therapists who were exposed to the physical manifestations of S.I, with the purpose of informing therapists, contributing to the research base and above all, giving voice to the lived experiences of those who have shared this experience but have yet gone unheard in the empirical literature.

Chapter 3: Methodology

Introduction

This chapter will provide a context for implementing this research methodology; the aims and objectives of the research are reviewed within this chapter and include an overview of I.P.A and its origins. In addition, this chapter will discuss the research positioning, data gathering, sampling, recruitment and data analysis. Finally, the ethical considerations and the overall quality of I.P.A research will be discussed.

The intention was to capture a rich, in-depth, and detailed account of the lived experience for therapists, and that a qualitative approach- in particular a phenomenological approach- would therefore, meet this criterion. Specific focus was placed on moving beyond a mere description of their experience and toward gaining insight into how participants made sense of the phenomenon and reaction in their everyday lives. The emphasis on 'sense-making' pointed in the direction of Smith's (2009) I.P.A method. I.P.A represents a qualitative approach to research, which aims to offer insights into how a given person, in a particular context, makes sense of a given experience. I.P.A has its theoretical origins in phenomenology, hermeneutics and idiography and as one of several approaches to qualitative research, is distinctive because of its combination of interpretative, and idiographic components.

Research Aims and Objectives

The overall aim of this study is to gain an in-depth understanding of the therapist's experiences of witnessing the physical manifestations of self-injury. The principal objectives are:

- To capture the therapist's lived experience of witnessing the physical manifestations of S.I.
- To gain an understanding of how this has affected them personally and professionally.
- To discover what therapists regard as the most challenging aspects of witnessing these events.
- To illuminate the strategies that therapists use to manage the presentations that they have witnessed.

As a novice researcher, it was difficult to arrive at a decision as to which research methodology would be most suited to ensure the successful execution of this project. On a personal level, I appreciated the step-by-step approach offered by I.P.A and the idiographic component ensured that each participant's story was captured in its uniqueness. According to Cresswell and Poth (2016) qualitative research is conducted when a problem needs to be 'explored' and that exploration is needed in circumstances in which variables cannot be easily measured. Hence, I considered I.P.A particularly suited to exploring a distinctive and multifaceted phenomenon as in therapists' experiences of witnessing S.I.

I.P.A as a Research Methodology

I.P.A is a relatively new approach that has become more popular in qualitative research and is rooted in psychology. When considering I.P.A as the methodology for this study, it was important to examine its philosophical underpinnings because, as Lopez and Willis (2004) observe, "implementing a method without an examination of its philosophical basis can result in research that is ambiguous in its purpose, structure, and findings" (p. 726). Notwithstanding this, as a novice I.P.A researcher, I struggled in becoming knowledgeable and confident in the method and despite reading numerous I.P.A studies and reading about the underpinning philosophy, I relied heavily on my supervisor's knowledge and guidance to assist me in my understanding, until such time when I finally came to terms with the methodology.

I.P.A is underpinned by three main philosophical ideas, phenomenology, hermeneutics, and idiography. The I.P.A approach has been strongly influenced, by the work of four main figures in the study of phenomenology, Edmund Husserl, Martin Heidegger, Maurice Merleau-Ponty and Jean-Paul Sartre. Smith, et al. (2009) suggest that Husserl's work highlights the importance of concentrating on lived experiences and the insights it provides. Husserl's studies were further developed by Heidegger, Merleau-Ponty, and Sartre, and it appears that their philosophical approaches assume that "a person is embedded and immersed in a world of objects and relationships, language and culture, projects and concerns", (Smith, et al., 2009, p. 21). Phenomenology is "a science which aims exclusively at 'knowledge of essences' (Husserl, 2012, p. 3). In this instance the goal of this study was to bring the participants back to the things themselves, in order for them

to recant their stories in an evocative and embodied way, as they made sense of their experiences.

According to Smith, et al. (2009), hermeneutics can be broadly defined as, “the theory of interpretation”, (p. 21) and Friedrich Schleiermacher, Martin Heidegger, and Hans-Georg Gadamer are the three key contributors to hermeneutics. As Smith, et al. (2009) explain that “following Heidegger, I.P.A is concerned with examining how a phenomenon appears and the analyst is implicated in facilitating and making sense of this appearance”, (p. 21). However, I.P.A recognises that this depends on what the participants reveal about their experience. Smith, et al. (2009) suggest that close interpretation is essential to make sense of what is said or written and discuss the importance of the hermeneutic circle, which “is concerned with the dynamic relationship between the part and the whole at a series of levels” (Smith, et al., 2009, p. 28). They note that this dynamic relationship stems from the fact that although we understand words by looking at their roles in the larger context of the sentence, we are also aware of how the meaning of that larger context; the sentence relies on the words. Smith, et al. (2009) also highlights the phenomenon of “double hermeneutics”, which occurs when the researcher adds his/her own interpretation to the one provided by those who have directly experienced the events concerned. Essentially, I.P.A appears to rely upon both phenomenology and hermeneutics because it aims to get as close as it can to the participants’ experiences. However, I.P.A remains aware that this is an interpretative process and both of the core elements are essential, “without the phenomenology, there would be

nothing to interpret; without the hermeneutics, the phenomenon would not be seen", (Smith, et al., 2009, p. 37).

The last key element that has influenced I.P.A is its idiographic focus. Idiography looks at a particular case in detail, and/or investigates how a particular person in a particular context makes sense of a particular phenomenon. Wadeley et al. (1997) suggests that by acknowledging the 'uniqueness' of an individual's perspective, the idiographic focus aims to give more depth to the analysis. Furthermore, Pringle, Drummond, McLafferty, and Hendry (2011) maintains that the "idiographic approach focuses on the individual's cognitive, linguistic, affective, and physical being" p. 21). I.P.A allows the participant's individual experiences to stand alone while allowing room to manoeuvre and make more general and wider claims as the analysis proceeds. Its focus is the in-depth exploration of the convergence and divergence of individual participant experiences (Miller, Chan, & Farmer, 2018).

Researcher Positioning

How the researcher positions oneself concerning the topic, the data, the participants, and the overall study process is of immense importance. I.P.A acknowledges that the researcher will have some knowledge of literature written in the research area, however Smith, et al. (2009) suggests that the researcher must not be positioned/influenced by a particular theory. With respect to the existing literature, I was aware of what the literature was saying, but aimed to hold my presuppositions in awareness and make every attempt to

bracket them and hold them in suspension to remain focused on hearing what the participant's experience was. Bracketing allows the researcher to understand and describe human experience without any prejudice, analysis or interpretation (Husserl, 1970). By doing this, the researcher adopts a "phenomenological attitude" (Finlay, 2009, p. 8) Smith et al. (2009) suggest that care should be taken, to minimise the researcher's bias in the process of selecting themes for analysis and the analysis must remain centred on the participant's account of their experience.

Many years of experience in psychotherapeutic practice have afforded me the opportunity to work with individuals who presented with S.I. However, despite the presentation similarities, everyone's story/narrative is unique not by the content but by the meaning placed upon them. Hence lies my interest in meaning and meaning-making, and what ultimately wove the research topic and I.P.A together. Notwithstanding this, much consideration was given to the fact that I was an "insider researcher" (Costley et al., 2010), having worked for many years providing both therapy for people who S.I. and supervision to some therapists doing this work. My own experiences therefore, posed some challenges regarding the integrity of the research. For example, there was a possibility that participants may not disclose the entirety of their experience to a peer, and a possibility that my interpretation of the data may be influenced by my own experiences of working with clients and therapists. To address these issues the participants were advised from the outset that while I was an accredited therapist and supervisor my role in this study was as a researcher and not as a psychotherapist. The integrity of the interpretation of the data was upheld by regular auditing of the analytic process by my

academic supervisors and reflexive journaling to identify my biases and blind spots.

Data Collection and the Semi-Structured Interview

Various methods of data collection can be used in an I.P.A study, such as focus groups or accessing participant's diaries. However, this study used one-to-one semi-structured interviews, which are usually employed in IPA studies Gill, 2014; Reid, Flowers, & Larkin, 2005; Willig, 2001) The semi-structured interview facilitated the exploration of the participant's individual experience, which is vital to IPA and therefore, makes this method of enquiry suitable for this study. A short interview schedule was prepared (Appendix A), with questions regarding concerns and issues that affect therapists who have witnessed the physical manifestations of S.I. This method of interview was chosen for the research because it was important to record the spontaneous reaction of the therapist's and provided ample opportunity to probe deeper into the experiences of those interviewed.

The semi-structured interview format took place once with each participant for approximately one hour. The face-to-face interviews were audio-recorded at a pre-determined location that best suited the participant. I gathered data relating to the participant's experience on witnessing the physical manifestations of S.I. The interview questions were open in format to allow participants to be expansive about their lived feeling and the embodiment of witnessing such life events, providing freedom to express their experiences in a looser narrative format or context. The semi-structured interview approach aims to be flexible in nature, so that the researcher can follow the participant's story- in this case facilitating the participant to feel comfortable enough to describe in

detail the meaning they gave to the S.I phenomenon. The semi-structured interview process was outlined to participants, explaining that there were no right or wrong answers, and that the focus was on hearing what they thought was relevant and important to their personal stories.

Throughout the interview, my aim was to listen with a high level of interest and adopt a sensitive and empathetic approach. My previous experience in clinical practice facilitated the building of an empathic and trusting relationship with participants and allowed for the natural flow of conversation, which assisted and supported the participants' in sharing their experiences. Using semi-structured interviews also enabled a sense of rapport to develop between the participants and I and provided a safe space for the participant to think, to speak, and feel heard. This approach also assisted and enhanced the ability to remain focused on the participants expression, whilst keeping to the forefront that my role was to conduct a research interview and not a therapy session, remaining cautious of the danger of boundary blurring. This was a potential pitfall that I was extremely conscious of and wanted to avoid. Willig (2001) suggests that I.P.A provides close contact with the participant's world, therefore, the semi-structured interview was collaborative and enabled a dialogue to occur in which the participant was seen as the expert concerning their own experience.

I conducted a number of pilot interviews with colleagues to gain some experience of interviewing as a researcher and to improve and develop my skills in this area. Despite having experience of communicating with people professionally, this tended to be in the role of a psychotherapist/supervisor, interviewing to recruit staff or delivering

presentations. I was conscious that although my experience may be of benefit to me, I was going to be interviewing in a completely different capacity. I found it helpful to listen over and over to the recordings and I identified areas that I could have pursued. However, due to my lack of experience as a researcher, I often missed opportunities to probe deeper as I was too cautious not to engage in a counselling session. Once the formal process of interviewing began, the focus was placed not only on *listening* to the participants,' but also on *observeing* the participant's non-verbal communication and notes were compiled immediately following the interviews to remind me of these observations. I was conscious that the non-verbal communications would not translate to the audio recordings and felt it too important to be lost. Many of the participants-at times- placed their hands on their stomach or chest, whether consciously or unconsciously, conveying their experience through non-verbal gestures, which seemed to place greater emphasis on some of their expressions.

Data Analysis Methods and Stages

I.P.A has a structured analytic method that draws attention to participant's attempts to understand their experience. This analytic method is non-linear and can be a complex process. Smith, et al. (2009) suggests that there is no right or wrong way of carrying out this sort of analysis. However, I expect what Smith means is that there are numerous ways to analyse the data and leaves room for creativity, such as colour coding, coding by numbers or writing potential themes on different pieces of paper and attracting like-to-like to form the themes. I remained consciously aware that the final account is always about what the researcher interprets the participant is thinking and feeling. The literature on I.P.A

has not always been ‘prescriptive’ in advocating a single method for analysis of data. Rather, I.P.A espouses an analytic focus that makes sense of a participant’s sense making. In employing the I.P.A analytic method, every endeavour was made to making sense of the participant’s ‘sense-making’, thus creating a ‘double hermeneutic’ (Smith, et al., 2009).

Furthermore, the analysis entailed employing the ‘hermeneutic circle’, which involves moving between the part and the whole to capture and record the unique experience of the individual participants. Smith, et al. (2009) strongly recommend this stepped approach to analysis. The following are the essential steps in the process:

1. **Reading and Re-Reading the Transcripts:** A slow, sustained engagement and review with the original data was maintained throughout, interview by interview. This was the early process of “zooming in/focusing down”, (Smith, et al., 2009, p. 39), unfolding each account individually and in-depth. This allowed me not just to engage with the data but to dwell in it.
2. **Initial Noting:** This involved analysing the transcript for the language used, gaining an understanding of the context as described by the participant and identifying concepts to explore patterns within the transcripts. The transcript of one participant demonstrates how I engaged with this method, and how I homed in on words and phrases pertinent to their experience, where some words are underlined to demonstrate their frequency and relevance to the story. (Appendix B)
3. **Developing Emergent Themes from the Data:** Themes emerging reflected the richness of the data collected from each participant. These themes represent not only the participant’s original data but also my own interpretation of the data as researcher.

This was, checked against the original data to ensure that the connections between the participant's experience and the themes were credible. Transcript 1 highlights a section of the analysed transcript and where initial thoughts are documented in the right column and emergent themes in the left column. (Appendix C)

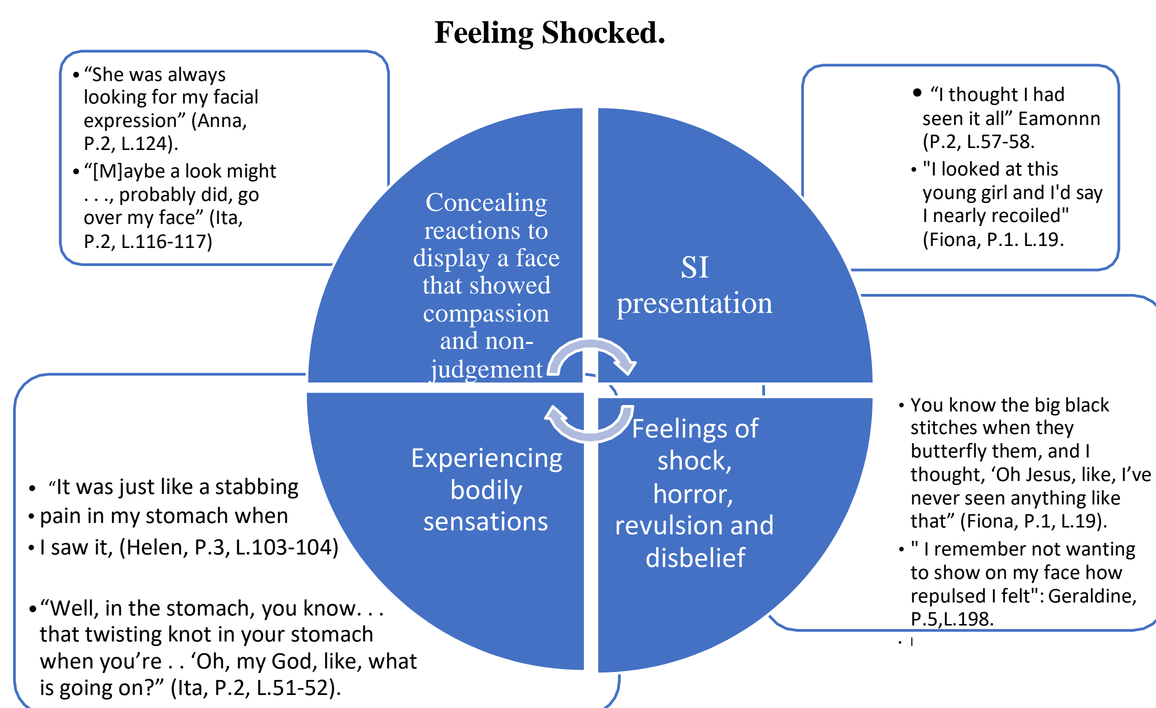
4. **Searching for Connections Across Emergent Themes:** The emerging themes were outlined on a table of themes, and a master table of subordinate themes was derived from the data. These themes were written on pieces of paper and placed on a large table. They were arranged and re-arranged in several sequence and through this exercise, the main pattern of themes became apparent. A deeper level of interpretation was expected to fulfil the double hermeneutic underpinning of I.P.A and focus on the number of times an emergent theme surfaced and/or a particular word used. This is not to say that the number of times a word appeared determined its value; it may only have presented once but deemed to hold importance for the participant and the researcher's interpretation. The I.P.A modes of 'abstraction' and 'subsumption' were used to create the various clusters into superordinate themes. Abstraction "involves putting like with like to develop a new name for the cluster", (Smith, et al., 2009, p. 101). 'Subsumption' allowed an emergent theme to become a superordinate theme due to its importance in bringing together related themes.

Looking for Patterns Across Cases: The analysis was a pain staking effort and took longer than I anticipated. This involved examining the convergence and divergence of themes across the data, "pointing to ways in which participants represent unique idiosyncratic instances but also higher-order concepts which the cases therefore share", (Smith, et al., 2009, p. 101). Finally, I searched for patterns across the

superordinate themes of each transcript to organise the master themes. The same method was implemented by writing on pieces of paper attracting like to like. **Table 2** demonstrates how the process took shape, beginning with overarching themes, superordinate themes and drilling down further to result in one superordinate theme and a number of subordinate themes.

Table 2. Master table of superordinate theme one:

Feeling Shocked.



The superordinate themes will be discussed and explored in detail in the following chapter, along with the subthemes associated with each superordinate theme. An example of key themes is outlined and includes the sub-themes that will also be discussed in the following chapter. Superordinate and Subordinate Themes are

illustrated in **Table 3.**

5. **Writing Up:** The study was written up in its entirety. This involved developing the data from a table and presenting it in a narrative account (Smith, et al., 2009). To demonstrate representative interpretations of the participant's understandings of witnessing the physical manifestations of S.I, I quoted direct passages of the text. Smith, et al. (2009) observed that the analytic method provides innovation and flexibility that helped me as the researcher to make sense of the participant's experience. The primary focus of I.P.A is the lived experience of the participant and the meaning which the participant makes of that lived experience, and the result is always an account of how 'the analyst thinks' the participant is thinking (Smith, et al., 2009).

Sampling, Method, Size, and Data Sources

The extent of 'homogeneity' is guided by the focus of the study; it is not intended to be statistically representative but rather 'information-rich' (Blore, 2012). Murray and Beglar (2009) state that "no study is designed to apply to all persons in all situations", (p. 157), hence the need to set limits to the study. Fade (2004) suggests that the case-study approach to I.P.A can be used to develop an in-depth description of just one individual's experience. Sometimes they may draw on the accounts of a small number of people (usually fifteen or fewer). Using a small sample size within the study was helpful to me as a novice researcher and allowed for nine participants to be scrutinized in detail as compared to a wider, shallow- as well as simply descriptive- analysis of several individuals (Heffron & Gil-Rodriguez, 2011). Participants in an I.P.A study are expected to have certain experiences in common with one another. A sample size of nine English-speaking

psychotherapists was recruited which allowed sufficient scope for comparison across cases while maintaining the quality of each individual analysis. The small-scale nature of a basic I.P.A study shows how something is understood in each context and from a shared perspective- a method sometimes referred to as ‘homogeneous sampling’.

Through purposive sampling, I.P.A allows the choice of a defined group for whom the research question will be significant. Smith and Osborn(2003) point out that this is a similar logic to that employed by the social anthropologist conducting ethnographic research in one community: that community is reported on in detail, but no claims will be made to generalise the findings to all other cultures (Smith, and Osborn, 2003). Nonetheless, the way the sample specificity is defined would hinge largely on the study; in certain instances, the topic that is being investigated might be quite rare and outline the boundaries of the pertinent sample. In other instances, when the issue being investigated is less specific, the sample could be drawn from a population that has the same socio- economic and/or demographic profile. The rationale is the same as applied by a social researcher executing ethnographic research in a specific community. The social researcher then presents detailed reports about a specific culture but does not make a claim to be able to generalize it across cultures.

However, over the course of time, through subsequent studies conducted later, it would be possible to make more general claims, wherein each would be grounded on an in-depth evaluation of an array of case studies (Smith & Osborn, 2007). Notwithstanding this, I.P.A allowed scope to apply inductive and iterative procedures that aided the researcher in developing an ‘insider’s’ perspective and ultimately, ‘theoretical transferability’ (Pringle, et al., 2011). Smith & Osborn (2003) further proposed that I.P.A

researchers usually try to find a 'fairly homogeneous' sample, the assertion being that if only a small number of participants are being interviewed, it is not constructive to force a consideration in terms of random or representative sampling. Fade (2004) postulates that researchers wishing to explore and/or develop theories for the shared meanings that a homogenous group of individuals attaches to a particular lived experience could/should make use of I.P.A as a framework for qualitative analysis.

One of the distinctive features of I.P.A is its commitment to a detailed interpretative account of individual participants as cases and increasingly researchers are recognising that this can only really be done with a small sample, thus sacrificing breadth for depth (Smith, and Osborn, 2008). Eatough and Smith (2006) plainly state that six to eight is recommended as an appropriate number of participants for a typical I.P.A study. Going beyond this could prove excessively burdensome for the novice I.P.A researcher. Between 2006 and 2009, the total number of I.P.A published studies was 136, with a mean sample size of twelve. Brocki, and Wearden (2006), and Cassidy (2011) have collated a coherent picture on the issue of sample size in I.P.A studies and have evidenced the legitimacy of smaller participant numbers. Perhaps Larkin (2013) best captures the essence of I.P.A participant selection/sampling when he advocates that these individuals are chosen above all else because they offer the researcher a level of insights from shared experiences. McAuley (2015) observes that in I.P.A the PhD minimum requirement would be between eight and twelve subjects. In general, I.P.A studies are conducted on small sample sizes due to the time consuming nature of the analysis and the aim of writing in detail about the perceptions and understandings of the participants (Smith et al., 2009). Moreover, I was mindful of practical issues such as the time constraint for completing the study and being a

novice I.P.A researcher. I therefore, considered nine participants to be a sufficient sample size for the study to achieve my goals: to capture rich and evocative accounts of the participants' stories and to attend, in detail, to the nuanced accounts and meanings of these stories whilst conducting the analysis. But perhaps the final words on sample size should be left to Smith and Osborn (2008) who state, "it should be remembered that one always has to be pragmatic when doing research; one's sample will in part be defined by who is prepared to be included in it", (p. 56). McAuley (2015) observes that in I.P.A the PhD minimum requirement would be between eight and twelve subjects. In general, I.P.A studies are conducted on small sample sizes due to the time consuming nature of the analysis and the aim of writing in detail about the perceptions and understandings of the participants (Smith et al., 2009). Moreover, I was mindful of practical issues such as the time constraint for completing the study and being a novice I.P.A researcher. I therefore, considered nine participants to be a sufficient sample size for the study to achieve my goals: to capture rich and evocative accounts of the participants' stories and to attend, in detail, to the nuanced accounts and meanings of these stories whilst conducting the analysis. But perhaps the final words on sample size should be left to Smith and Osborn (2008) who state, "it should be remembered that one always has to be pragmatic when doing research; one's sample will in part be defined by who is prepared to be included in it", (p. 56).

Participants

I recruited nine participants to take part in semi-structured face to face interviews. In order to take part in the study, participants had to meet the following criteria:

Inclusion Criteria

- Participants needed to be fully accredited psychotherapists.
- Participants were required to be attending regular clinical supervision.
- Participants had to have experience of *witnessing* the physical manifestations of S.I in their clinical practice.

In keeping with the principles of I.P.A, the inclusion criteria sought to generate a "fairly homogenous sample" (Smith et al., 2009, p. 49; Wagstaff et al., 2014). When implementing the I.P.A approach, a homogenous sample is used to reflect a shared experience of the phenomenon that is being explored. Demographic details collected from each participant are illustrated in **Table 3.**

Table 3: Participant Demographics and Profile

Participants' Pseudonym.	Years of psychotherapy experience at the time of interview.	More than one experience if witnessing S.I.	Years of experience working with S.I.	Was S.I part of your initial training?
Anna	**12 years**	**Yes**	**10 years**	**No**
Brenda	**11 years**	**Yes**	**9 years**	**No**
Carol	**7 years**	**Yes**	**4 years**	**No**
Declan	**12 years**	**Yes**	**4 years**	**No**
Eamonn	**7 years**	**Yes**	**5 years**	**No**
Fiona	**12.5 years**	**Yes**	**10 years**	**No**
Geraldine	**12 years**	**Yes**	**9 years**	**Yes**
Helen	**10.5 years**	**Yes**	**5 years**	**No**
Ita	**12 years**	**Yes**	**9 years**	**No**

Recruitment and Access to Participants

To ensure that nine relevant participants- each meeting the inclusion criteria- were located, the following recruitment strategy was carried out:

1. A recruitment advertisement was placed in the 'Research Section' of the monthly email sent to members of I.A.C.P, which has over 4,200 registered psychotherapists, and in the weekly email bulletin of I.A.H.I.P, which has more than 1,500 members. The advertisement ran monthly with IACP, and fortnightly with I.A.H.I.P, until the necessary sample of participants was established. (Appendix D)

2. Details of the study were sent to organisations such as 'Towards Healing' and the National Counselling Service (N.C.S) asking them to inform their panel of psychotherapists of the study. These organisations were selected as they work with trauma and sexual abuse; the literature highlights the link between trauma, abuse and S.I. Flyers and the Plain Language Statement seeking participants (clearly explaining the nature, purpose, inclusion, and exclusion criteria of the study and the researcher's contact details) were sent these organisations. (Appendix E)
3. Psychotherapists and Supervisors to psychotherapist- all known to the researcher- distributed flyers and posters in their practices and places of work. (Appendix F)

Exclusion criteria:

- Pre-accredited psychotherapists and therapists in training were not eligible to

participate in this study.

- The interpretation of language was pivotal to the research exercise therefore, psychotherapists who were not fluent in English were not included in the study.

Reflexive Commentary

Initially, it was planned that therapists known personally and professionally to me would be excluded from the study. Prior to recruitment, I worked as a senior clinician for an organisation providing therapy for people who engaged in S.I and people experiencing suicidal ideation. I gave much consideration as to how interviewing therapists who were known to me may have an impact upon the data collection and analysis. I wondered if my professional role might hinder their freedom to speak about their experiences in an open and honest way. However, I left this role and as a considerable amount of time had lapsed before I commenced with interviews, I reconsidered this decision and decided that if former colleagues volunteered to take part in the study, I would not exclude them on the basis of knowing them professionally. However, an important ethical issue was to ensure that participants did not feel any obligation to take part or to filter their data due to social pressure. Finally, I came to the conclusion that their exclusion contravened the principle of autonomy by failing to respect the individual's autonomy in choosing whether or not to participate. The principle of justice also came to the fore here in that the researcher considered the potential benefits to be greater than any potential risk to participants. There were additional important ethical considerations that required attention, and these will now be discussed.

Ethical Considerations, Anonymity and Confidentiality

As the researcher, I made every effort to reduce any potential risk or harm to the participants in this study. I sought ethical approval from the Research Ethics Committee at Dublin City University. The ethical guidelines as outlined by the Research Ethics Committee at the University guided me through every aspect of the research study.

The research study adopted the ethics model by proposed Ramcharan and Cutcliffe (2001). This model supports the view that not all issues can be predicted at the beginning of the research process and unexpected issues may arise through the course of the study. Moreover, unforeseen ethical issues surfaced during two of the interviews, where one participant (Brenda) became terribly upset and began to cry as she recalled her experience. I did not want to cause any harm or undue distress for her and I sensitively asked if she would like to pause the interview or indeed, abandon the interview altogether. Brenda declined and expressed her willingness to continue. I wanted to ensure that she felt no sense of pressure to continue and reassured her that it was fine to stop the interview and we could revisit the interview at another time or she could withdraw entirely. She assured me that she was 'O.K' and wished to continue. I respected Brenda's autonomy and right to self-determination. Respect for autonomy refers to the importance of participants being given the opportunity to make informed decisions on their own behalf (Beauchamp & Childress, 1989).

Beneficence refers to "the obligation to provide positive outcomes, or benefits" (Ramcharan & Cutcliffe, 2001, p. 360). Following the interview, Brenda explained how she experienced a

sense of relief following the interview. She appeared unburdened by the experience and stated that she had not realised how much she had been impacted by witnessing S.I and that it was beneficial to reflect on her experiences. Moreover, Brenda shared that the client had reminded her of her own son. She again expressed that she felt a sense of 'relief' after sharing her story, and 'felt heard'.

Brenda was actively engaged in supervision and informed me that she attends a therapist on occasion when additional support was needed. I offered the opportunity for a debriefing in order to address any challenges that arose due to participation; she assured me that she was fine and declined a debrief.

During the interview with the participant Helen, she revealed that she had engaged in S.I in the past. Helen generously shared her experience of S.I and gave incredibly detailed accounts on how she injured herself. When she spoke about observing wounds on her client's arms, she continuously reverted to speaking about the neglect that her client experienced. I sensed that this was a 'sore spot' for Helen and asked about her own experience of neglect, as she was so forthcoming with her personal experiences of S.I. The following is an excerpt from Helen's transcript:

Q: "Does the neglect resonate with you as well Helen?"

A: "It does yea Cindy, but to be honest I don't think it was always intentional. I was very misunderstood {long pause} enough said… but anyway going back to my client".

I took the phrase ‘enough said’ as a cue not to probe any further. It was apparent that Helen preferred not to address this issue and in line with Ramcharan & Cutcliffe’s (2001) view of non-maleficence, I had “the obligation to avoid harm” p. 360). I respected her choice not to elaborate upon her own experience of neglect. Lakeman, McAndrew, MacGabhann, and Warne (2013) highlight that participants in a research study might become aware of unresolved or painful issues. Despite the participants being fully qualified psychotherapists with access to personal therapy and clinical supervision, this situation confirmed that interviews had the potential to cause some distress or upset to its participants highlighting the importance of remaining sensitive to the needs of the participants.

All the participants were fully accredited psychotherapists with training and experience of working with sensitive and emotional issues. The participant’s training involved personal therapy and ongoing clinical supervision which is mandatory throughout training and as practicing therapists. All participants were attending clinical supervision at the time of the research. This resource facilitated a means of support if they experienced any distress due to participation in this study, as consideration was given to the element of risk that the recalling of these events could be potentially distressing. However, as a qualified psychotherapist and supervisor, it was possible to provide participants with a sensitive debriefing following their interviews if required. (Appendix G) If a participant requested further counselling support following debriefing, the contact details of several accredited psychotherapists were compiled by me; this was however, not requested by any of the participants.

The importance of protecting confidentiality and safeguarding anonymity was an ethical practice that I was careful to respect. This resulted in removing/deleting information from the transcripts that identified an individual or an organisation. This research study is underpinned by several ethical principles and practice (such as informed consent, confidentiality, anonymity etc.) which guided me as the researcher in planning and conducting the study with the utmost regard for the safety of all concerned. Whilst ethical codes are described in different ways within moral philosophy (Bond, 2015) and professional practice, (Beauchamp & Childress, 1989; Robson, 2002) several core ethical values and principles are regarded as forming a basic foundational guide to good research practice. I shall now move on to consider the quality in I.P.A and discuss some of the criticisms.

Quality in IPA Studies

Pringle, et al. (2011) argue their scepticism about findings derived with I.P.A because it has been subject to criticisms as being riddled with uncertainties and that it is devoid of standardisation. There are some who also state that it is largely descriptive and not interpretative in an adequate manner. Smith, et al. (2009) highlight that being thorough is what rigour is about, and that conducting a good interview demonstrates this. Smith, et al. (2009) also suggest that an external audit of the research can improve rigour and trustworthiness. Furthermore, I.P.A is not about discovering one truth but rather aims to have an account that is valid and clear from the participant in their own words (Smith, et al., 2009). I.P.A is potentially a significant methodological contributor to knowledge; through its capacity for context-sensitive, within-person idiographic research design.

Notwithstanding this, it is important to acknowledge that there have been significant criticisms of I.P.A made by Giorgi (2010) as well as Van Manen (2017, 2018) who question the I.P.A methodology. Giorgi (2010, p. 6) Proposes it should be termed “interpretative experiential analysis (IEA)” while Van Manen (2017, p. 778) considers “interpretative psychological analysis” as a more fitting title. Moreover, Yardley
’s (2008) much lauded principles; sensitivity to context; commitment and rigour, transparency and coherence and impact and importance, are viewed as presenting a multitude of means of establishing quality and rigour in IPA research and potentially, these principles allow for external scrutiny of the I.P.A research format. These principles will be elaborated further in the final chapter of the thesis.

Conclusion

This chapter has set out the reasons I.P.A was chosen as a fitting methodology for this research study. The intention aimed to provide a concise overview of I.P.A and its origins, and discuss the issues of sampling, data gathering and analysis, researcher positioning, writing up of findings and a brief introduction to the quality of I.P.A research. I.P.A exposed the gap between what is assumed about S.I, how witnessing its consequences was experienced, and as Nash, and Basini (2013) so eloquently point out: “is sewn together with I.P.A’s idiographic sensitivity to context. I.P.A treads new furrows in that it revels in a supremacy of idiographic expression and gives voice to participants’ sense-making of a phenomenon through systematic analysis of the dataset and the evolution of structured themes”, (p. 26). The philosophical underpinnings of I.P.A influenced how I, as the researcher, positioned myself in relation to all aspects of the research study. A purposive sample of nine psychotherapists was recruited and semi-structured interviews were conducted, taking account of the ethical considerations needed in exploring a sensitive topic such as witnessing the physical consequences of S.I.

Reflexive practice was engaged in through the use of journaling and research supervision and assisted me in critically attending to my pre-suppositions about the phenomenon, while demonstrating study rigour. In methodological diversity terms, I.P.A contributed greatly by giving voice to the participants, which was at the core of context. There is little doubt that, as a methodological approach, I.P.A offers a significant opportunity in the re-conceptualising of what constitutes valid data in the re-casting of research. More widely, I.P.A and its sensitivity to (requirement for) context, has the potential to drive methodological diversity, and therefore to yield insight into previously unexplored territory. In I.P.A, theorising is done from within rather than being imported “from without”, (Smith, et al., 2009, p. 166). The attraction to I.P.A, and the enduring confidence in it, is that it is strongly grounded in a phenomenological approach that encourages researchers to explore their participants experiences, interpretations, and meanings in the context of their working life and beyond.

Chapter 4: Findings

Introduction

This chapter discusses the superordinate themes identified in the current study, the aim of which was to uncover and explore the varied experiences of therapists who have witnessed the physical manifestations of S.I. Emphasis was placed on how the client's S.I presentation affected the therapist both professionally and personally, and what the participants regarded as challenging aspects of witnessing the manifestation of S.I and how they managed these.

All nine participants had experienced working in organisations that provided counselling for people engaging in S.I behaviour and/or experiencing suicidal ideation. The findings are represented in a number of themes identified under the two superordinate themes:

- Feeling Shocked
- Sitting on the Edge of your Seat

These superordinate themes and subordinate themes encapsulate how the participant's experienced, perceived, and understood their own reactions to the client's S.I presentation within the therapeutic work (See **Table 4:** superordinate and subordinate Themes)

Table 4: Superordinate and subordinate themes:

Superordinate Themes	Subordinate Themes
1: Feeling Shocked	I. Struggling to Hold Face II. When your Stomach Turns III. Keeping a Lid on It IV. Carved in my Mind
2: Sitting on the Edge of your Seat	I. "You Need to be on Top of your Clinical Skills" II. Shouldering Responsibility III. Feeling Inspired IV. Protecting the Self

The first superordinate theme "Feeling Shocked", includes four subthemes. Although the participants in this study worked primarily with clients engaging with S.I, they all expressed that in general clients did not tend to display their injuries, resulting in the participant's sense of shock and disbelief when faced with overt S.I presentations. The second superordinate theme "Sitting on the Edge of your Seat" also consists of four subthemes, describing the participants' intense sense of responsibility to their clients as they constantly assessed the level of suicidal risk and as therapists, they often felt they were dealing with a life-or-death situation.

Superordinate Theme 1: Feeling Shocked

All nine participants spoke of their initial reaction being one of shock when presented with S.I presentations. Fiona, an experienced psychotherapist, supervisor and manager of a

counselling service that supports clients with suicidal and S.I behaviour, described her reaction to seeing the injuries of a client with severe S.I. Assuming that the client had been in a car accident and had "gone through the windscreen", Fiona struggled to conceal her reaction. She described the injuries as "slashes" or "gashes" that appeared to be "fresh and clean", injuries that perhaps occurred in one S.I episode. While relaying the details, Fiona shuddered, raised her shoulders, shook her head, and conveyed, "You know the big black stitches when they butterfly them, and I thought, 'Oh Jesus, like, I've never seen anything like that" (Fiona, P.1, L.19).

Fiona was surprised not only by the client's injuries but also by the client's choice of attire, which made the injuries very visible to others: "Well, I thought I was seeing things. I had to take a double take. She was just sitting there in a vest top" (Fiona, P.2, L.52-53). Fiona repeatedly referred to the "vest top". Although she was obviously questioning the client's reasons for wearing such a revealing top. Fiona seemed reluctant to acknowledge her sense that the client might be 'attention-seeking': "I went, Jesus, like, she's got…. Everyone can see. Normally it's covered over" (P.1, L.22-23). Having initially perceived the client as "arrogant", Fiona was eager to say that her initial interpretation changed when she had heard the client's story: "At first I thought it was arrogance. Like, I'm showing this to the world because that doesn't happen usually, or it hasn't happened to me, should I say?" (P.1, L.27-28). This was a new experience for Fiona; she characterises the event as something that has happened to "me". She chooses a strong turn of phrase to illustrate how shocking she found her experience with this client: "I don't think I will ever forget that 'till the day I die" (P.1, L.19). Fiona appears doubly shocked; initially her shock relates towards the sight of the injuries and the client's willingness to put them on display.

Moreover, as an experienced therapist she seems shocked by the fact that she was so shocked. Regardless of how shocking this experience was for Fiona she still tried to conceal her sense of shock and keep it hidden and maintain her composure to portray a calm and measured response. “I opened the door and kept calm as possible you know. And then trying to hold face, because of judgement, that’s the last thing you want somebody to feel, judged” (Fiona, P.9, L.371-373).

Eamonn, shared his reaction to a client with severe facial S.I. Before training as a therapist, Eamonn spent many years dealing with the public in challenging situations. Eamonn therefore “thought [he] had seen it all” (P.2, L.57-58), but he was nevertheless shocked by the client’s injuries. He wondered what might have occurred in her life experience that could account for them. He suggested that “she must hate herself” to inflict such personal injury; he bases his interpretation on what he considers to be her interpretation of herself and concluded that the S.I represented a deeper manifestation of self-loathing. Eamonn described the client as a “beautiful young woman” who had “cut parts of her face and lips and had “both her eyelids . . . cut and pieces hanging off. And her nose . . ., it was very unusual to see a face, and a woman’s face, she was quite an attractive woman, but this horrible injury around her face” (Eamonn, P.3, L.97-100). It seems part of his reaction is a result of the dissonance between her relative beauty and “horrible” self-inflicted injuries. He also seems shocked by the fact that a “woman” would do this to her *face* and in particular a face of beauty. This might suggest that he believes that women’s bodies are more stringently policed than men’s and a woman’s face considered more precious.

The words “shock”, “shocked” or “shocking” were used thirty six times by the participants. Furthermore, expressions such as “Oh my God”, “Jesus” and “Jesus Christ”

appeared a total of 84 times. The frequent use of such words and expressions emphasises the participants' sense of shock whilst wanting to present as a composed professional. These struggles themselves were sources of conflict and challenge for the participants. Participants indicated that they did their utmost to conceal reactions that were prompted by exposure to the injuries of others. At the same time, these therapists experienced a contrary desire to express themselves openly. Ita, an experienced psychotherapist and a manager of a service that provides counselling for people experiencing suicidal ideation and engaging in S.I and described how she is "very real" and Eamonn expressed how he has "a face that people can read like a book".

This proved challenging for participants as all but one participant spoke of how they would become aware of their facial expressions to ensure their sense of shock was not evident on their faces. Four subthemes emerged from this superordinate theme. Although themes are closely related, the following subtheme, "Struggling to Hold Face" is distinct in that it illumes one of the strategies the participants drew upon to conceal their sense of shock.

Subordinate Theme I: Struggling to Hold Face

Eight out of the nine participants described how they tried to alter their facial expressions to conceal their sense of shock. They believed that maintaining their facial composure protected the client from any sense that the therapist was reacting negatively to them or judging them. They aimed to convey a face that expressed sensitivity, compassion and a relaxed and/or measured response. When Ita was asked to recall a time when she witnessed the physical manifestations of S.I, she quickly recalled an event that took place in the early

days of her career as a psychotherapist. Ita spoke about the very first client she saw when she began working in suicide prevention and S.I, hence, illuminating how significant the event was for her at the time and how clearly, she could recall the events despite the passage of time.

Ita's client had presented with numerous cigarette burns on his arms and Ita spoke about her initial sense of shock. She had never encountered anything of this nature. Moreover, she was conscious that she did not want her response to be evident on her *face,* for fear her client would perceive this as a form of judgement. Ita wondered if she had sufficient ability to cover up her reactions to the client's S.I and attempted to justify her struggle to maintain her facial composure: "I kept thinking, well, no matter what I am feeling, I can't show any sort of distaste about what I am seeing. So, I was very conscious of that . . . and I am probably someone. ......I am very real" (P.3, L.114-116). Ita clearly struggled to conceal her reaction to the client, revealing her emotions as she moves to an inauthentic self: "[M]aybe a look might..... , probably did, go over my face" (Ita, P.2, L.116-117). Ita's language here is revealing. She first uses the word "might", and then moves to "probably", which may indicate a greater degree of certainty and/or growing awareness of the internal conflict. She then chooses the word "keeping" as opposed to "kept", and this shift from past to present tense may represent a sense of Ita grappling with her uncertainty as to whether she was successful in her concealment. It appears difficult for Ita to acknowledge that she may have shown distaste toward the client's S.I and she might have perceived this as failing in her duty of care, as her client may have interpreted such reaction as a judgement. The use of words such as "might" and "probably"' may be an exposure of Ita's ambivalence and/or her reluctance to believe that her experience was detectable from her

expression. If Ita could acknowledge that her face mirrored her internal response, she could be vindicated in her belief that she is “very real”. Ita’s use of language clearly reflects the uncertainty that arises when attempting to manage two very distinct responses and not wishing to fail at either. She must conceal this from her client. She must be the “container” of emotion and move away from the “real” person she is.

Carol used the metaphor of “wearing a mask” when describing her engagements with her clients (P.2, L.91). She expressed her belief that the “mask” was important not only to protect the client from her reactions, but also to protect herself within the therapeutic relationship. It appears that “wearing a mask” assists her in the expectation that she places on herself to be able to manage the S.I presentation.

> In the role that you do, you’re supposed to be okay with it, you’re supposed to be…, you know, “I can manage this. This isn’t going to faze me. I’m not going to show that I’ve been impacted by that visual. So, there’s a protection in it as well, because you can’t fall to the ground. (P.2, L.83-86)

Carol once again uses metaphorical language as she indicates that she cannot “fall to the ground”. This metaphor possibly reflects her internal response and relentless effort to maintain her facial composure so that she does not give anything away.

With one exception, all the participants commented on being mindful of their facial expressions and the risk of exposing their inner dialogue and/or reactions to the client.

Anna, a very experienced psychotherapist, supervisor, and clinical director in the service she worked for believed her client monitored her facial expressions: "She was always looking for my facial expression" (Anna, P.2, L.124). Anna also suggested that the sense of being scrutinised/monitored places focus on the *then* and *there,* which can become a barrier for what is happening in the *here* and *now.* This client had a diagnosis of Borderline Personality Disorder (B.P.D) and Anna had worked with her for more than two years. Despite the longevity of the relationship, Anna always remained conscious of her facial expressions. Similarly, having previously worked as a nurse, Geraldine had witnessed many physical injuries. Nevertheless, she recalled consciously concealing her facial reactions when confronted with a client who described a different form of S.I that she had never encountered before.

Maintaining their facial composure was deemed essential so as not to increase the sense of "shame" that participants believed their clients experienced. Moreover, most of the participants said that they preferred not to see the wounds/self–injuries, and most clients do in fact present with their S.I covered. Therefore, they did not anticipate being confronted by extreme cases. Not alone did they experience a sense of shock and the need to alter their faces to conceal this from their clients. Participants also experienced a sense of revulsion when faced with such violent S.I. Apart from Declan, all other participants experienced a feeling of nausea, revulsion, or a desire to recoil.

Subordinate Theme II: When your Stomach Turns

Although participants' work with suicide ideation and S.I, eight of the participants used emotive language to describe their responses, expressing a sense of being "sickened", "repulsed" and/or "revolted" by what they saw in the S.I presentations. When Fiona spoke about the client that she thought "had gone through a windscreen" due to the severity of the wounds she explained: "I looked at this young girl, and I'd say I nearly recoiled" (Fiona, P.1, L.19). Anna believed herself to be someone with a "strong stomach". However, she recalled her nauseous reaction when a client presented, and she noticed a strong "smell of burn". Having initially thought the smell was that of a burning candle, Anna then realised that it was the smell of "burnt flesh". The client informed Anna that she had placed a hot iron on her ankle that morning before the session, and the flesh was still burning. Anna recalls feeling "physically sick" or nauseous at that point. However, Anna distracted herself from her reaction and focused instead on encouraging the client to attend the hospital for medical attention. Anna believes she managed to contain her sense of nausea and successfully concealed her nauseous response in this instance as she grappled with the internal struggle of containing her reaction. In addition, Eamonn clearly felt that showing his revulsion at that point would be to the client's detriment: "I think if I showed revulsion that I would basically be showing them the door" (P.5. L206-207).

When Geraldine (a nurse and psychotherapist) spoke about seeing cuts and burns on people, for example, she relayed the details in very factual and unemotional language.

Seeing physical injuries did not seem to unduly distress her. By contrast, Geraldine recalled that she struggled when she *heard* the client describing their episodes of S.I and felt physically "repulsed". Geraldine recalled an adolescent female client who told her that she had swallowed a tampon and needed a surgical procedure to have it removed, as it had

expanded within her oesophagus: “She was a girl, she did this there . . . and it was a repeat thing for her, and then she needed to be hospitalised, and in this case the thing needed to be taken out by surgery” (Geraldine, P.4, L.181-182).

Geraldine’s facial expressions contorted as she spoke, revealing her sense of disgust: “[I]t was horrible. I couldn’t really get my head around that. Cutting, yes, I know that I’ve seen that, and I’m okay with that. But this . . .this was different. It was revolting” (Geraldine, P.1, L.41-42). Interestingly, Geraldine was initially reluctant to disclose what it was that the client had swallowed. When she was reassured that being specific would in no way risk breaching confidentiality, she relented. However, her initial avoidance of the word “tampon” and her subsequent reference to the tampon simply as “the thing” seem also to reflect her reluctance to relive her feelings of revulsion: “I really found it difficult to hear, and I even find it difficult to recall. I feel nauseous, even thinking about it now” (Geraldine, P.1, L.56). It occurred to me that Geraldine may have associated a tampon with menstruation, fertility, and womanhood, and therefore found it difficult to associate with “a girl”. Menstrual blood has different composition to regular blood, which may also have added to Geraldine’s sense of repulsion at this form of S.I.

> I do remember not wanting to show on my face how repulsed I felt. I think she must already be ashamed of her behaviour. Having to have surgery because you chose to swallow a tampon. Yes, I would not have wanted her to know how difficult it was for me to hear that. After all it is our job to hear and that is what we do. (Geraldine, P,5. L.198-202)

When Eamonn recalled the experience of the woman who had cut her face he described how he had felt anxious in his stomach and struggled to conceal his emotions. The body could not betray itself in this instance and, despite his efforts to conceal his responses, his "face went white" (P.2, L.54). Even if he had successfully maintained his composure, he was conscious that the colour of his face alone could possibly give something away. This illuminates his struggle: the tension between what he wanted to portray and the difficulty of regulating the physiological response that ultimately tells on his face. The sight of the client took his breath away: "even thinking about it now, I am conscious of being short of breath. . . God, how can someone hate themselves so much to do that?" (Eamonn, P.1, L.45). This shortness of breath could be viewed as the bodies protest to respond to the internal struggle to regulate emotion.

Ita had never seen cigarette burns on a client's body and she found this more disturbing than seeing cuts: "It's interesting, because my right eye, I regularly get . . . it's like a low-grade infection, and I often think it's because I don't like what I'm seeing, you know" (P.10, L.424-425). It appears Ita perceives her "low-grade eye infection" to be a manifestation of the distressing images she witnesses and now this comes out in her body. Despite her outward portrayal of remaining calm and unaffected the internal distress she believes surfaces on her body. She links the eye infection to being the bodies way of trying to manage her distress. As previously outlined, Ita had also struggled with acknowledging whether she was successful or not in concealing her response. She was unsure if her face gave way to the betrayal of concealment.

Helen described her internal responses in this way: “It was just like a stabbing pain in my stomach when I saw it, you know, and then, instantly, the flashback of my own self-injury” (Helen, P.3, L.103-104). Helen’s choice of language appears to relate to her own experiences of S.I, and she seems to have been confronted by past emotional and physical pain: “So, I mean you’re dealing with . . . I suppose, a physical sensation in the body; it’s deep, stabbing pain or a hurt, you know, certainly an unbelievable connection, the stomach area and the heart” (Helen, P.3, L.105-106). Helen appears to have had a visceral response to the “sight” of the injuries. Although she thought that she successfully concealed this response from the client, the initial experience was one that, as she saw it, emerged within the body or “under the skin”. Ita also speaks of how her experience of S.I got “under the skin”: “[I]t was almost like he was doing it there in front of me even though he wasn’t and I could nearly, almost smell and taste the wounds, and how the wounds had happened if that makes sense” (Ita, P.9, L.392-393). As Ita spoke, she placed her hand on her stomach, rubbing in a circular motion, as if to ease the sensation she was now reliving and to comfort herself as she recalled the experience, “well, in the stomach, you know. . . that twisting knot in your stomach when you’re . . ‘Oh, my God, like, what is going on?” (Ita, P.2, L.51-52). Ita returns to this conversation again:

> Like, initially, the first time, I did see that, yeah, that stomach thing where your stomach turns ......I wouldn’t say it’s revulsion or whatever, but just, yeah, just that. What is it if it’s not revulsion? What is it? I’m trying to think what word I’d use.......I don’t know, I can’t put a word on it. But that horrible feeling in the stomach. (Ita, P.5, 205-208)

Brenda explained that although she was "wincing inside" at the sight of the injuries. Fiona described a "butterfly feeling" that she experienced, a feeling that extended beyond the session, and that recurred at the prospect of the client coming to each session: "It's like it could hit you in the stomach where you get that butterfly feeling or that anxiousness, because 'Will she come in? Has she done something in between the sessions?' (Fiona, P.4, L.178-179). Eamonn recalled having similar anxieties: "Well yeah, there would have been anxiety, and I can feel that even now in my tummy as I'm talking about it" (Eamonn, P.2, L.52-53). It appears that what the participant's experienced extended beyond an emotional/feeling response and involved a physiological reaction to what they had seen and/or heard. Anna describes herself as having a "strong stomach", but she nevertheless "felt sick" when she saw the burn mark on her client's ankle and recalled that she "could actually feel the pain; you know if you burn your little finger" (Anna, P.4, L.145-146). Anna once again returns the conversation to her successful concealment to regulate emotion: now, in my tummy, I could feel it but I would never give it to her" (Anna, P.3, L.131).

These sensations that were experienced "under the skin" proved difficult to regulate and on occasion the body ultimately betrayed them, with one participant describing a discolouration of the skin. Almost every participant experienced an oppositional dynamic that can be understood as 'pulling'. Participants struggled with the tension and inner conflict, to manage, contain and conceal their reactions/responses. These elements became even more challenging when participants experienced a physiological response within the body that could be described as a 'sensory overload'. The emotional response pulls them in one direction. The voice of logic and reason however, pulls the participants in the opposite

direction. This ultimately left the participants in a quandary- a state of perplexity- as they grappled with the uncertainty of what dynamic may surface. In addition, the participants must maintain the ability to listen to their clients and engage in the therapeutic process. There was consensus that there was no space for their reactions to spill or pour out of them and into the sessions.

In contrast, Declan, an experienced therapist who had also worked at the coalface of S.I for several years differed in his response. Declan explained:

[O]n one occasion a girl put her hand out and it was all cuts and I said do you mind if I touch it, you know, until I see what the skin is like because it was very red. She said yeah, yeah, it’s no problem, yeah, she held her hand out. And I, if I’m squeamish I’ll say gee, I’m a bit squeamish or I’m a bit nervous about this but is it alright like, come here. (P.8, L.346-350)

Despite naming that he may be a bit “squeamish”, he does not convey any feelings of disgust or horror at the sight of the injuries. Instead, Declan spoke with almost a fascination towards the injuries:

I would have asked is it healing, and she’d show you whatever, the way the wound would be healing, and you’d see it, the cleanliness coming around the wound or the skin beginning to normalise in colour and stuff like that, you know, maybe the marks of the cut would be left there. Yeah so, it’s an interesting piece of work, yeah. (P.5, L 218-222)

Subordinate Theme III: Keeping a Lid on It

Several participants related how they would "hold" for the sake of their clients. When Ita spoke about witnessing the cigarette burns on her client's arms and managing her internal response she explained: "But I remember keeping thinking, I have to hold this for him" (Ita, P.2, L.117). Ita's use of language is interesting in that she refrains from using the past tense when telling her story. Instead, she uses the word "keeping" as opposed to "kept", as if she is still 'holding' as she relives her experience. Similarly, Brenda recalled that a client once asked if she would like to see the injuries, and she declined. Despite this, however, the client stretched her arms above her head, raising her jumper and revealing her wounds. Brenda expressed her belief that the client did so "deliberately" and she made a conscious decision not to acknowledge the client's injuries: "I was holding, you know; I was holding it in the room that if I had actually gone to verbalise anything that the inside piece would have come out" (Brenda, P.6, L. 277-279). Brenda expressed that this client was "very challenging", however, she seemed reluctant to say that she perceived the client as manipulative, although it appears the client manipulated her movements to expose her wounds. Considering this client ignored the declined invitation to see the injuries, perhaps Brenda is holding more than she is willing to reveal. She was certainly 'withholding' from her client any acknowledgement of the injuries she had seen.

Had Brenda acknowledged the SI, her negative inner response/reaction, and the tension/conflict that she was "holding" may well have spilled over. Brenda viewed herself as successful in her struggle to hold and contain and with a clipped tone of voice she expressed: "[S]he didn't get a thing from me, because that would have been something that

I would have been very conscious of ” (Brenda, P.1, L.42). Brenda sensed that the client was aware that she had seen her injuries, but this aspect of their face-to-face interaction remained unacknowledged between them. Brenda held this information to herself. Despite their attempts to conceal their responses to what they witnessed, the visual memory remained with them long after the client had completed therapy.

Subordinate Theme IV: Carved in my Mind

The participants’ ability to effortlessly recall incidents of exposure to violent S.I in detail reflects the extent to which this was permanently embedded within their psyches. They were also impacted by hearing depictions of S.I episodes. Although Eamonn thought he had “seen it all”, he acknowledged that he had found it extremely difficult to forget seeing the facial injuries of a client who had presented with S.I. Like other participants in the same situation, Eamonn found himself troubled by recurring images of difficult S.I presentations. For participants’, the memory of exposure to “fresh” and/or “raw” S.I wounds remains “fresh” in the present. The participants often found themselves ruminating over these images and found it hard to “let go of them”, and the images often presented unexpectedly when they were at home, intruding on their personal living environments. Anna recalls how she brooded on and visualised the “mark of the iron” on her client's ankle long after the actual experience of seeing it and could clearly remember the smell of burning flesh. It appears that the fresher or more violent the injury, the more deeply exposure to that injury affects the participant, and the more difficult it is for them to protect the self from the lasting image:

> When you have time to drop down into yourself, and you go home of an evening, and you're sitting, and you have your alone time, you're reflecting back over the day. And she would be the one client that I reflect back on, because it was very visual. (Anna, P.4, L.157-157)

Having experienced suicidal behaviour in his previous role of working within the community, Eamonn felt that he understood such behaviour, and said that he had no difficulty saying the word "suicide". He struggled to make sense of S.I, however, and struggled to say the phrase "self-harm" aloud. Eamonn recalled how his lack of previous experience of S.I made him feel that he did not fully understand the behaviour, which made it difficult for him to treat a client who presented with S.I. He avoided verbalising the term "self-harm" until he became more comfortable with the behaviour itself and increased his ability to make sense of such a violent practice:

> I remember when I started to speak about it, I'd say I had no problem saying the word "suicidal ideation", but I'd whisper "self-harm". I'd notice my voice was going down. It was like I couldn't say it........I suppose I didn't know enough about it; I didn't like to say it. It was nearly a visual thing in sound or something. I was trying to avoid it, I suppose. It's interesting, isn't it? Why would I whisper it? I often wondered about that, and then after a while, you know I was used to it. (Eamonn, P.3, L.119-124)

As Eamonn spoke, his voice lowered; it was as if he were back in that moment of time.

Eamonn was rendered almost speechless because the words conjured up disturbing visual images that he found almost intolerable: “I couldn’t say the word, the words. Another client comes to mind and he would talk about it. He would say, ‘I’ve cut myself to ribbons’, even the sound, the visual piece would come into my mind. Jesus, cutting yourself to ribbons, you know” (Eamonn, P.3, L.129-130).

The participants clearly expressed a variety of physical responses that are activated by the ‘sight’, smell and ‘sound’ of the client’s S.I presentation. Most participants reported being disturbed by what they saw and heard, and one expressed olfactory repulsion and described how she imagined she could “smell” and “taste” the wound. The majority experienced a physiological sensation of unease; the more unfamiliar the form of S.I, the greater the impact and/or response it evoked. Geraldine believed that, to fulfil her duties as a nurse, she needed to desensitise herself to this impact. Similarly, Eamonn eventually “got used to” verbalising the words “self-harm”. Therefore, from an individual perspective, each episode of S.I did not warrant the same response from participants. When Fiona recalled her experience of meeting the woman who wore the “vest top”, she wondered what would have happened to another therapist if that was their first experience of witnessing such S.I. Fiona found that her previous experience of exposure to S.I helped her to conceal/contain her response in this instance. Ironically, the client who had burned himself with cigarettes was the first client Ita encountered when she began working with S.I. The common thread of building up tolerance is woven throughout the tapestry of Ita’s experience:

> I know definitely, as you work with things, and looking back now, I wonder, you know, that the more you see self-harm, do you get desensitised to it? I

> often ask myself that and I often asked about the suicidal thing as well, do you become that it's not, I don't mean that it's not as big of a thing, but desensitised to some degree. (Ita, P.3. L 129-131)

There is considerable consensus among the participants that with continued exposure to S.I presentations they gained an increased tolerance with the passage of time. It appears that greater experience is not the only thing that helps. Having previously worked as a nurse, Geraldine was used to seeing and treating physical injuries, but nevertheless struggled with her response when she *heard* that a client had swallowed a tampon. Similarly, although Fiona had experience of working with S.I, she still found herself shocked by the woman in the "vest top". Fiona still struggled to conceal her response, just as Ita struggled with her first experience of working with S.I. It seems likely that the response is shaped by the type of injury, by how familiar the injury type is, by how fresh the injuries are and by how exposed they are. Brenda, an experienced psychotherapist, supervisor, and clinical director in the organisation she worked for, observed that the visual memory of the client's wounds/injuries brought home the true reality of the situation: "[F]or me . . . actually seeing it first-hand was like, that is the reality, you know" (Brenda, P.5, L.188-189).

In the following passage, Carol uses the word "visual" four times as she reflects on being unable to forget the injuries she saw. She explains that these images are so firmly etched in her memory that it is exceedingly difficult to let go of them or protect oneself from them:

For me, an image stays in my brain way longer, maybe, than a conversation about

something. . . So I'm quickly able to recall the clients that have come in where there's been a visual. . . I'm quickly able to recall them ones, rather than the ones that have come in and spoke about their self-injuries. (Carol, P.5, L.237-238).

Although she sometimes struggled to find the language to express what she felt, Carol emphasises how quickly she can recall the clients who exposed their S.I to her, in comparison to those who did not. The sight of the wounds/injuries appears to affect this participant greatly, making it particularly difficult for her to forget seeing them. This suggest a permanence – an image that is carried and enduring. Fiona shared a similar experience in relation to visual memory, and her sense of shock and disbelief was conveyed in the language she used. The fact that she shook her head repeatedly during her interview also indicates the disbelief and how taken aback she was by the experience: "I'll never forget [this client] and the shock and the severity of the wounds, and the fact that they were so visible" (Fiona, P.5, L.196-197). Ita discussed the "flashbacks" that brought her back to the S.I wounds/injuries she had witnessed, and that disturbed her sleep: "I had a lot of images after I saw that client for the first time. I would have had disturbed sleep and a lot [of] sort of, you know . . . vivid images coming into my mind of the marks" (Ita, P.1, L.41-42).

Helen recalled the images of the more violent S.I wounds/injuries in detail, outlining how the client's skin had been "stabbed and dragged" (P.11, L.459). Witnessing these injuries, Helen recalled that she found herself "thrown back" to the acts of S.I that she had herself carried out in the past. Helen became tearful as she revealed the scars from her own past

S.I behaviour. She explained that although she has witnessed many injuries in her therapeutic engagements with clients presenting with a broad spectrum of psychological issues, including addiction, dual diagnosis, suicide ideation and self-harm behaviour, the effect that one young client had upon her stood out and remained fresh in her mind. Helen spoke of "being haunted" by what she saw and identified with what she characterised as a "carbon copy" of her own S.I experience. Helen shared how she too had "stabbed and dragged" at her skin and was "dragged back" to that difficult time in her life. Having openly shared her personal history of S.I and her experience of disassociation, Helen said that she recognised that "unforgettable look" on her young client's face. She used vivid language to describe the haunting images and physical experience: "It's like somebody sucked their soul out of their body" (Helen, P.10, L.407). These expressions represent how difficult the visual aspects of S.I are to forget; for Helen, they clearly evoke a dark and difficult time in her own past. It appears that although Helen has created a new identity for herself as a healer, rather than a self-harmer, the ghosts of the past can at times re-emerge. For some participants, it is clear to see that what they heard was at times every bit as distressing as anything they saw. Their overwhelming reactions/responses were felt within the body and based on emotional reactions rather than reason or thought. Notwithstanding this, the participants felt a responsibility to manage and regulate their emotions. Furthermore, their sense of responsibility spanned across many aspects of their professional lives and at times filled them with fear and anxiety as they believed they were dealing with a possible life or death situation.

Superordinate Theme 2: Sitting at the Edge of your Seat

Eight of the participants described feeling fearful when working with clients who engaged in S.I behaviour and/or expressed suicidal ideation. The fear that a client might take their life was a real concern for all but one participant. Geraldine expressed the challenge and responsibility attached to assessing and monitoring the risk levels for suicide when working with young clients. It was clear that the participants faced varying levels of anxiety, levels differing according to the client's presentation in each case. Participants indicated that if a client were to complete suicide, they would be faced with a sense of accountability in relation to their approach and the therapeutic support they had provided. Questions would be asked about what measures had been put in place to protect the life of the client and this could possibly result in litigation. There was also a concern that the clients could S.I to the point that could cause their death, even if death was not the intended outcome. Being driven by fear can greatly affect the therapist's ability to engage with the client in a congruent manner while also exercising caution and diligence.

Subordinate Theme I: You Need to be on Top of your Clinical Skills

Carol described her sense of responsibility as "quite intense. ...... [T]here's an urgency about it. ....[Y]ou're feeling very responsible for that client" (P.3, L.126-127). Helen also highlighted her concern for her client: "So, yeah, there was fear, definitely, that she would take her own life, that she would die by suicide whether it be accidental or intentional. It was always there that that would happen too." (Helen, P.13, L.532-534). Eamonn questioned his own level of competency and expressed this sense of self-doubt quite starkly: "Doubting myself? Jesus, how can we help? How can I help this woman?" (P.2, L.60). As he describes this feeling of self-doubt, Eamonn begins with himself as an

individual (“myself”) and then switches to the level of his organisation (“we”) before returning to the individual level (“I”).

Brenda also shared her concerns in relation to another younger client and her ability to support the client and her fear that he might be at risk of suicide when she saw fresh lacerations on his arms: “That was kind of probably the first time that I actually thought… he could take his life, you know, this guy could actually take his life. And that was scary.” (Brenda, P.11, L.492-494). S.I is considered a strong risk factor for completed suicide and participants spoke of continuously assessing risk when working with their clients. Geraldine elicits her sense of having to “be on top of my clinical skills” (P.2, L.60- 63). She also expressed her sense of being “weighted by responsibility” to ensure best care and the safety of her clients:

> The challenge is the thought of the risk that they are going to self-harm to the point of suicide and evaluating whether and when they are using this to cope, or it’s going to turn the other direction and end up being actual suicide. That is challenging, just that responsibility. I’m very aware that I need to be on top of my clinical skills and be very careful, and there is a lot of responsibility on that (Geraldine, P.2, L.60-63)

Each participant’s strong sense of responsibility is apparent in the language they used: words such as “urgency” and “intensity”. There is a clear sense that there is no escape from the burden of responsibility, from the fear that their actions/inaction could result in the loss of life. At one point when Carol spoke, her pace of speech quickened and the sense of

urgency became evident in her voice: “You are at the edge of your seat, you are, because there is an element of, time is ticking here if something does not change. How do we get this client to hook onto hope, to life?” (Carol, P. 3, L.119-122). Carol seems to have a desperation in her tone and to feel that she must conceal this from her client. She continues to present as if she is not “fazed” as she grapples internally with the urgent sense of responsibility. Interestingly, her use of language shifts from “you” to “we” and then back to “you” again. She refrains from using the word “I”, however. This may reflect her reluctance to carry the burden alone: using the term “we” allows her to share the responsibility with the organisation she works for.

There is consensus across participants that there is an increased sense of responsibility when faced with younger clients, children, and adolescents. Despite this however, there appears a contradiction, as participants also express more hope that the younger people may transition from this destructive behaviour. Notwithstanding this, perhaps the prospect of losing a child or younger person to suicide is even more terrifying than losing an adult client to suicide. Ita perceived an increased risk of suicide in the younger clients due to their tendencies toward more impulsive behaviours- tendencies influenced in some instances by the adolescents’ use/misuse of alcohol, recreational drugs and other mood-altering substances. Ita shared her concern:

> [H]e was definitely smoking hash as well. So, he was a concern and drank quite a bit as well. So, the concern around what would happen if he was out and took, you know, a lot of alcohol or whatever. So, there was the concern about suicide as well. (P.2, L.62-65)

The participants observed that they often had to manage the parents' anxiety levels and appease their fears for their child's safety. The participants also noted that they faced the additional responsibility of educating the parents in relation to S.I. They needed to explain how S.I behaviour usually served as a strategy for coping with difficult life experiences and that the aim of the therapeutic intervention was to introduce the young client to alternative coping skills. Participants indicated their belief that parents often assumed that cessation of the S.I behaviour would automatically result from therapeutic intervention. Participants were under increased pressure and faced a greater sense of responsibility towards their young clients. Most of the participants reported that managing parents' anxiety and expectations of therapy, along with their own fears that the client might attempt to take their life, further increased their own levels of anxiety and sense of responsibility. Anna related how parents added an increased pressure: "[T]he pressures from the parents, that their expectation is that, by the end of it, the child needs to be stopped self-harming" (P.7, L.306-307).

It is clear that participants carry a heavy burden of responsibility towards all their clients. However, they also face a level of responsibility for self-care and for their own families. The participants' sense of responsibility spilled into their personal lives as they grappled with their clients' ambivalence about life and death.

Some of Ita's clients had her personal telephone number which was standard practice within the organisation where she worked. While at home one evening, she received a call from a client in distress. The client told Ita that she was highly suicidal and

was about to end her life. Ita explained that although she tried her best to intervene, being at home and outside of her working environment, she could not avail of the support of colleagues or her manager to guide her in supporting the distressed client. Ita recalled being in a "complete panic" when the client would not disclose her exact location, indicating only that she was in a car park, intending to complete suicide by attaching a hose to her car's exhaust pipe and ingesting poisonous fumes:

> They were in their car and they had the hose in the car, and they wouldn't tell me where they were, and I was absolutely. . . But my family were there. I went into another room, but then two of my sons came in to see was I okay and witnessed my concern on the phone. (P.6, L.235-258)

Ita felt completely overwhelmed by her sense of being responsible for the client's life. Moreover, while she was attempting to intervene, her children were also exposed to the distress. Ita then felt "huge guilt" because she felt it was her duty to shield her children from such distressing events. Essentially, Ita's work had pierced the walls of what had been her safe home environment. She began to rethink how she might best protect her family, home and personal life: "That was some experience. After that happened, I remember thinking it isn't okay for clients to have our phone number at all. I really felt it crossed the line in my personal life" (Ita, P.6, L 243-244). Following the incident, Ita informed her organisation about her concerns regarding clients having their therapists' personal phone numbers. As a result, the organisation changed its policies, acknowledging the need for healthy boundaries between work and home.

At an earlier point in her interview, Ita had shared her concern about her children's safety, a concern triggered by her exposure to younger clients engaging in S.I and/or presenting with suicide ideation: "I think we all know . . . that 'out there' can sometimes come in, inside. . . [A] close friend of mine, her son had died by suicide" (Ita, P.3, L.96-97). Ita was aware that the rate of S.I behaviour and/or suicide ideation was extremely high among young people, and that suicide rates among young males were particularly high at the time. Not only was Ita anxious to protect her own three sons from this terrible threat; she also felt that she should shield them from her own heightened anxiety. She recalled the words that one of her sons had used to reassure her when he was sixteen years of age and had experienced the ending of a romantic relationship: "It's OK, Mom. I'm not going to kill myself". Ita remembered what his choice of words had told her about his awareness of her professional concerns and how they affected her personally as a parent:

> I remember thinking, wow, I probably created that; he can pick up from me that that was in my head, because obviously when you are exposed to that, it's something that's at the forefront of your mind even in your home life. (Ita, P.4, L.163-165)

Brenda also expressed her sense of fear and responsibility regarding her own children. She noted how one client bore an uncanny resemblance to her own son:

"[It] was like having my son sitting in front of me. He looked like him, he looked so like him, he had all the same interests as him, I picked up straight away he was on the spectrum and that was really difficult. "[I]t made me worry for my own son, you know" (P.10, L.

449-451).

Brenda's own son had a diagnosis of being on the autism spectrum. Due to the similarities between her own son and her client, she was afraid that when her own son was experiencing difficulties in his life, he too might contemplate suicide as a means of escape. This kind of anxiety and sense of responsibility surfaced on many fronts for participants. Participants worried about their responsibilities to their clients, to their families, to themselves and to the organisations for which they worked.

Subordinate Theme II: Shouldering Responsibility

Fiona, a manager within an organisation, and one with considerable clinical skills, recalled an incident when a client presented at the centre with extreme S.I and wearing a vest top. Fiona remembered being concerned that others in the waiting area, including the centre's receptionist, might be affected by the client's presentation. Fiona strongly felt that she had to proactively manage this incident, and that she needed to support the receptionist by arranging a debriefing meeting for her. This story stood out for her because the experience was quite unusual and out of the ordinary realm of her experience. Fiona felt responsible not only for the client's manner of openly displaying her injuries, but also for any impact that the sight of these injuries might have on others, such as clients and parents who sat in the waiting room in addition to her staff. Here and in many other cases, there is a clear indication that the participant's sense of responsibility extended in many directions and was certainly not confined to the therapy room. Eamonn believes he is charged with the responsibility of maintaining the reputation of the organisation he works for. He describes

the organisation as having:

> [A] huge reputation and so, I'm very conscious that when people come in, they already have an expectation than say if you were coming to see Joe Bloggs privately, so that would be different. But they are coming in looking for support in this and I feel duty bound not to show revulsion and to support. Sometimes it can be difficult. (Eamonn, P.5, L. 207-212)

Feeling responsible for the reputation of the organisation is one thing. However, combined with being responsible for the lives of clients makes this a heavy burden to carry. In addition, participants also expressed their sense that the younger clients' parents placed a level of responsibility on the therapist to change/adjust their child's behaviour, and most participants referred to the parents' expectations as a difficult challenge. Alongside this, at times participants struggled with holding hope and questioned their clinical skills.

Some of the participants said that they had experienced times when they wondered if anything would ever change for a client and they doubted their own ability to work successfully with them. They expressed their sense that "being in that place" was difficult and "uncomfortable" and could ultimately result in both the therapist and the client feeling hopeless in the therapeutic space. Brenda recalled how she had felt hopeless while working with an older client: "I think there were times when I went in and out of her hopelessness, definitely because nothing in her life was really changing" (Brenda, P.9, L.415-416).

Brenda goes on to say that following the completion of therapy, the client came back to the

service again, requesting Brenda as her therapist. Brenda declined to see her:

"I suppose there was a piece of me thinking that somebody might see something different and that she would move differently or that she would maybe get more skills or something, that seeing somebody else might improve things for her more than just coming back to me" (Brenda, P. 7, L.321-325).

Brenda's energy is low when she speaks about this client and a sense of dread detected in her voice. However, she justifies the fact that she no longer wanted to work with the client by expressing that she may do better with someone else. Despite acknowledging that: "She was the, was the type of client that came back "(P. 7, L.298). In some way Brenda relates this to her own ability to bring about change for this client. Brenda expressed that: "[I]t would just be the same thing over and over" (Brenda, P.7, L.315). Brenda herself seems worn down by the client's "resistance" to change and believes that any intervention she were to make would be futile.

There appeared to be a belief that the S.I behaviour is far more difficult for the older client to let go of as a coping strategy. As Declan put it, "[T]he differences that I see is the younger person, they haven't got all them years of this, they have a chance of discovering help earlier in life that might be really useful for them" (Declan, P.10, L.450-452). In general, the participants appeared to share a sense of surprise that adults would continue to engage in S.I behaviour as a coping strategy. They expressed an expectation that the adult would have acquired the necessary skills to manage and/or resolve life's difficulties without resorting to S.I due to cognitive maturity. The participants appeared to be more

accepting of younger clients with S.I because those clients were still in the early stages of cognitive development.

Despite the participants' concerns that younger clients may pose a greater risk of suicide due to their impulsivity and misuse of drugs/alcohol, ironically, the participants' sense of hopelessness appeared to decrease when they were engaging with the younger clients. Overall, the participants believed that they were more helpful to clients who were children or adolescents, because these clients appeared more likely to transition from destructive S.I behaviour to healthier coping strategies through therapeutic intervention. Believing that S.I was less ingrained in the younger clients than in the older ones, the participants therefore, held out more hope for the younger clients.

Subordinate Theme III: Feeling Inspired

The language used by the participants when they discussed their younger clients' progress in the therapeutic space was revealing. It appeared that there was more hope than hopelessness. There also appeared to be a noticeable shift in the participants' energy; they smiled and became more animated when they discussed the progress of their younger clients. When articulating this positive and engaged attitude, Eamonn used a striking football-related metaphor:

"When it happens that I see people who become empowered . . . it's like scoring at Wembley. Now I never scored at Wembley, but it's like scoring at Wembley" (Eamonn, P.6, L.241-242).

Smiling as she spoke, Helen used similarly upbeat metaphorical language when she recalled a client's progress: "[S]he'd moved out of home, which was feckin' music to my ears, and she was flying" (Helen, P.14, L.582-583). Another participant, Anna, articulated her sense of pride in a young client and compared her therapeutic relationship with that client to a "mother–daughter relationship" (P.2, L.85). In addition, Declan smiled broadly as he compares himself to a "lifeboat guy":

"[T]alk about the sheer jubilance of pulling a person off the rocks or saving a person's life. Oh, it's a grand feeling" (P.12, L.540-541).

He described this sense of "jubilance" as "payback", indicating a perceived sense of reward.

These participants clearly described the shift they experienced from great concern to a sense of pride in and hope for their client's progress. It was apparent that this aspect of providing help and instilling "hope" resulted in a strong sense of personal satisfaction for participants. This might also indicate a marked increase in their sense of being able to help, rather than feeling helpless. It seemed that the increased sense of hope for the younger client might also relate strongly to the participant being a parent and therefore, having greater understanding of and empathy for the client. At times participants spoke about their own children's struggles in life; they had experience of how difficult it can be for young people as they transition through difficult periods in their lives.

As a parent and as a psychotherapist, Anna had a particular interest in "attachment" styles.

She indicated her sense that her young client's relationship with her mother appeared to be "fractured" due to an "insecure attachment" style. Anna believed that providing an appropriate level of attachment within the therapeutic relationship might provide a "second chance" for the client to resolve her attachment issues and was comfortable in nurturing this important relational aspect for her client. The repeated use of the word "soothe" in this passage emphasises Anna's willingness to nurture and perhaps to act as a healing mother:

> I think it's the mother part of me comes out, the maternal instinct. It's the same as if your own child, when they're small, and they fall, and they graze their knee. Immediately you're going to go and soothe it, and soothe it and soothe it. (Anna, P.7, L.284-287)

Subordinate Theme IV: Protecting the Self

When participants reflected on their ability to protect themselves while doing their therapeutic work. They noted supervision as a means of support. Helen was aware of her responsibility and the need for a supportive environment and relationship to be able to separate/disentangle her own experience from that of her young client. She addressed these issues in supervision:

> [S]upervision is very good for me. So yeah, it actually just brings you right back into that little piece where you were a child and where you're vulnerable and when you had no one really taking care of you and indeed you thought nobody cared. (Helen, P.9, L,271-273)

Helen had to ensure that she did not become complacent in her responsibility by assuming

her client would survive just because she herself had survived and relinquished her S.I behaviour. Helen also indicated that she relied heavily on supervision, particularly in relation to S.I clients, who triggered memories of her own S.I behaviour when she was young. As Helen saw it, supervision ensured not only that she could protect herself, but also that her experience did not adversely influence her response to her clients:

> Oh, Jesus, yeah. Yeah, straight in the door . . . I need to talk about something . . . and to be able to have a supervisor that you can be vulnerable with. I've had supervisors in the past that you cannot be vulnerable with, you know. You do go in guard up. But yeah, I'm delighted to have a fabulous supervisor in the last couple of years [and] now as well. That's amazing, you know. (Helen, P.8, L.321-325)

Carol describes supervision as her place of "letting go" (P.6, L.265: "[S]o you know . . . talking about it with a professional supervisor or peer support is what I would do, letting go, releasing, and parking. At the end of every day, you have to detach" (Carol, P.6, L.264-266). The participants expressed the importance of protecting the self by having clear boundaries between home and work and availing of supervision to discuss the impact of their work. They noted that the home environment was not the appropriate place for such discussion, as this could adversely affect their families and their own sense of safety in the home. Eight of the participants recognised the need for a place to "offload" their work experiences and the importance of protecting the self from the distressing content of their client's presentations. Geraldine explained how she instinctually reacted following exposure to something unprecedented: "I wanted to protect myself. I hadn't encountered

anything like this before, and I didn't want to encounter anything like it again" (Geraldine, P.5, L.206). Geraldine reflected on how she was affected by seeing a form of S.I (swallowing a tampon) that she had not previously encountered: "Because I haven't encountered that, or seen that, maybe that's why I'm not desensitised to it. Because you become a little desensitised, I think" (Geraldine, P.5, L.207-208).

Ita also questioned the idea of becoming "desensitised" in her work and if becoming desensitised increased her level of tolerance:

"I often ask myself that, and I often asked about the suicidal thing as well, do you become that it's not . . . I don't mean that it's not as big of a thing, but desensitised to some degree" (Ita, P.3, L.130-131).

Eamonn shared similar sentiments: "After a while, you know . . . I was used to it" (P.3, L.124). It appears that "desensitisation" or building up tolerance may also be viewed by the participants as a means of protecting the self from the impact of witnessing injuries.

Some of the participants appeared to believe that their experiences of S.I could be understood only by others working in the same field. The participants highlighted the importance of getting peer support from colleagues and of attending supervision to ensure ongoing awareness of the importance of self-care. All of the participants expressed their belief that supervision was important, as it provided the space and opportunity to reflect on their client work and to receive the necessary support to protect the self in relation to the adverse impact of the clients' presentations. The participants also acknowledged that, by being bound by their governing body's code of ethics and by the importance of client

confidentiality, they were limited as to where and with whom they could discuss their experiences.

To promote a sense of trust and safety for the supervisee/therapist, supervision relies heavily on a collegial alliance between supervisor and therapist. The quality of this relationship was not always guaranteed. Declan described having a problematic experience in supervision and felt that his supervisor had misunderstood him. Declan believed that his supervisor had implied that his request to touch a client's wounds had been inappropriate. Declan expressed: "[T]here was an insinuation that there was something between me and the girl which I thought was, it was very upsetting, but I let it go"(P.9, L.376-377. Declan was upset when he thought that his supervisor had inferred that he had behaved inappropriately by requesting to touch his young client's wounds. Declan was upset by this perceived accusation of inappropriateness because- as a parent- he would want his own children to feel cared for in this way if they were engaged in S.I behaviour. Declan's tone became sharp and a sense of annoyance could be detected as he describes his experience:

"Someone said to me you're really fond of that girl aren't you and I said I am. And I could have said, if I had the space, 'I have two daughters at home, I'm very fond of them too'" (Declan, P.8, L. 373-375).

All participants expressed their belief that peer support from colleagues, including managers in their workplaces, enhanced their ability to protect the self. Having access to colleagues and managers presented an opportunity to discuss difficult cases and off-load; it enabled them to detach and was seen as a means of protection from carrying work home. To facilitate self-care, Ita asked her manager if she could change her working hours. The

manager agreed to this change, which gave her time to exercise, walk her dogs and unwind after work. Ita also discovered that changing her hours gave her more access to peer support, which made a significant difference to her ability to effectively be supported in her work. Previously Ita had worked evening shifts with fewer staff which limited her access to colleagues and her manager.

With one exception, all participants indicated that their core training had not addressed the specific needs of the client presenting with S.I and/or suicidal behaviour. They acquired these specialised skills through in-house training given by the organisations for which they worked. Two of the participants indicated that they had encountered S.I before working in an organisation that specifically addressed S.I and/or suicide ideation. The majority of participants agreed that the value of the clinical experience they gained working with this client base, enhanced their clinical skills, increased their confidence and provided a greater understanding of S.I.

Conclusion

Based on the experiences of the nine psychotherapists that took part in this study, eight of the nine participants clearly indicated a level of difficulty in their ability to remain professional and composed when faced with some of the more distressing S.I presentations. A majority of participants spoke about their sense of shock and disbelief at witnessing these injuries as they wrestled with feelings of revulsion and the bodily sensations experienced as a result. Some participants considered that what they *heard* at

times was every bit as distressing as what they saw and what they smelt. They often listened to very graphic details of episodes of S.I that conjured up intolerable images. Furthermore, eight of the participants shared the belief that they must conceal their reactions/responses as they feared their clients would perceive this a judgement or rejection and they felt duty bound to protect their clients from any further distress. They expressed that their clients already carried a sense of shame due to their self-injurious behaviour and they did not want to add to that shame. Participants also wanted to portray themselves as composed professionals who could manage and tolerate the injuries they were faced with.

Participants described how they experienced their emotions in an embodied way and they struggled to manage the inner conflict/tension they experienced as they were being pulled in opposite directions. They experienced a physiological response within their bodies that, at times, left them feeling repulsed and nauseous. However, they continued to wrestle and conceal this inner tension from their clients.

Participants also expressed their feelings of fear and anxiety and were concerned that their clients S.I could ultimately result in a completed suicide. Having “to be on top of your clinical skills” as Geraldine puts it and the sense of urgency described by Carol to get her client “to hook onto hope” as she sits “at the edge of her seat”, indicates the level of intense responsibility experienced by the participants.

In order to protect themselves and sustain themselves in their work, they needed a place to “off-load” and “let go”. In this context, all of the participants highlighted the importance of supervision, support from colleagues and finding time to exercise and unwind as a means

of self-care. Witnessing their client's progress brought a great sense of pride and personal satisfaction to their work and this helped sustained them in their practice. In the following chapter, these findings will be explored against a backdrop of previous literature, highlighting similarities and differences to earlier findings. It will also explore the uniqueness of this current I.P.A study with regards to the participants' voices and experiences, which have illuminated the phenomenon of therapist's experiences of witnessing the physical manifestations of self-injury.

Chapter 5: Discussion

Introduction

Many evocative accounts unravelled, as nine psychotherapists spoke about what it was truly like to witness the physical manifestations of S.I. As they shared their experiences it illuminated a number of key findings that are highlighted in this chapter. The chapter will discuss the embodied and lived experiences of psychotherapists who were at times impacted beyond voice when faced with the issue of S.I.

Concealing your Inner World

The participants expressed their belief that concealment of their inner emotions was sometimes necessary to ensure that the client did not feel judged or react adversely to the therapist's response. Participants wrestled to conceal their sense of shock and horror, and to offer instead a face that displayed compassion and care. These finding echo the conclusions drawn by Fleet & Mintz (2013), who examined therapists' perceptions of clients who presented with S.I and the impact that this work had on the therapist. The five participants in their study concurred that their intense feelings, including feelings of shock and horror, needed to be contained and concealed from the client. They believed that the therapists should be a "robust enough container" to conceal their emotions (Fleet, and Mintz, 2013).

Notwithstanding this, Fleet, and Mintz's (2013) investigation did not attend to how their participants managed their inner responses/reactions whilst they aimed to conceal them from their clients, or indeed if the concealment of these responses posed any specific challenges for participants. In this current I.P.A study I probed more deeply and found that although the participants in this study aimed to conceal their initial responses. It illuminated how difficult this proved for them as they tried to suppress their reactions and responses. Moreover, this finding is aligned with the findings of Dowling, and Doyle (2017) who examined the experiences of guidance counsellors and teachers in Ireland and how they respond to S.I within the school setting. Similarly, the six participants (three guidance counsellors and three teachers) expressed a range of negative feelings and emotions in response to S.I. Two prominent reactions were shock and anxiety. Dowling, and Doyle (2017) found that their participant's sense of shock primarily related to students' ability to inflict this amount of pain on themselves and the anxiety experienced related to their ability to assist the pupils in their struggles.

In addition, participants with less experience of working with S.I were more prone to experience shock and panic and felt less equipped as to how to respond to the S.I presentation, which is in keeping with others (Berger, Hasking, & Reupert, 2014a; Best, 2006; Roberts-Dobie & Donatelle, 2007). This current I.P.A study is aligned with the findings of being shocked, however, the study highlights that even with therapists who have extensive experience working in the area of S.I, they can also be shocked and clinical experience in itself is not a protective factor. The study highlighted that different and unfamiliar forms of S.I appeared more shocking than those that therapists were used to seeing presenting. Crowell, Beauchaine, and Linehan (2009) highlighted the difficulties

that people who S.I, especially those with a diagnosis of Borderline Personality Disorder (B.P.D), experience whilst trying to regulate and manage emotion. Any hint of rejection might prevent the client from entering or remaining in therapy, hence, the need for the concealment. Moreover, a series of studies by (Long et al., 2018; Long et al., 2015) reported that how practitioners respond to S.I can impact the future behaviour of those engaging in S.I. Moreover, Long et al. (2015) suggested that negative responses from practitioners could potentially lead to further self-degradation and S.I and increase the risk of suicide attempts by clients. The participants in this current I.P.A study were not only trying to conceal a sense of shock, they also endeavored to conceal their sense of disgust and revulsion at the sight of the injuries themselves.

Eamonn had a client present for therapy with their lips, nose and eyelids cut and had no forewarning of what to expect. This clearly could be considered a "crucial event". Hochschild (2012) argued that "at some point the fusion of what is" concealed and revealed "will be tested by a crucial event" (p. 107). Morrissey (2015) asserts that injuries to the face are not common with presentations of SI. Morrissey's view seems to be evidenced in the findings of this study as Eamonn was the only participant who experienced facial injuries in a client's S.I presentation. Many people who engage in S.I behaviour are dealing with loss and/or rejection issues (Banks, 2006; Shaw, 2002, and Trepal, 2010). It is, therefore, especially important to create a trusting therapeutic alliance and nurture a sense of togetherness.

Muehlenkamp (2006) maintains that the experience of a secure and trusting relationship with the therapist can prove corrective and fruitful for the client. The formation of a

connection with the therapist can serve as a model of a healthy relationship and may enhance a client's relationships with others (Trepal, 2010). Insecure attachment has been associated with S.I behaviour in adolescent clinical samples (Adam, Sheldon-Keller, & West, 1996). In the present study, for example, Anna attributed a client's long history with S.I to her insecure attachment with her mother.

Glazebrook, Townsend, and Sayal (2015) conducted a six-month-follow-up study to investigate whether insecure attachment was associated with poorer outcomes with adolescents who S.I. Their study involved 52 adolescents (13–17 years) with recent histories of S.I who had been referred to specialist child and adolescent mental health services. They found that fourteen (27%) of these were securely attached to their mothers. Of the forty nine (94%) of adolescents followed up, those with insecure maternal attachment and insecure peer attachment were more likely to have engaged in repeated acts of S.I. Bostik's (2009) Grounded Theory study of adolescents who were overcoming experiences of attempted suicide found that the building of secure attachments through therapy can help people to open up; develop self-agency; increase their self-understanding and create lives worth living. Bostik concluded that the development of secure attachments in therapy is intricately linked to the development of resiliency that was lacking previously.

According to Murphy, et al. (2012), the process of therapy involves mutual experience of the core conditions identified by Rogers: empathy, unconditional positive regard and congruence. Empathy, congruence, and positive regard are all elements that contribute to strengthening the therapeutic relationship and sense of connectivity. The real connection that enables successful therapy is based on the genuine and authentic feelings that both the

client and therapist have toward one another, feelings that differentiate a real connection from a transference relationship. The participants in this study experienced a strong need/desire to conceal their responses to their clients' S.I presentations. Further along in this chapter, I will argue that this need/desire in no way detracts from the genuine feelings of care that participants held for their clients. Research has highlighted the importance of a "bi-directional' view" that considers client and therapists' experiences to be intertwined in a deep reciprocal connection (Tudor, 2010; Wiggins, Elliot, & Cooper, 2012). Through the participant's efforts to conceal their reactions/responses to protect their clients from any perceived sense of judgement, this present study has demonstrated the deep desire of participants to provide a warm and caring environment for their clients and create a safe haven in which they can explore their difficulties.

According to McLeod (2013), when clients were invited to describe what had been both helpful and unhelpful in the therapeutic process, they consistently identified the relational factor as being more important than the use of therapeutic techniques. Marchand (2015) describes the therapeutic relationship as a "shared presence" and a place where compassion lives. When therapists are working with clients with S.I, however, the therapeutic relationship can face serious challenges. Writing about her own experience of working with clients who S.I, Turp (1999) recalls having to confront such difficulties in the therapeutic relationship. Moreover, Brenda characterised the behaviour of a client as challenging and struggled to address what she saw as the client's apparent inability or unwillingness to change. Brenda also described the client as being unfair to others as the client would often phone the service at weekends and express her intent to die. The receptionists on call would often feel panicked despite this apparently being a regular

occurrence. Brenda was reluctant to work with this client again but appeared reluctant to say that she had a lack of empathy or any negative feelings towards her client. According to Brown (2007) a lack of empathy on the part of the therapist can make the therapeutic process less effective: “When we fail to evoke the clients’ experiences of being seen and known and when empathy is absent and therapy done by rote, then even our most empirically supported interventions work less well” (p. 259). As therapists we are expected to be empathic towards our clients and it can be difficult when negative feelings seep into the therapeutic relationship, hence Brenda’s struggle to express her negative feelings towards her client.

Anna acknowledged the depth of her connection with the client when she described their relationship as a “mother–daughter” attachment. This level of togetherness or connectivity in the therapeutic relationship relates to Bowlby’s attachment theory, which has become one of the most influential approaches to therapy. Bowlby (1988) highlighted our capacity to form powerful “affectional bonds” with significant people in our lives, and the positive influences that these bonds have on how we experience the world. It stands to reason, therefore, that a violation of the “affectional bond” can have far-reaching consequences for the injured party, and by extension for the therapeutic relationship itself. Johnson, Makinen, and Millikin (2001) articulated these “negative attachment-related events” as “attachment injuries” that usually manifest in the form of betrayals and abandonment (p. 145).

Not as Plain as the Nose on your Face

The participants in this study concurred that psychotherapy is essentially a face-to-face encounter and that they often place considerable importance on the client's face, particularly when the client's words do not align with their facial expression. The participants related that sometimes they altered or interrupted their own natural facial reactions in an attempt to conceal any sense of inner conflict or turmoil they might experience when they see a client's self- injuries. As individuals we often speak of "taking things at face value", of making an initial judgement "on the face of things" or of something being "written all over someone's face". The common use of such phrases illustrates an innate sense that what we see on the face of another is a core or genuine response and reaction. If there is any element of doubt about what is being heard, the *face* is often scrutinised as we look for further evidence that the speaker is being genuine.

In a face-to face encounter, however, there is no real possibility of hiding the *face*. The central importance of the face is well encapsulated in Bob Plant's seminal essay on the relevance to therapy of Emmanuel Levinas's philosophical writings on ethics and the face-to-face encounter: "The human face has a privileged role in our ordinary intersubjective lives. After all, we speak from the face and (most often) address ourselves to the face" (Plant, 2018, p. 282). For the participants in this study, the face was also an arena in which they struggled to maintain composure as they grappled to conceal their sense of shock, disgust, and disbelief in order to preserve the face-to-face encounter and the ongoing dialogue taking place within it. One of the most fundamental aspects of human social interaction is the communication of emotions, primarily through the exchange of various social signals, including facial expressions. An individual's facial expression is a significant influence on shaping first impressions of that person. This study highlighted the

participants' awareness that clients looked at a therapist's facial expressions to gauge the therapist's initial responses or reactions to their S.I presentations. A key finding in this study was how participants indicated a level of responsibility to ensure that their facial expressions conveyed a sense of them as being approachable, empathetic listeners and as people who could accept their clients and not appear shocked and horrified by their injuries.

There is an extensive body of research to be found investigating how "facial expressions can reveal emotions including happiness, anger, fear, disgust, sadness, and surprise, which are identified cross-culturally and regarded as universal," (Falconer, et al., 2019, p. 2). On the other hand, there appears to be a paucity of research in relation to the therapist's experience of having to alter their facial expressions in the therapeutic environment when faced with difficult client presentations. Falconer, et al. (2016) agree that there has been little research into facial expressions relating to motivational states like compassion. They posit that information about the facial expressions relating to such states can be useful in designing and tuning interactions that contain a compassionate element, such as therapeutic interventions. The participants in this current I.P.A study indicated that they were eager to display facial expressions that conveyed compassion and acceptance, whilst all the while trying to conceal their sense of shock.

Eight of the participants in this I.P.A study spoke of altering their initial facial expression as part of their concealment, as they too endeavoured to be a "robust enough container" for their clients. The idea of being a "robust enough container" aligns itself with the theory of containment by Bion (1962) and depicts how a mother can receive unwelcome and

overwhelming projections from her baby that are then processed by the mother and given back to the baby in a more pleasing fashion. A similar process can occur in the therapeutic relationship, with the therapist representing the "container", consuming the client's thoughts and feelings, and returning them to the client in a more acceptable format. The desire to manage, hold and contain responses came across as a key function for the participants in the present study. The role of the therapists is to create a warm and safe environment for the client. Greenberg (2007) suggests that "the affective climate is created predominantly by facial, vocal, gestural, and postural cues" (p.416). Anna recalled feeling as if she were being "tested" by one client: "[S]he was always looking for my facial expression when she would come in, and she'd be bandaged up".

It is understandable that therapists would adopt this protective stance towards their clients considering the number of studies that had highlighted the often-negative attitudes of healthcare professionals to patients/clients who presented with S.I (Cooper, 2010; McHale & Felton, 2010; O'Donovan, 2007; Reece, 2005; Saunders et al., 2012) Among the more negative attitudes and responses addressed by the literature were common assumptions that S.I was "attention-seeking" and "manipulative" behaviour (Reece, 2005; Klonsky et al., 2014). However, research has rarely focused on the psychotherapeutic setting or on how therapists respond in the face of S.I. Facial expressions are considered one of the most important sources of non-verbal information for humans interacting in social situations. Izard (1994) and Matsumoto, and Willingham (2009) maintain that facial expressions have long been considered a "hardwired human behaviour." To describe something as "hardwired" suggests that efforts to forcefully interfere with it might cause great difficulties. To interfere with a natural facial response, for example, might lead to tension

and stress.

The participants in this study faced this risk because they deemed it necessary to separate face from feeling in order to protect their clients from any perceived sense of judgement or rejection. This element of concealment pulled the therapists in opposite directions and at times left them uncertain as to whether or not they managed to conceal sufficiently. For example, Ita questioned her ability to conceal her reaction sufficiently, and the other participants faced similar difficulties and had to cope with various negative internal emotions as a result. This led to what could be described as a "tug of war" as therapists wrestled to display an outward response that was in conflict with what was happening to/for them internally.

The Push-Pull Struggle

> *Language is a very poor medium for expressing our emotional nature. It merely names certain vaguely and crudely conceived states but fails miserably in any attempt to convey the ever-moving patterns, the ambivalences and intricacies of inner experience, the interplay of feelings with thoughts and impressions, memories and echoes of memories, transient fantasy, or its mere runic traces.* (Langer, 1942, p. 100).

According to Aryani, Hsu, and Jacobs (2019), "recent studies have shown that a similarity between sound and meaning of a word (i.e., iconicity) can help to more readily access the meaning of that word" (P. 5298). The findings in this study support this view and echo

Eamonn's response to the language a client had used to describe how he had badly cut himself: "I've cut myself to ribbons. Even the sound, the visual piece would come into my mind. Jesus, cutting yourself to ribbons, you know". Similarly, Geraldine experienced feelings of revulsion when she merely *heard* that a client had swallowed a tampon as it conjured up intolerable injuries for her. At times, then, participants described how they had been discomfited by visual images based on what they had *heard*. At other times, though, they struggled to articulate their experiences with the use of words alone. Eamonn struggled to even say the word "self-harm". When Ita related her story of witnessing cigarette burns on her client's arms, she too struggled to verbalise her response with words alone: "[W]hat is it if it's not revulsion? What is it? I'm trying to think what word I'd use. . . I don't know. I can't put a word on it. But that horrible feeling in the stomach". Ita's description of this particular situation in her world, exemplifies how she was impacted beyond voice.

For the participants being shocked and disgusted by some of what they encountered — burning flesh, cigarette burns, eyelids "hanging off" — could be considered a normal, typical and/or natural response. However, Turp, (1999) suggests that the therapeutic relationship can be strengthened if therapists are not shocked or disgusted by the physical manifestations of S.I. Based on the findings of this current I.P.A study, Turps opinion appears a somewhat unrealistic response to witnessing the physical manifestations of S.I. Furthermore, this attitude could be considered a judgement on the therapist if they do indeed feel disgusted by what they witness. Moreover, Turp (1999) does not discuss the consequences for the therapeutic relationship if therapists fail in their efforts to conceal.

A majority of participants in this current I.P.A study conveyed that they made every effort to contain their feelings and reported that they had experienced bodily sensations when they concealed their feelings of shock and revulsion. This study has highlighted an important issue for therapists and as human beings recognising that there is no right or wrong with feelings; they are only feelings. Many clients who S.I struggle to express their emotions verbally and instead resort to injuring their bodies as a means of expression and communication. Merleau-Ponty claims that for speech to appear, there must be a structure of reflexivity in and between self, other and world (Merleau-Ponty 1968, p, 145). Through the art of reflective practice in the form of supervision, therapists could be encouraged to express their embodied experiences when faced with difficult S.I presentations.

Furthermore, if their responses/reactions have impacted on the therapeutic relationship then that too can be explored but first there must be an acknowledgement that their response is part of their experience which can be revealed in supervision without fear or judgement.

The phenomenologist Maurice Merleau-Ponty placed great emphasis on the inseparable relationship between our experience and our need to communicate it: "Merleau-Ponty's theory of language implies that, since language is an out-growth of our bodily existence, human experience will and always must be communicated" (McLane, 1996, p. 107). Merleau-Ponty describes the spoken word as "that language-thing which counts as an arm, as action, as offense and as seduction because it brings to the surface all the deep-rooted relations of the lived experience wherein it takes form" (Merleau Ponty, 1968, p.126). For the person who engages with S.I, "experiences are communicated through the skin as well

as the language that grows out of bodily existence; however, this transition from gesture to language is not simple" (McLane, 1996, p. 107). Research indicates that individuals who S.I can be effectively silenced through numerous life events, including experiences of trauma or ruptures in their childhood attachments. For those who have been silenced, S.I can become a way of communicating the psychological distress that lies beneath. Motz, (2010) has characterised this non-verbal and violent communication as an expression of "anger, contempt and shame through injuring as well as asserting control over otherwise unspeakable areas of life" (p. 85).

The participants in this study spoke of their struggles to exercise self-restraint when sitting face-to-face with clients whose self-inflicted injuries were causing the therapists to experience negative internal reactions. For Husserl, "the Body is, in the first place, the medium of all perception; it is the organ of perception and is necessarily involved in all perception" (Husserl, 1989, p. 12). For Husserl, the key to embodiment was the fact that when we use our hand, for example, to touch our other hand, we do not just feel the texture of the hand that we are touching; there are also senses which are being apprehended by the hand that is being touched. We experience both. There are different touch sensations which are located in both hands. There are senses on the body and senses in the body. Husserl (1989) was keen to argue that bodily sensations are "missing in 'merely' material things" (p. 25). The participants expressed their physical internal reactions to the clients' presentations. Fiona spoke of a "butterfly feeling" within and struggled to verbalise what she was experiencing *beneath the surface* of what she externally presented to the client. Eamonn described being "short of breath" and during her interview, Anna said: "Now, in my stomach I can feel it". Adler (1931) observed significantly, that both the mind and

body of individuals "come to us for treatment" (p. 33). Similarly, this study found that the therapists providing support to their clients also presented with both mind and body as what lay beneath the surface simmered away inside of them. Merleau-Ponty also focuses on how a person can withdraw from situations in which they are involved with other people as a subject by withdrawing into an anonymous and internal life within their own body in addition to experiencing the external world as part of their embodied state. He acknowledges that "It may be said that the body is the hidden form of being ourself'" (Merleau-Ponty, 1981, p. 165). The body is the conscious subject of experience and if it is the hidden form of us, then it would be a means through which to demonstrate inner torment or struggle which a person otherwise finds impossible to articulate.

Therapists often scan the faces and bodies of their clients to reveal clues to their individual particular sensitivities, anxieties and "tender spots". Reciprocally, the participants in this study found that their own faces and bodies could be scanned by the clients as the therapists grappled to suppress/conceal the physical responses within themselves. Goffman, (1959) in 'The Presentation of the Self in Everyday Life', suggests the idea that as soon as an individual comes into the presence of others, he or she is immediately presenting him or herself in a particular way. For Goffman," [W]hen an individual appears in the presence of others, there will usually be some reason for him to mobilize his activity so that it will convey an impression to others which it is in his interests to convey" (Goffman, 1959, p. 15).

Despite Eamonn's struggle to conceal his emotion and convey the impression that he considered to be in the best interest of his client, his body betrayed him as his "face went

white”. In conflict to what Goffman (1959) suggests, Eamonn’s efforts to mobilize his activity failed in this instance. He may have been in control of his facial expression but his true reaction broke through the skin barrier: the colour drained from his face.

Ita also believed that her eye infection was linked to the disturbing images to which she had been exposed. Perhaps the inner dialogue that is being silenced appears as a sort of “voice” on the skin. When emotion is bubbling under the surface and the individual deems it essential to conceal those strong feelings, it is not surprising that it spills over and appears on the skin. Merleau-Ponty (1962) uses the metaphor of “the boiling point”, which sums up these experiences nicely. Merleau-Ponty’s understanding of embodiment is the idea that there is a flow between physical movements and thought processes – the two are inextricably intertwined rather than two mutually exclusive terms.

Hayes et al. (2004) makes a related point when he postulates that “experiential avoidance is the phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioural dispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them, even when doing so creates harm” (p. 14). The term “harm” seems a strong claim to make within the present study, since none of the participants explicitly said that they had been “harmed”. They did, however, speak of “recurring images”, “disturbed sleep” and “flashbacks”. Carol also characterised the experience of witnessing very violent injuries as a “traumatic experience”. It is therefore, reasonable to say that these experiences do not fall under the term “harmless” because disturbed sleep alone compromises an essential aspect of positive mental health and well-being.

During their interviews, the participants shared experiences of witnessing sights and hearing stories that they had never expected to encounter in their life worlds. There is no denying that these experiences resulted in a multitude of bodily sensations as they experienced feelings of disgust and revulsion. The therapists found themselves having to decide whether to turn the heat off completely; to let their emotions simmer or to run the risk of reaching the “boiling point” where emotions spill over. If they choose the latter, this could possibly lead to another wound to the client, as ultimately it would be the client who would get burned. From the findings in this study, it appears that “boiling point” is reached when reactions become more difficult for participants to regulate as they experience the pull of emotion and grapple to push the emotion down. If they choose to switch off, however, their decision conflicts with the warm and safe environment in addition to the sense of compassion that they want to offer to their clients. Such an apparently cold response risks reminding some clients of difficult relationships they may have encountered in the past.

Carol described her encounter with a client’s S.I presentation as “traumatising”. “Trauma” derived from the Greek word for “wound”. According to the Oxford English Dictionary (2004), a trauma is a “deeply distressing experience” or an “emotional shock following a stressful event” (p. 1534). Figley (1995) postulates that, being exposed to the emotional suffering of others causes wounds to the self, and Johnson, et al. (2001) describe the onset of “existential vulnerability” with the potential for symptoms reminiscent of post-traumatic stress disorder.

Ita's disturbed sleep pattern due to recurring images of S.I and the instant "flashbacks" of her own self-injuries that Helen experienced following exposure to the client's S.I both seem to indicate such vulnerability and trauma. Many of the participants spoke of their experiences of the S.I presentations they witnessed as unforgettable, distressing and stressful events. This could possibly lead to constructs such as compassion fatigue, vicarious trauma and burnout from traumatic stress which has been found to occur in trauma working therapists, as noted by (Penz et al., 2018; Craig and Sprang). Furthermore, there is no doubt that the participants in this study experienced a physiological response to the S.I presentations, though some injuries had a more traumatic impact on participants than others.

There was a conscious or active attempt by participants to conceal their responses and withhold their true feelings and this could certainly be construed as "dishonesty". However, Jackson (2020) makes the distinction that "therapist dishonesty involves an active intention to mislead, whereas therapist non-self-disclosure does not" (p. 288). The motivation of the therapists in this current I.P.A study was to protect the client from any perceived sense of judgement or rejection.

Curtis & Hart (2015, p. 285) conducted a study with 112 psychotherapists and found that 96% of their participants withheld information from their clients if they thought it protected them. They went on to coin the term "benevolent deception" (Curtis, and Hart, 2015, p. 285). This current I.P.A study also revealed that the participants' "benevolent deception" or "concealment of emotion" was motivated by the desire to protect the face-to-

face relationship by protecting the client from any perceived sense of judgement; this response strongly echoes the ethical priorities we find in the philosophy of Emmanuel Levinas:

> Levinas's ethics is based on the Other/other. He argues that we are in an asymmetrical relationship with our neighbour that pre-destines us with ethical responsibility even before consciousness or choice, as cited by De Voss(2006, p. 5).

It is important to note that clients who presented with S.I would- by definition- be considered a vulnerable client population. Therapists are bound by ethical responsibility to provide care for the client and to cause them no harm or additional distress. Levinas speaks of the "face-to-face encounter with the other, an experience in which an individual is made aware of the other's mortality and vulnerability and is thus called upon to respond ethically to the other's cries for help" (Levinas, 1984, p. 130). Striking a similar note, Martin Heidegger sees concern for others as fundamental to "being-in-the-world", and he refers to this concern as "care" or the "care-structure". From this philosophical perspective, what Heidegger describes as "the phenomenon of care" is a basic mode of being. With this in mind, it is the role of psychotherapists to care for their clients, and the concealment of their negative emotions is considered an important aspect of this care (Heidegger, 1927/1965:122).

Some participants found certain kinds of injuries easier to tolerate than other kinds. Geraldine, as a trained nurse, had no difficulty in witnessing cuts, burns and bruises in the therapy room. Although this served her well in relation to the physical injuries to which she was exposed, it did not preclude her from being impacted when she *heard* that a client had swallowed a tampon. Geraldine felt repulsed by this disclosure. She still felt nauseous when she recalled the event during her interview. Ita shared a similar experience, explaining that witnessing cigarette burns on her client was more distressing to her than witnessing cuts. Anna found it difficult to witness the print of a hot iron on her client's ankle, though she found that she could cope with seeing the client's cuts. Although she had described herself as having a "strong stomach", Anna recalled how she felt "physically sick" at the sight of the burn mark, and her sense of nausea was increased by the smell of burning flesh. With a similar intensity, Ita recalled that she could almost smell and taste the cigarette burns she witnessed.

At one point during her interview, Fiona described a client who presented with severe S.I and who wore a revealing vest top. Fiona recalled how she "almost recoiled" at the sight of the big butterfly stitches that were consequently on display. She wondered what it would be like if this was someone's first client. When she raised this speculative question, Fiona seems to have been tentatively suggesting that an inexperienced therapist would not be able to contain or conceal their response in this instance. Such a suggestion may indicate that this presentation brought Fiona closer to "boiling point". In this instance, the wounds were fresh and raw. The passage of time had not yet allowed them to heal. If they had healed, it might have made seeing them seem more tolerable. The level of injury and how

recent the injuries were may have added to Fiona's anxiety that this client was at a greater risk of completed suicide.

Fear and Anxiety

Feelings of fear and anxiety featured heavily in the participants' interview responses and was a key finding in this study. The suicide risk that S.I carries, coupled with the fear that a client could die unintentionally from their S.I was very much present for the participants. Heidegger claims that we are 'thrown' into moods and that they 'assail us'- that is to say that they take over, pre-reflectively and emerge out of unique experiences of being-in-the-world (Heidegger, 1927/1962:137). This suggests that these psychotherapists were 'thrown' into anxious, worried and concerned moods, simply by their experience of witnessing the physical manifestations of S.I.

This was particularly relevant for participants who were engaged with child/adolescent clients. Participants outlined the sense of anxiety they experienced due to their heightened awareness of the connection between the S.I presentation and the risk of suicidal behaviour. They also indicated that S.I presentations combined with the misuse of alcohol/drugs- along with the impulsivity associated with adolescence- increased their concerns and sense of responsibility when working with young clients. Beckman, et al. (2018) propose that all young people presenting with S.I should be monitored closely due to the elevated risk of suicide. Due to the strong correlation that S.I bears to suicide, the participants found that they were continually assessing the client's level of suicide risk. It seems natural therefore, that Geraldine indicated how she needed to be "on top of her clinical skills". Many of the participants highlighted their concern that the clients might

complete suicide or die accidently through their S.I behaviour.

A majority of the participants reported that the clients S.I presentations were coupled with varying degrees of suicidal ideation. Similarly, Morrissey, et al. (2018) “note the complexity of working with S.I and the ambivalence associated about their intent to live/die” (p. 35).

O’Reilly, Kiyimba, and Karim (2016) posit that conversations about S.I and suicide in those under eighteen years of age are especially challenging for therapists. O’Reilly, et al. (2016) also consider this work to be emotionally demanding and requiring a high level of communication skill. Participants felt that if a client completed suicide, they would be held accountable and questioned as to what level of care they had offered to mitigate the risk of suicide. At times participants expressed their self-doubt and worry as to whether or not they could help their clients.

Sanderson (2006) maintains that when working with clients who engage in S.I behaviour, clinicians can experience a range of negative emotions, including a sense of “powerlessness and inadequacy” (p. 287). Research studies have also found that clinicians in this situation experience self-doubt and a decreased sense of professional competence; they question their ability to practice appropriately and safely, hence fuelling their anxieties, (Deutsch, 1984; Gulfi, et al., 2010; Menninger, 1991; Reeves, and Mintz, 2001; Wurst, et al., 2013). The findings of the present study support these claims including the participant Eamonn, who expressed his sense of self-doubt and questioned his ability to assist the client who had presented with extreme S.I on her face.

Almaliah-Rauscher, Ettinger, Levi-Belz, and Gvion (2020) conducted a study with 331 mental health professionals to explore their willingness to treat suicidal clients and how likely they were to refer these clients to other professionals. The results of the study indicated that the mental health professionals in question were less likely to treat suicidal clients compared with depressed patients and more likely to refer suicidal clients to other agencies. Furthermore, their sense of competency was found to be the strongest predictor of a mental health professional's willingness to treat clients.

One of Heidegger's key terms is Dasein. Dasein is the German vernacular for 'existence' or 'being-in-the-world' and he uses it in his own distinctive way to describe how we are always in a state of becoming. In his highly influential book 'Being And
Time' (1929). Martin Heidegger deals with such existential issues as our finitude, our consciousness of mortality and how that consciousness in a way gives meaning to our lives. To be a being-in-the world is not always easy and is accompanied with a great degree of anxiety or angst. Heidegger (1962) refers to the function of anxiety (angst) as a basic and fundamental mood. In times of anxiety, life can often appear meaningless which can lead to fear, guilt and a great deal of despair which can lead us to experience an existential crisis.

According to Spinelli, (1989) anxiety is not necessarily 'a bad thing' or a problematic presence that must be reduced or removed as a sense of anxiety can be stimulating and put us in touch with our sense of being alive. Furthermore, it can be the source to all creative and original insight and/or decision-making. Upon reflection, one could say that a life that

is anxiety-free would be empty of meaning, enthusiasm, curiosity and lack the urge to advance itself. This study found that anxiety, however, can reach crisis point, especially if the therapist feels ill-equipped to help or support the client. Dowling, and Doyle. (2017) found that worry and anxiety were also keenly felt by the participants in their study and that they expressed doubt in their own ability to manage S.I presentations. Their worry and anxiety seeped beyond their work environment and bled into their personal lives.

This issue also seemed ever-present for the participants in this study and was frequently mentioned in their interviews. The issue of completed suicide and/or sense of pressure is outlined in 'Discipline and Punish', where Foucault (1977/1991), speaks of a "field of documentation" in which examinations are used to place the individual into a "field of surveillance" where they feel the pressure to achieve sufficiently well against the achievements of others, so that their own achievements are compared to the 'norm', (p. 189). Foucault explains that:

> [W]e are in the society of the teacher-judge, the doctor-judge, the educator-judge, the 'social-worker'-judge; it is on them that the universal reign of the normative is based; and each individual, wherever he may find himself, subject to it his body, his gestures, his behaviour, his aptitudes, his achievements (Foucault, 1977, p. 304).

Hochschild (2012) investigated the concealment of emotions among airline stewards, who were encouraged not to display any negative reactions towards their passengers/customers.

Although the context and the motivations are different in this case, there is nevertheless a clear correlation with the present study's findings with respect to privileging the needs of the other. Hochschild refers to this concealment as "emotional labour"; it could be argued that the psychotherapists in this study, to some degree, mirrored this situation.

The participants acknowledged their need for resources that would help them to cope with the difficult and distressing experiences they had while supporting clients with S.I presentations. They highlighted the need for help to manage their anxieties and their visceral challenges. It is, therefore, especially important that therapists have the opportunity to engage in reflective practice so that they can process their experiences of trauma and/or vicarious trauma. Turp (1999) emphasises the need for supervision stating that, "until there are changes in thinking in some quarters, clients will continue to present for counselling or psychotherapy with a legacy of dismissive or punitive responses and a consequent reluctance to confide in us about their self-harming behaviour", (p. 311). Engaging in reflective practice aids realignment of the self and is essential to develop the "art" of solving problems that are unique or uncertain and can also "serve as a corrective to overlearning", (Schon, 1983, p. 61). Although supervision is an ethical requirement for therapists, more importantly it creates an environment for contemplation and reflection that can ultimately lead to transformational learning and an opportunity to critically self-reflect on the assumptions we make. Mann, Gordon, and MacLeod (2009) suggest that the capacity for reflection is an essential characteristic of professional competence and therefore, critical reflection can support professional development (Mezirow, 1994; Morrow, 2009). Supervision is a unique space in which to discuss the most challenging aspects of clinical work and provide the therapist with an opportunity to process the

emotions carried as a consequence of working with distressed clients. Reflective practice also facilitates the opportunity to examine prejudices and biases and assist in suspending judgement.

Therapists naturally possess values and opinions and few are without pain and shame. Therapists are human beings and experience instinctive responses to distressing behaviours and/or presentations. At times, the innate responses can conflict with how expectations of their ability as therapists developed during training. Clinicians therefore, need ongoing support and an empathic relationship within supervision.

Glover, and Philbin (2017) place emphasis on the role of supervision in helping therapists to better understand their lived experience, stating that "[U]nconcealing of lived experience potentially brings into sharper focus that which is hidden in view", (p. 241). The participants in this study concurred that supervision is an essential means of support, providing the opportunity to reflect and realign the self.

One participant vividly recalled a negative experience within supervision, in which they expressed feeling misunderstood and upset as a result. Furthermore, the sense of being unsupported or misunderstood could lead to further concealment by the therapist. Overall, the participants in this study expressed that they experienced supervision as a valued source of support, particularly when they sensed that their supervisors understood the difficult aspect of their client's work.

Hawkins, (2005) and Herman, (2001) acknowledge the importance of supportive contexts for therapists when working with trauma. Morrissey and Tribe (2001) also highlight the

ability of supervision to address parallel processing- the situation in which "the therapist is said to have the experience briefly of being like a client whom s/he does not actually resemble" (p. 105). Two of the participants in this study describe their experiences of 'parallel processing', although they did not name the experience using this specific term. Brenda expressed that at times she sensed that she mirrored her client's sense of hopelessness, while Helen was strongly affected by a S.I presentation that closely resembled her own past experience of injuring herself. Both maintained that supervision was essential to disentangle what belonged to them from that which belonged to the client. The participant, Helen, recalled her experience of supervision, expressing that she did not always feel safe enough to be as open as she needed to be, stating: "I've had supervisors in the past that you cannot be vulnerable with, you know. You do go in guard up. But yeah, I'm delighted to have a fabulous supervisor in the last couple of years [and] now as well. That's amazing, you know".

In one case of supervision, Declan may well have experienced what Glover and Philbin (2017) describe as a "leaping in". Glover and Philbin explain "leaping in" in the following terms: "The psychotherapy supervisor who leaps-in may often be worried about the indirect presence of clients and the quality of the therapeutic responses that they are receiving" (p. 243). The "leaping in" that Declan felt he had experienced prevented him from reflecting, processing and realigning the self within the supervision space. In turn, this ultimately risked creating further vulnerability within the therapeutic space both for him and the client. The majority of participants agreed that to utterly understand the difficulties of working with S.I client presentations, supervisors needed real experience of this level of distress and trauma. Supervision's primary aim is to provide a safe space for

the therapist to verbalise that which has been contained/concealed in the face of S.I; process the impact; reveal what lies beneath; share the burden of responsibility; reflect appropriately and realign the self.

Supervision and therapy share the common element of connection which is necessary to nurture a supportive relational alliance when facing adversity. Through the therapeutic relationship, the therapist aspires to relieve suffering by providing empathy, compassion and hope, which contribute to the creation of a "shared presence" and a sense of connectivity or togetherness. De Stefano, and Atkins (2017) suggest that in the therapeutic sphere the attachment to the therapist is the catalyst that fosters emotion regulation, among other things. The "containment" of safety provided by an empathic, responsive therapist allows the client to express upsetting emotions and thoughts (p. 298).

According to Cole-King, Green, Gask, Hines, and Platt (2013), engaging with clients compassionately in a competent manner through active, non-judgmental listening should be the bedrock of all clinical practice for S.I. The participants in this study endeavoured always to privilege the needs of their clients and ensure that they experienced compassion and acceptance, however difficult and distressful their S.I presentations had been. Collectively, the interview data highlighted the level of connectivity or togetherness that is an essential aspect of the therapeutic relationship:

> Healing through meeting is a two-sided event that is not susceptible to techniques in the sense of willing and manipulating to bring about a certain result. What is crucial is not the skill of the therapist but, rather, what takes

> place between the therapist and the client and between the client and other people, (Friedman, 2008, p. 300).

In facing adversity together through the human ability to connect, Long, and Jenkins (2010) maintain this as a necessary skill set of a therapist when working with clients presenting with S.I. They propose that therapists must be able to connect with their own feelings, remain aware of transference, be conscious that the client's progress can go in more than one direction, have practical understanding and experience of S.I, undertake continuing professional development, adopt best professional practice and know when and how to refer a client on. The complexity of the "space between" was experienced by the participant, Helen, when entanglements developed as her past self surfaced and interacted with the self of the present. Helen recalled how, having been "thrown back" to a past event, she required supervision in order to disentangle what belonged to her from what belonged to her client.

Participants in this study agreed that shared reflection, through the art of supervision facilitates more effective exploration of the "meaning" of the client's S.I behaviour. This is particularly relevant when examining the possible "function" of the S.I behaviour and what this behaviour might signify. Studies indicate that S.I behaviour might be understood as a form of communication intended to externally express internal experience (Hjelmeland et al., 2002; Hjelmeland et al., 2002; Latakienė et al., 2016; Zayas & Gulbas, 2012). Additionally, S.I may be a coping strategy used to distract from negatively attributed emotional states (Lenihan, 1993; Selby, 2014). It may also be an effort to eradicate perceptions of imperfection, an effort motivated by a sense that the expectations of others

and/or oneself can never be met (Flett, Hewitt, & Heisel, 2014) or by a feeling of being a burden to others (Joiner, 2005).

In summary, the unique and novel key findings that have been illuminated in this study have been discussed and positioned within the current literature. Participants wanted to greet their clients with a face that conveyed a composed professional, whilst secretly cloaking their sense of shock and horror at what they witnessed. The sense of disgust and revulsion they experienced, when witnessing injuries, bubbled beneath the surface as they desperately tried to control it. This was a key finding in the study: eight of the nine participants provided rich descriptions of how they grappled with their physiological responses to the sight of extreme cases of S.I. As participants approached "boiling point", due to either seeing S.I wounds or from hearing stories about acts of S.I, they wrestled to contain their physiological responses. Whilst being relationally bound in the face-to-face relationship, the participants reflect a self that is subject to change depending on which client they are seeing and/or what injuries they are exposed to. The participants allude to a self that has the potential to shift and/or alter within each therapeutic encounter, instead of necessarily remaining static and uniform. The participants were strongly aware of the separation between facial expression and internal feeling. According to the psychoanalysts Slavin, and Kriegman (1992), "Even in a so-called well-put-together person, multiple identities and versions of self also contribute perceptibly to the self's sense of I-ness or me-ness" (p. 370). At times participants felt nauseous or short of breath. Eamonn's physiological response seeped through the skin as his "face went white".

The ambiguous and complex nature of the presentations and the clients' ambiguity about

life and death brought an intense level of fear and anxiety to the therapists. An especially heavy burden was the urgent responsibility for assessing the level of increased risk of suicide ideation in any client who had presented with extreme S.I. The therapists' responsibilities included providing a safe, comfortable environment for clients to engage in therapy. All participants noted an increased sense of risk when working with children, although they also held out more hope that younger people might succeed in adopting healthier coping strategies and moving away from S.I. Moreover, a valuable contribution was made to psychotherapy by illuminating the taken-for-granted attitudes and expectations that are placed on therapists, either by themselves, their place of work and by society in general. Yes, therapists are trained to listen and to be empathic, however, this study illuminates the struggles that therapists can encounter as they wrestle to conceal feelings of disgust, shock, horror, and disbelief.

Chapter 6: Conclusions

Introduction

This chapter discusses the implications and recommendations for: psychotherapy practice, supervision, training and policy. The strengths and limitations of this study are outlined, followed by recommendations for future research. I will revisit Yardley's four broad principles for assessing the quality of qualitative research, which was introduced in Chapter Three (Yardley, 2000; Yardley, 2008), with commentary on how I have aimed to address these issues. Finally, the chapter will conclude with a personal reflection of my experience of this study.

Implications and Recommendations for Practice

This research study has implications for psychotherapy and supervision practices. Eight of the nine participants noted that S.I had not been part of their core training. This study may therefore also have implications for training programmes. Participants in this study noted the need for their clinical supervisors to have training that will enable them to understand the reactions/responses that therapists may have when they have been exposed to extreme S.I. However, what has not been investigated to the same extent are the strong responses/reactions that therapists may experience at the sight of injuries and to hearing explicit accounts/details of clients S.I. To the best of my knowledge this study is the first of its kind to address therapists' experiences of witnessing the physical manifestations of S.I and provides rich accounts of the therapists struggles and challenges as they grappled to conceal their reactions/responses from their clients which involved them moving to an

inauthentic self, which conflicts with the concept of genuineness and congruence- the very foundations that the therapeutic relationship rests upon.

Recommendations for Practitioners

This study has highlighted the gap in training for psychotherapists working in the area of S.I, hence the recommendation to attend appropriate training which explicitly outlines the specific challenges that therapists may face as they witness the physical manifestations of S.I and listen to graphic and explicit details of self-injurious acts. It is recommended that psychotherapists have access to regular supervision that is both effective and with a supervisor who has an understanding of the complexities of working with S.I. This is whilst also attending to what is being said and what has gone unsaid.

Psychotherapists should remain mindful of the emotional toll that working with S.I can have and utilise supportive supervision to realign the self as this study has shown how therapists' believe they have to 'perform' and move to an inauthentic self in order to protect the client from a sense of rejection, shame or judgement. Therapists should make their own self-care a priority when working with S.I and have clear boundaries as to where the work starts and ends in order to adopt a healthy work/life balance.

Implications and Recommendations for Supervisors

This study has highlighted how therapists often felt unheard in supervision with their supervisors attending to the level of risk their clients presented with and remaining focused on the risk of suicide as opposed to allowing the freedom to explore, uncover and reveal the true implications of working with S.I. This study highlighted the therapists' struggles to 'hold face' whilst at the same time experiencing feelings of disgust and revulsion. These experiences need an opportunity to be voiced and may also have a strong emotional impact on the supervisor who listens to such depictions. These issues warrant attention in the supervisory space not just for the supervisee but also the supervisor as there may be a parallel process at play. Therefore, supervisors should also engage in appropriate training and use supervision themselves to explore their own true experiences of what it is like to be dealing with such disturbing issues and to be listening to stories that have the capacity to conjure up intolerable images that remain long after the therapy or the supervision session. Supervisors should attend to the parallel process- after all, S.I usually tends to be a hidden behavior and so it is important to shed light on what the supervisee and the supervisor may also want to keep hidden as they too may have fear of judgement.

Recommendations for Policy

The main findings of this study would suggest that current policy and procedure surrounding the management of S.I presentations need to consider the impact on the therapists both personally and professionally when working in the area of S.I. Furthermore, the sense of responsibility experienced by therapists responding to S.I -which, in a majority of the cases, was coupled with suicidal ideation- requires support in the form of supervision. Hence organisations operating in this area should source funding to ensure

that therapists can avail of this support as and when required and at no additional cost to the therapists. The impact of the work both personally and professionally should be acknowledged and supported by the organisations they work for, as a duty of care to their staff. As it stands the accredited therapists in this study were only required to attend supervision on a monthly basis to meet their ethical requirements, due to the length of time that they were accredited. Supervision may need to be accessed more than once a month and funded by the organization and seen as a necessity to sustain staff in their therapeutic work.

Theoretical Transferability

The findings of this current I.P.A study may well be transferable. Psychotherapists working with stories of trauma such as sexual abuse or domestic violence may also benefit from the findings of this study. The findings have shown that hearing depictions of issues that are graphic in nature can conjure up disturbing images, strong emotions and physiological responses that bubble away under the surface. It is highly probable that other psychotherapists hearing about traumatic experiences may share similar responses/reactions.

Strengths and Limitations of the Current Study

One obvious limitation of the study was that all the participants practiced within services that worked primarily in the area of self-injury and suicide prevention. Participants had the

opportunity to receive peer support as well as in-house training and had extensive experience in providing therapy for clients presenting with S.I behaviour. They may, therefore, be better equipped to manage the impact of witnessing the physical manifestations of S.I, as opposed to psychotherapists working in more general practice, or indeed psychotherapists working alone in private practice with fewer supports available to them. Moreover, due to the pandemic crisis of Covid-19, many therapists are now offering their services online and may never be exposed to their client's S.I. Notwithstanding this, the participants in this study expressed how distressing it was for them to hear graphic details of S.I, which left them with disturbing images in their heads. Another possible limitation stems from the fact that I was conducting academic research of this kind for the first time. I have extensive experience as a psychotherapist, but the specific skill of the interviewer is critical to the success of such research (Smith, et al., 2009). To mitigate the risk of such inexperience, I engaged in practice run interviews to improve my skills in this area. Moreover, I attended an I.P.A colloquium, two I.P.A research summer schools and joined a weekly I.P.A peer group.

The sample size in this study is small, but this research does rely on nine interviews, which is considered sufficient for a Doctoral thesis by I.P.A standards. In addition to the limitations specific to this study, it might also be argued that I.P.A is open to criticism, in that it is not a prescriptive research method. It offers guidelines, as opposed to rules. A further criticism of I.P.A, reported by Van Manen (2017), is that it can prove problematic to determine if a research study is truly phenomenological. He posits that the term 'phenomenology' is often used at liberty in qualitative studies that are simply concerned with human experience. With regards to classifying if a research study is truly

phenomenological, Van Manen (2017) suggests asking if the questions and objectives are phenomenological and if the meaning targeted is phenomenological understanding as opposed to psychological, autobiographic, theoretic, case study or general qualitative. In the case of the current study, the meaning aimed for is phenomenological in that it seeks to understand the lived experience of therapists with specific reference to their experiences of witnessing the physical manifestations of S.I.

Despite the limitations of the current study, its strengths suggest that it could serve as a useful instrument for enriching and deepening the knowledge of psychotherapists working in the area of S.I and prepare them for the strong emotional and physiological reactions/response that they may experience. This research raises awareness of the authentic, first-hand embodied experiences of therapists who are exposed to S.I presentations.

With respect to some of the strengths of this study, I worked with self-injury issues for thirteen years prior to conducting this research and still work within this field today. I was careful to minimise bias through the research design and the use of I.P.A “bracketing” to redact occurrences of such bias. From a reflexive point of view, I was surprised to see that feelings of shame did not emerge as a theme for the participants in this study. This was based on my own responses when I witnessed some S.I presentations. I clearly recall a client who presented with excoriation, more commonly referred to as skin picking disorder. I recall my sense of shame when at that at the end of the session I did not want to shake her hand. Her hands were covered with a multiple of weeping sores that had been picked at over and over again. I felt a sense of shame that I could not bear to touch her, despite the

fact that she had come to me for help. Ordinarily, I would always shake my client's hand especially at the end of our first meeting.

When gathering and analysing the data for this study I paid careful attention not to influence the participants or manipulate the data in any way. When I thought that one participant was hinting towards a similar experience to mine, I had to be mindful that my own experience could naturally draw me to this finding, and I held in my awareness my own potential to focus on this issue. I will revisit the issue of bias and my attempts to hold my presuppositions in awareness in my final reflexive commentary.

Recommendations for Future Research

As this is a small study analysing the responses of nine psychotherapist who worked in services that provided therapy for people engaging in S.I and suicidal ideation, similar research could be undertaken targeting psychotherapists working in general practice to see whether similar superordinate themes are identified. During the recruitment process, only psychotherapists working in such organisations put themselves forward to partake in the research, despite therapists working in more general practice being included. In addition, whilst it may prove difficult to gain ethical approval for qualitative research with what would be considered a vulnerable population, it would be beneficial to interview clients who have engaged in self-injury and displayed their injuries in therapy. It would be interesting to see if clients concur with the findings of this study and perceive any negative reactions to their injuries as rejection, or indeed if they understand that their injuries may

be difficult for therapists to witness and are comfortable with therapists expressing their distaste.

Another recommendation for future research is based upon the fact that three of the nine therapists in this study had left the organisations they worked for. One participant openly expressed her sense of relief that she was no longer working in the area of S.I. It would be interesting to examine the rate of 'burn-out' amongst these therapists, considering the challenges they faced when witnessing S.I presentations. It is appropriate at this stage to assess the extent to which the aims of the study have been met. The research design and interviews for this study were shaped by questions that have not received a great deal of sustained attention in the existing literature. (See Chapter Two)

Review of the Aims of the Research Study

The research aims for this study were:

- To capture the therapist's lived experience of witnessing the physical manifestations of S.I.
- To gain an understanding of how this has affected them personally and professionally.
- To discover what therapists regard as the most challenging aspects of witnessing these events.
- To illuminate the strategies that therapists use to manage the presentations they have witnessed.

One consequence of the I.P.A approach is the clear importance of language and narrative in the interpretation of therapist's experiences. As I.P.A makes full use of verbatim interview transcriptions, language represents a medium of interpretation and so this should not be a surprise. However, the frequency with which language reveals implied meaning, or represents notable reactions by the therapist, is striking. It is difficult to see how such insight might emerge from alternative, more structured approaches, which may limit the broadness of expression in the interview process. It is hoped this research confirms that I.P.A provided an appropriate methodology for gathering rich data in examinations of new areas, particularly when addressing sensitive events in therapeutic relationships. It may be argued that a semi-structured interview process such as that employed in this study risks deviating into other areas that interviewees want to pursue and may not be relevant to the purposes of this study. These risks should be outweighed by the benefits of directly accessing undiluted data about these difficult experiences and therapists' attitudes towards

them. Moreover, the skill of the researcher can minimise the risks themselves (Smith, 2010). Although I am new to academic research, I was able to draw on twenty years of clinical experience as a psychotherapist, experience that required me to deal with complexity, where communication skills are key and addressing issues that required careful consideration, sensitivity and above all clarity.

Although the participants occasionally strayed into peripheral areas, the explicit goal of each interview was to describe their experiences of witnessing S.I presentations. The transcripts demonstrate that this goal has been achieved. In cases where the participants tried to distract from painful or embarrassing experiences, this was noted as relevant behaviour. Finally, Yardley's (2000; 2008) four broad principles for assessing the quality of qualitative research, as recommended by other qualitative researchers (Heffron and Gil-Rodriguez, 2011; Smith, et al., 2009) is presented here with commentary on how I have aimed to address these issues.

Sensitivity to context: I attended workshops on I.P.A and joined an I.P.A group to increase my knowledge of the chosen methodology. I continued to review the literature on S.I to keep myself abreast of current literature.

From an ethical perspective, I was mindful that this was a sensitive issue for participants to discuss. On occasions participants became emotional during their interviews and I asked if they would like to pause or abandon the interviews to ensure that they were not overwhelmed. I believe the rapport that I established and the empathy that I demonstrated by being mindful of my own tone of voice and body language allowed the participants to

continue to share their stories in a comfortable and supportive environment. I reassured participants that there was no right or wrong answer to the questions that I prepared in the semi-structured interview. I was interested in their experience, their thoughts, their feelings, and their meaning-making. This approach seemed to relax participants and gave them freedom to share their experiences without filtering the data or trying to portray themselves in a particular way. I assured them I was not interested in pre-conceived notions of how therapists should or should not respond to S.I. Instead, I wanted their honest experiences of what it was like to witness S.I presentations. This allowed the individual voices of participants to be heard whilst remaining faithful to the idiographic component of I.P.A. I included a considerable number of verbatim extracts from participants in support of the arguments being made in the study. Extracts of interviews demonstrating the engagement with the data are included in the appendices.

I paid attention not solely to the words that participants used. I also attended too and noted their body language. I was mindful that their body language would not translate through audio recordings and made notes immediately after the interviews took place, as their body language in itself, spoke volumes through facial expressions and hand gestures. I believe the body language often brought additional meaning to the words themselves and was something that participants seemed unaware of as they shared their stories.

I allowed ample time for participants to settle before I started the interviews while also being mindful and respectful of their time. Simple things like having water and tissues available was particularly helpful when participants became upset during the interviews. I allowed sufficient time to ensure that participants were settled before they left and

discussed any additional supports that they might need and of course taking the opportunity to express my sincere and heartfelt gratitude.

Under commitment and rigour, Yardley includes prolonged engagement with the topic, development of competence in the method used and immersion in the research data. Phenomenological research, in particular, requires dedication in completing a full analysis and moving further than glib interpretations. I attempted to completely immerse myself in the data and spent a huge amount of time dwelling in the research process. I read and re-read the transcripts and listened repeatedly to the recordings, up to the point where I could probably recant them verbatim. The research process is detailed and presented fully to the reader, attempting to illuminate how the study was conducted systematically and rigorously. Participant quotes are present in the analysis chapter, to demonstrate rigour. Research supervision was used and proved invaluable to ensure that balance was maintained between the idiographic component and meaningful interpretations made by myself.

I.P.A offers clear guidance on how to plan, gather and analyse data (Eatough & Smith, 2006; Smith & Osborn, 2008; Smith et al., 2009). This I.P.A study has followed such guidance and from the outset, considerable thought was given to make certain that the sample who were recruited were in a position to answer the research question. With regard to transparency and coherence: I have presented a manageable number of superordinate themes (two) demonstrating reduction and engagement with the data. However, I have placed myself in the shoes of the reader with the hope that I have demonstrated consistency with the underlying principles of I.P.A. In addition, working papers, including transcripts,

source audio files and sequential note-taking documents, will be made available on request to other academics wishing to evaluate how the methodology was applied. The appendices include extracts of transcripts demonstrating the application of the double hermeneutic of I.P.A and how, as a researcher, I dug deeper when engaging with the data to make sense of the participants' meaning-making and uncover a more in-depth interpretation of their experiences. In relation to impact and importance, the literature shows that there are different schools of thought with regard to S.I. There appears to be two distinct views: one suggesting that the motivation behind S.I is a way of coping and staying alive and some literature acknowledging the risk that suicide bears to S.I. This study has highlighted how the vast majority of clients that participants worked with also presented with suicidal ideation and this often left therapists literally "on the edge of their seat". If psychotherapists view S.I purely as a coping strategy, they may not enquire as to whether or not thoughts of suicide are present. These findings ultimately have implications for practice and training. The final principle 'Impact and Importance' queries if the research has something valid and useful to say, and I believe that I have fulfilled these criteria throughout this study. To date, the findings have been disseminated to psychotherapy colleagues through workshops on the subject of S.I. Dissemination of findings via conferences and journals will also be pursued. I submitted an abstract of my research for presentation at the Suicide and Self-Harm Research Workshop, to be held in May 2021. However, reviewers agreed that my submission may be better suited to their Research Seminar, which will take place in October 2021 and they have encouraged me to submit again.

A Reflexive Journal Entry

I would like to conclude with a personal reflection as I look back over my venture on this programme. Firstly, to be accepted on to the Doctorate programme at D.C.U was a great honour and a major achievement for me. I will be forever thankful to Dr Rosaleen Mc Elvaney and Dr Evelyn Gordon who interviewed me and accepted me onto the programme. They took a chance on me and- with the help of Dr Mark Philbin and the tutors on the Doctorate programme- they stretched me, challenged me, educated me and above all believed in me, even at times when I did not always believe in myself.

It took me time to gain confidence in the methodology and the study in general. There were times when I felt I was making my way through a thick fog and not knowing which direction to take. Notwithstanding this, I have taken great learning from this study which has ultimately changed my clinical practice. I continue to shed light and probe deeper on issues that surface in therapy to uncover, reveal and assist my clients in making sense and meaning of their experiences.

It is important at this point, to examine how effective I too was, when it comes to knowing what I have uncovered and acknowledging what I may have left unearthed due to my own blind spots. As I read back over the study, I wonder how much I was actually influenced by being an 'insider researcher' as I too, often struggled to conceal my true and authentic reactions/responses when witnessing S.I. Furthermore, I can recognise the parallel process of not wanting to be 'found out' or exposed, as I grapple with how authentic I can be at this point by pointing out my "blind spots" and exposing

myself to my academic supervisors and examiners. I may well have been influenced by my own experiences more than I "thought", despite believing/assuming I was more aware of them. On reflection, I wonder: did I want the therapists to be successful in their active and contrived concealments as they so desperately wanted to believe they were? We are all human. We are always in a state of becoming and I hope that I will not cease in my explorations of life both in a personal and professional capacity.

I have made every effort to approach this study with an open mindset, however, the hermeneutic cycle is ultimately an account of what the researcher believes the participants are saying and sometimes that is reflected by what they are not saying. Naturally, we are influenced by our own experiences. Notwithstanding this, I believe the audit trail that was monitored by my academic supervisors has assisted in the verification of the findings of this study as has my ongoing reflexive stance.

Going back to the things themselves, as in, the beginning of my studies, I now believe that I have come full circle- or there abouts! Final words go to the participants in the study as without them this study would never have been complete. To you, I will be forever grateful- thank you.

References

Adam, K. S., Sheldon-Keller, A. E., & West, M. (1996). Attachment organization and history of suicidal behaviour in clinical adolescents. *Journal of Consulting and Clinical Psychology*, *64*(2), 264–272. doi:10.1037//0022-006x.64.2.264.

Adamson, V., & Braham, L. (2011). Pathways to episodes of deliberate self-harm experienced by mentally ill men in a high secure hospital over the course of their lives: An exploratory study. *British Journal of Forensic Practice*, *13*(3), 169–182. Retrieved from: doi:10.1108/14636641111157814.

Adler, A. (1931). *What life should mean to you*. Boston, MA: Little, Brown.

Almaliah- Rauscher, S., Ettinger, N., Levi- Belz, Y., & Gvion, Y. (2020). 'Will you treat me? I'm suicidal!' The effects of patient gender, suicidal severity, and therapist characteristics on the therapist's likelihood to treat a hypothetical suicidal patient. *Clinical Psychology and Psychotherapy*, *27*(3), 278–287. doi:10.1002/cpp.2426.

American Psychiatric Association (2013) Diagnostic and statistical manual of mental disorders, 5th edn. American Psychiatric Association, Washington DC

Andrewes, H. E., Hulbert, C., Cotton, S. M., Betts, J., & Chanen, A. M. (2019). Relationships between the frequency and severity of non-suicidal self-injury and suicide attempts in youth with borderline personality disorder. *Early intervention in psychiatry, 13,* 194–201.

Andreasson, K., Krogh, J., Wenneberg, C., Jessen, H. K. L., Krakauer, K., Gluud, C., . . . Nordentoft, M. (2016). Effectiveness of dialectical behaviour therapy versus collaborative assessment and management of suicidality treatment for reduction of self-

harm in adults with borderline personality traits and disorder-a randomized observer-blinded clinical trial. *Depression and Anxiety, 33*(6), 520-530. doi:10.1002/da.22472.

Anonymous (2016) Self harm and the emergency department. British Medical Journal 353: i1150.

Aryani, A., Hsu, C. T., & Jacobs, A. M. (2019). Affective iconic words benefit from additional sound–meaning integration in the left amygdala. *Human Brain Mapping*, *40*(18), 5289–5300. doi:10.1002/hbm.24772.

Baer, M. M., Tull, M. T., Forbes, C. N., Richmond, J. R., & Gratz, K. L. (2020). Methods matter: Nonsuicidal self-injury in the form of cutting is uniquely associated with suicide attempt severity in patients with substance use disorders. *Suicide and Life-threatening Behavior, 50*, 397–407.

Banks, A. (2006). Relational therapy and trauma. *Journal of Trauma Practice*, *5*(1), 25–47. doi:10.1300/J189v05n01_03.

Barker, P. J., Reynolds, W., & Stevenson, C. (1997). The human science basis of psychiatric nursing: Theory and practice. *Journal of Advanced Nursing*, *25*(4), 660–667. doi:10.1046/j.1365-2648.1997.1997025660.x.

Beauchamp, T. L., & Childress, J. F. (1989). *Principles of Biomedical Ethics*. New York: Oxford University Press.

Bergen, H., Hawton, K., Waters, K., Ness, J., Cooper, J., Steeg, S., & Kapur, N. (2012). How do methods of non-fatal self-harm relate to eventual suicide? *Journal of Affective Disorders, 136*(3), 526-533. doi:10.1016/j.jad.2011.10.036.

Bergen, H., Hawton, K., Waters, K., Ness, J., Cooper, J., Steeg, S., & Kapur, N. (2012b). Premature death after self-harm: A multicentre cohort study. *The Lancet*, *380*(9853), 1568–1574. doi:10.1016/S0140-6736(12)61141-6.

Berger, E., Hasking, P., & Reupert, A. (2014a). We're working in the dark here: Education needs of teachers and school staff regarding student self-injury. *School Mental Health*, *6*(3), 201–212. doi:10.1007/s12310-013-9114-4.

Best, R. (2006). Deliberate self-harm in adolescence: A challenge for schools. *British Journal of Guidance and Counselling*, *34*(2), 161–175. doi:10.1080/03069880600583196.

Bion, W. R. (1962). *A theory of Thinking. In Second Thoughts*. New York: Aronason.

Blore, D. C. (2012). *An interpretative phenomenological analysis (IPA) investigation of positive psychological change (PPC) including post traumatic growth (PTG)* [PhD Thesis]. Birmingham: University of Birmingham.

Bockian, N. (2002). *New Hope for people with borderline personality disorder*. Roseville, CA: Prima Publishing.

Bond, T. (1993). *Standards and ethics for counselling in action*. London: SAGE.

Bostik, K. E. (2009). *Creating a life worth living: A grounded theory investigation of attachment in suicidal adolescents' process of healing*. Portland, OH: ProQuest Information and Learning.

Bowlby, J. (1969). *Attachment and loss, 1. Attachment.* New York: Basic Books.

Bowlby, J. (1979). *The making and breaking of affectional bonds*. London: Tavistock Publications.

Bowlby, J. (1988). *A secure base*. New York: Basic Book Company.

Breakwell, G. M., Hammond, S., Fife-Schan, C., & Smith, J. A.. *Research methods in psychology*. London: SAGE. *Quoted Smith J. A. & Eatough, V. (2006) Interpretative*

phenomenological analysis.

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*. Routledge, *21*(1), 87–108. doi:10.1080/14768320500230185.

Brown, T. B., & Kimball, T. (2013). Cutting to live: A phenomenology of Self-Harm. *Journal of Marital and Family Therapy, 39*(2), 195-208. doi:10.1111/j.1752-0606.2011.00270.x.

Brown, L. S. (2007). Empathy, genuineness-and the dynamics of power: A feminist responds to rogers. *Psychotherapy: Theory, Research, Practice, Training, 44*(3), 257-259. doi:10.1037/0033-3204.44.3.257

Brown, S. A., Williams, K., & Collins, A. (2007). Past and recent deliberate self-harm: Emotion and coping strategy differences. *Journal of Clinical Psychology, 4; 63*(4; 9), 791-803. doi:10.1002/jclp.20380.

Bunclark, J., & Crowe, M. (2000). Repeated self-injury and its management. *International Review of Psychiatry*, *12*(1), 48–53. doi:10.1080/09540260074120.

Burke, T. A., Ammerman, B. A., Hamilton, J. L., Stange, J. P., & Piccirillo, M. (2020). Nonsuicidal self-injury scar concealment from the self and others. *Journal of Psychiatric Research, 130*, 313-320. doi:10.1016/j.jpsychires.2020.07.040.

Cannon, J. L., & Umstead, L. K. (2018). Applying dialectical behavior therapy to self-harm in college- age men: A case study. *Journal of College Counselling*, *21*(1), 87–96. doi:10.1002/jocc.12089.

Carroll R, Metcalfe C, Gunnell D (2014) Hospital Presenting Self-Harm and Risk of Fatal and Non-Fatal Repetition: Systematic Review and Meta-Analysis. *PLoS ONE* 9(2): e89944. https://doi.org/10.1371/journal.pone.0089944.

Cassels, M., van Harmelen, A., Neufeld, S., Goodyer, I., Jones, P. B., & Wilkinson, P. (2018). Poor family functioning mediates the link between childhood adversity and adolescent non suicidal self-injury. *Journal of Child Psychology and Psychiatry, 59*(8), 881-887. doi:https://doi-org.dcu.idm.oclc.org/10.1111/jcpp.12866.

Chaney, S. (2011). 'A hideous torture on himself': Madness and self-mutilation in Victorian literature. *Journal of Medical Humanities*, *32*(4), 279–289. doi:10.1007/s10912-011-9152-6.

Chakraborti, K., Arensman, E., & Leahy, D. (2021). The experience and meaning of repeated self-harm among patients presenting to irish hospital emergency departments. *Issues in Mental Health Nursing,* , 1-16. doi:10.1080/01612840.2021.1913681.

Chen, W. L., & Chun, C. C. (2019). Association between emotion dysregulation and distinct groups of non-suicidal self-injury in Taiwanese female adolescents. *International Journal of Environmental Research and Public Health*. MDPI AG, *16*(18), 3361. doi:10.3390/ijerph16183361.

Choi, N. G., DiNitto, D. M., Marti, C. N., & Choi, B. Y. (2016). Non-suicidal self-injury and suicide attempts among ED patients older than 50 years: Comparison of risk factors and ED visit outcomes. *The American Journal of Emergency Medicine, 34*(6), 1016-1021. doi:10.1016/j.ajem.2016.02.058*le*. *American Journal of Emergency Medicine*, *34*(6), 1016–1021. doi:10.1016/j.ajem.2016.02.058.

Cole, J. (1997). On being faceless: Selfhood and facial embodiment. *Journal of Consciousness Studies*, *4*(5–6), 5–6.

Cole-King, A., Green, G., Gask, L., Hines, K., & Platt, S. (2013). Suicide mitigation: A compassionate approach to suicide prevention. *Advances in Psychiatric Treatment*,

19(4), 276–283. doi:10.1192/apt.bp.110.008763.

Collins, K., & Nicolson, P. (2002). The meaning of “satisfaction” for people with dermatological problems: Reassessing approaches to qualitative health psychology research. *Journal of Health Psychology*, *7*(5), 615–629. doi:10.1177/1359105302007005681.

Comtois, K. A., Jobes, D. A., S. O'Connor, S., Atkins, D. C., Janis, K., E. Chessen, C., Yuodelis-Flores, C. (2011). Collaborative assessment and management of suicidality (CAMS): Feasibility trial for next-day appointment services. *Depression and Anxiety, 4; 28*(11; 2), 963-972. doi:10.1002/da.20895.

Cooper, J. (2010; 2011). High mortality and reduced quality of life in people who have presented to hospital for self-harm in the UK. *Evidence-Based Mental Health, 13*(3), 74-74. doi:10.1136/ebmh1067.

Costley, C., Elliott, G., & Gibbs, P. (2010). *Doing work based research: Approaches to enquiry for insider-researchers. Sage.*

Creswell, J. (2013). *Qualitative inquiry and research design: Choosing among five approaches*. (3rd Ed). Thousand Oaks, CA: SAGE.

Crowell, S. E., Beauchaine, T. P., & Linehan, M. M. (2009). A biosocial developmental model of borderline personality: Elaborating and extending Linehan’s theory. *Psychological Bulletin*, *135*(3), 495–510. Retrieved from https://doi-org.dcu.idm.oclc.org/10.1037/a0015616. doi:10.1037/a0015616.

Curtis, D. A., & Hart, C. L. (2015). Pinocchio’s nose in therapy: Therapists’ beliefs and attitudes toward client deception. *International Journal for the Advancement of Counselling*, *37*(3), 279–292. doi:10.1007/s10447-015-9243-6.

De Stefano, J., & Atkins, S. (2017). Nonsuicidal self-injury, interpersonal neurobiology,

and attachment: Implications for counsellors and therapists. *Journal of Mental Health Counselling*, 39(4), 289–304. doi:10.17744/mehc.39.4.02.

De Voss, V. V. (2006–)03) EMMANUEL LEVINAS ON ETHICS AS THE FIRST TRUTH. *(MA (philosophy))—University of Stellenbosch* [Thesis].

Delaney, E., & Gordon, E. (2017). Grappling with the suicidal monster: A grounded theory of how parents experience living with suicidal distress. *Grounded Theory Review: an International Journal*, *16*(1).

Dowling, J., Hodge, S., & Withers, P. (2018). Therapists' perceptions of the therapeutic alliance in "mandatory" therapy with sex offenders. *Journal of Sexual Aggression*, *24*(3), 326–342. doi:10.1080/13552600.2018.1535139.

Dowling, S., & Doyle, L. (2017). Responding to self-harm in the school setting: The experience of guidance counsellors and teachers in Ireland. *British Journal of Guidance and Counselling*, *45*(5), 583–592. Retrieved from https://doi-org.dcu.idm.oclc.org/10.1080/03069885.2016.1164297

Doyle, L., Treacey, M.P., & Sheridan, A. (2015). Self-harm in young people: Prevalence, associated factors and help-seeking in school-going adolescents. *International Journal of Mental Health Nursing.* 24, 485-494.

Doyle, L., Sheridan, A., & Treacy, M. P. (2017). Motivations for adolescent self-harm and the implications for mental health nurses. *Journal of Psychiatric and Mental Health Nursing*, *24*(2–3), 134–142. https://doi-org.dcu.idm.oclc.org/10.1111/jpm.12360

Duffin, C. (2010). Creating a better educated workforce to support people with a personality disorder: People with the condition are often viewed as manipulative and attention seeking. Christian Duffin reports on an education initiative to change attitudes and client care. *Mental Health Practice*, *13*(5), 8–9. doi:10.7748/mhp.13.5.8. s8.

Eatough, V., & Smith, J. (2006). I was like a wild wild person: Understanding feelings of anger using interpretative phenomenological analysis. *The British Journal of Psychology, 97*(4), 483-498. doi:10.1348/000712606X97831.

Edmondson, A. J., Brennan, C. A., & House, A. O. (2018). Using photo-elicitation to understand reasons for repeated self-harm: A qualitative study. *BMC Psychiatry*, *18*(1), 98. https://doi-org.dcu.idm.oclc.org/10.1186/s12888-018-1681-https://doi-org.dcu.idm.oclc.org/3.

Elliott, R., Watson, J., Goldman, R., & Greenberg, L. (2004). *Learning emotion focused therapy*. Washington, DC: American Psychological Association.

Ellis, T. E., Rufino, K. A., Allen, J. G., Fowler, J. C., & Jobes, D. A. (2015). Impact of a suicide-specific intervention within inpatient psychiatric care: The collaborative assessment and management of suicidality. *Suicide & Life-Threatening Behavior, 45*(5), 556-566. doi:10.1111/sltb.12151.

Ellis, T. E., Rufino, K. A., & Allen, J. G. (2017). A controlled comparison trial of the collaborative assessment and management of suicidality (CAMS) in an inpatient setting: Outcomes at discharge and six-month follow-up. *Psychiatry Research, 249*, 252-260. doi:10.1016/j.psychres.2017.01.032.

Eriksson, E. (2013). To tell the right story: Functions of the personal user narrative in service user involvement. *Journal of Comparative Social Work*, **8**, 1– 32.

Falconer, C. J., Lobmaier, J. S., Christoforou, M., Kamboj, S. K., King, J. A., Gilbert, P., …. Brewin, C. R. (2019). Compassionate faces: Evidence for distinctive facial expressions associated with specific prosocial motivations. *PLOS ONE*, *14*(1). Retrieved from https://doi-org.dcu.idm.oclc.org/10.1371/journal.pone.0210283.

Falconer, C. J., Rovira, A., King, J. A., Gilbert, P., Antley, A., Fearon, P., and Brewin, C.

R. (2016). Embodying self-compassion within virtual reality and its effects on patients with depression. *BJPsych Open*, *2*(1), 74–80. doi:10.1192/bjpo.bp.115.002147.

Favazza, A. R. (1989). Why patients mutilate themselves. *Hospital and Community Psychiatry*, *40*(2), 137–145. doi:10.1176/ps.40.2.137, PubMed: 2644160.

Favazza, A. R. (1996). *Bodies under siege: Self-mutilation and body modification in culture and psychiatry*. (2nd Ed.). Baltimore, MD: Johns Hopkins University Press.

Finlay, L. (2009). Debating phenomenological research methods. *Hermeneutic Phenomenology in Education, 3(1), 6–25.*

Fleet, D. (2010). Counsellors' perceptions of client progression when working with clients who intentionally self-injure and the impact such work has on the therapist. *Counselling and Therapeutic Research, 13*(1). 1–9.

Fleet, D., & Mintz, R. (2013). Counsellors' perceptions of client progression when working with clients who intentionally self- harm and the impact such work has on the therapist. *Counselling and Psychotherapy Research*, *13*(1), 44–52. doi:10.1080/14733145.2012.698421.

Flett, G. L., Hewitt, P. L., & Heisel, M. J. (2014). The destructiveness of perfectionism revisited: Implications for the assessment of suicide risk and the prevention of suicide. *Review of General Psychology, 18*(3), 156-172. doi:10.1037/gpr0000011

Fortune, S., Sinclair, J., & Hawton, K. (2008a). Help-seeking before and after episodes of self-harm: A descriptive study in school pupils in England. *BMC Public Health*, **8**(1), 369.

Foucault, M. (1977/91). *Discipline and Punish: The birth of the prison*. London: Penguin Books.

Fox, C., & Hawton, K. (2004). *Deliberate self-harm in adolescence*. London: Jessica

Kingsley Publishers.

Friedman, M. (2008). Buber and dialogical therapy: Healing through meeting. *The Humanistic Psychologist*, *36*(3–4), 298–315. Retrieved from https://doi-org.dcu.idm.oclc.org/10.1080/08873260802350014.

Friedman, T., Newton, C., Coggan, C., Hooley, S., Patel, R., Pickard, M., & Mitchell, A. J. (2006). Predictors of A & E staff attitudes to self-harm patients who use self-laceration: Influence of previous training and experience. *Journal of Psychosomatic Research*, *60*(3), 273–277. doi:10.1016/j.jpsychores.2005.07.007.

Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: Literature review. *Journal of Advanced Nursing*, *49*(6), 616–623. doi:10.1111/j.1365-2648.2004.03331.x.

Gill, M. J. (2014). The possibilities of phenomenology for organizational research.*Organizational Research Methods,* 17(2), 118–137. https://doi.org/10.1177/1094428113518348.

Giorgi, A. (2010). Phenomenology and the practice of science. Existential Analysis, 21(1), 3.

Glazebrook, K., Townsend, E., & Sayal, K. (2015). The role of attachment style in predicting repetition of adolescent self- harm: A longitudinal study. *Suicide and Life-Threatening Behavior*, *45*(6), 664–678. doi:10.1111/sltb.12159.

Glover, R., & Philbin, M. (2017). Leaping- in and Leaping- Ahead: A hermeneutic phenomenological study of being- responsible in psychotherapeutic supervision. *Counselling and Psychotherapy Research*, *17*(3), 240–247. doi:10.1002/capr.12127.

Goffman, E. (1959). *The presentation of self in everyday life*. London: Penguin Books.

Goffman, E. (1963). *Stigma*. Englewood Cliffs: Prentice-Hall.

Gratz, K. L. (2003). Risk factors for and functions of deliberate self- harm: An empirical and conceptual review. *Clinical Psychology: Science and Practice*, **10**(2), 192– 205.

Greenberg, L. S. (2007). Emotion coming of age. *Clinical Psychology: Science and Practice*, *14*(4), 414–421. doi:10.1111/j.1468-2850.2007.00101.x.

Griffin, E., Dillon, C. D., Arensman, E., Corcoran, P., Williamson, E., & Perry, I. J. (2017). The 2016 annual report of the National Registry of Deliberate Self-harm. Retrieved from http://www.nsrf.ie/wpcontent/uploads/reports/NSRF%20National%20SelfHarm%20Registry%20Ireland%202016.pdf. National Suicide Research Foundation.

Happell, B., Platania- Phung, C., Scholz, B., Bocking, J., Horgan, A., Manning, F., … Biering, P. (2018). Changing attitudes: The impact of expert by experience involvement in mental health nursing education: An international survey study. *International Journal of Mental Health Nursing*, *28*(2), 480–491. doi:10.1111/inm.12551.

Happell, B., Waks, S., Horgan, A., Greaney, S., Manning, F., Goodwin, J., . . . Biering, P. (2020). “It is much more real when it comes from them”: The role of experts by experience in the integration of mental health nursing theory and practice. *Perspectives in Psychiatric Care, 56*(4), 811-819. doi:10.1111/ppc.12496

Haw, C., Hawton, K., Houston, K., & Townsend, E. (2003). Correlates of relative lethality and suicidal intent among deliberate Self- Harm patients. *Suicide & Life-Threatening Behavior, 33*(4), 353-364. doi:10.1521/suli.33.4.353.25232.

Hawton, K., Harriss, L., & Rodham, K. (2010). How adolescents who cut themselves differ from those who take overdoses. *European Child & Adolescent Psychiatry, 19*, 513–523.

Hawton, K, Saunders, KE, O'Connor, RC (2012) Self-harm and suicide in adolescents. *The Lancet 379*(9834): 2373–2382.

Hawton, K., Linsell, L., Adeniji, T., Sariaslan, A., & Fazel, S. (2014). Self-harm in prisons in England and Wales: An epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. *Lancet*, *383*(9923), 1147–1154. doi:10.1016/S0140-6736(13)62118-2.

Hayes, S. C., Follette, V. M., & Linehan, M. M. (2004). *Mindfulness and acceptance: Expanding the cognitive-behavioural tradition*. London: Guilford.

Heffron, K., & Gil-Rodriguez, E. (2011). Reflecting on the rise in popularity of interpretive phenomenological analysis. *Psychologist*, *24*(10), 756–759.

Heidegger, M. (1962). *Being and time*. Oxford: Blackwell Publishing

Herman, J. L. (2001). *Trauma and recovery: From domestic abuse to political terror*. London: Pandora Press.

Hewitt, K. (1997). *Mutilating the body: Identity in blood and ink.* Bowling Green, OH: Bowling Green State University Popular Press.

Hjelmeland, H., Knizek, B. L., & Nordvik, H. (2002). The communicative aspect of nonfatal suicidal behavior—are there gender differences? *Crisis*, *23*(4), 144–155. doi:10.1027/0227-5910.23.4.144.

Hochschild, A. R. (2012). *The managed heart : Commercialization of human feeling*. Berkerley: University of California Press.

Horgan, A., Manning, F., Bocking, J., Happell, B., Lahti, M., Doody, R., . . . Biering, P. (2018). 'To be treated as a human': Using coproduction to explore experts by experience involvement in mental health nursing education—The COMMUNE project. *International Journal of Mental Health Nursing*, *27*(4), 1282–1291.

doi:10.1111/inm.12435.

Hu, N., Taylor, C. L., Li, J., & Glauert, R. A. (2017). The impact of child maltreatment on the risk of deliberate self-harm among adolescents: A population-wide cohort study using linked administrative records. *Child Abuse and Neglect*, *67*, 322–337. doi:10.1016/j.chiabu.2017.03.012.

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology: An introduction to phenomenological philosophy*. Northwestern University Press.

Husserl, E. (1989). Ideas pertaining to a Pure Phenomenology and to a Phenomenological Philosophy, Book 2: Studies in the Phenomenology of Constitution' translated by Richard Rojcewicz and Andre Schuwer, Collected Works, *3. Drorecht: Kluwer in Welton D* (ed.), 2004 The Body: Classic and Contemporary Readings. Oxford: Blackwell Publishing.

Husserl, E. (2012). *Ideas: General introduction to pure phenomenology*. Routledge.

Inckle, K. (2017). *Safe with self-injury: A practical guide to understanding, responding and harm reduction*. Monmouth: PCCS Books.

Self-harm in Irish Prisons 2019 Third report from the Self-Harm Assessment and Data Analysis (SADA) Project April 2021.

Jackson, D. (2020). The therapist's dilemma: Tell the whole truth? *Journal of Clinical Psychology*, 76(2), 286–291. doi:10.1002/jclp.22895.

Jagger, G. E., & Sterner, W. R. (2016). Excoriation: What counsellors need to know about skin picking disorder. *Journal of Mental Health Counselling*, *38*(4), 281–297. doi:10.17744/mehc.38.4.01.

Jeffery, D., & Warm, A. (2002). A study of service providers' understanding of self-harm. *Journal of Mental Health*, *11*(3), 295–303. doi:10.1080/09638230020023679.

Jobes, D. A., & Joiner, T. E. (2019). Reflections on suicidal ideation. *Crisis : The Journal of Crisis Intervention and Suicide Prevention, 40*(4), 227-230. doi:10.1027/0227-5910/a000615.

Johnson, S. M., Makinen, J. A., & Millikin, J. W. (2001). Attachment Injuries in Couple Relationships: A new perspective on impasses in couple's therapy. *Journal of Marital and Family Therapy*, 27(2), 145–155. doi:10.1111/j.1752-0606.2001.tb01152.x.

Kapur, N. (2005). Management of self-harm in adults: Which way now? *British Journal of Psychiatry, 187*(6), 497-499. doi:10.1192/bjp.187.6.497.

Klineberg, E., Kelly, M. J., Stansfeld, S. A., & Bhui, K. S. (2013). How do adolescents talk about self-harm: A qualitative study of disclosure in an ethnically diverse urban population in England. *BMC Public Health*, **13**(1), 572.

Klonsky, E. D. (2009). The functions of self-injury in young adults who cut themselves: Clarifying the evidence for affect-regulation. *Psychiatry Research*, *166*(2–3), 260–268. https://doi-org.dcu.idm.oclc.org/10.1016/j.psychres.2008.02.008.

Klonsky, E. D., & Muehlenkamp, J. J. (2007). Self- injury: A research review for the practitioner. *Journal of Clinical Psychology*, **63**(11), 1045– 1056.

Klonsky, E. D., May, A. M., & Glenn, C. R. (2013). The relationship between non suicidal self-injury and attempted suicide: Converging evidence from four samples. *Journal of Abnormal Psychology*, *122*(1), 231–237. doi:10.1037/a0030278.

Klonsky, E. D., Victor, S. E., & Boaz, Y. S. (2014). Non-suicidal self-injury: What we know, and what we need to know. *The Canadian Journal of Psychiatry*, *59*(11), 565–568. doi: 10.1177/070674371405901101

Lakeman, R., McAndrew, S., MacGabhann, L., & Warne, T. (2013). 'That was helpful … no one has talked to me about that before': Research participation as a therapeutic

activity. *International Journal of Mental Health Nursing, 22*(1), 76-84. doi:10.1111/j.1447-0349.2012.00842.x.

Langer, S. (1942). *Philosophy in a new key*. New York: Penguin.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. Qualitative Research in Psychology, 3(2), 102–120. https://doi.org/10.1191/1478088706qp062oa.

Latakienė, J., Skruibis, P., Dadašev, S., Grižas, A., Dapševičiūtė, I., & Gailienė, D. (2016). They Don't take it seriously: Perceived reactions of surrounding people to suicide communication. *Illness, Crisis, and Loss, 24*(3), 123-136. doi:10.1177/1054137315589691

Lewis, S. P., & Heath, N. L. (2015). Nonsuicidal self-injury among youth. *The Journal of Pediatrics, 166*(3),526 530.doihttps://doiorg.dcu.idm.oclc.org/10.1016/j.jpeds.2014.11.062

Levinas, E. (1961/9). *Totality and infinity*. Pittsburgh: Duquesne University Press.

Levinas, E. (1972/2006). *Humanism of the other:* University of Illinois Press.

Levinas, E. (1985). *Ethics and infinity: Conversations with Phillipe Nemo*. Pittsburgh: Duquesne University Press.

Lilley, R., Owens, D., Horrocks, J., House, A., Noble, R., Bergen, H., Hawton, K., Casey, …. (2008). Hospital care and repetition following self-harm: Multicentre comparison of self-poisoning and self-injury. *British Journal of Psychiatry*, *192*(6), 440–445. https://doi-org.dcu.idm.oclc.org/10.1192/bjp.bp.107.043380.

Long, M., & Jenkins, 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. doi: 10.1080/14733140903474293.

Long, M. (2018). 'We're not monsters ... we're just really sad sometimes:' hidden self-injury, stigma and help-seeking. *Health Sociology Review, 27*(1), 89-103. doi:10.1080/14461242.2017.1375862.

Mackay, N., & Barrowclough, C. (2005). Accident and emergency staff's perceptions of deliberate self-harm: Attributions, emotions and willingness to help. *The British Journal of Clinical Psychology*, *44*(Pt 2), 255–267. https://doi-org.dcu.idm.oclc.org/10.1348/014466505X29620.

Meehan, T. & Glover, H. (2007). Telling our story: Consumer perceptions of their role in mental health education. *Psychiatric Rehabilitation Journal*, **31**, 152– 154.

Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qual Health Res, 14*(5), 726–735.

Mangnall, J., & Yurkovich, E. (2008). A literature review of deliberate self- harm. *Perspectives in Psychiatric Care*, *44*(3), 175–184. doi:10.1111/j.1744-6163.2008.00172.x.

Mann, K., Gordon, J., & MacLeod, A. (2009). Reflection and reflective practice in health professions education: A systematic review. *Advances in Health Sciences Education: Theory and Practice*, *14*(4), 595–621. doi:10.1007/s10459-007-9090-2.

Marchand, L. (2015). Shared presence: The heart of the therapeutic relationship. *Families, Systems and Health: The Journal of Collaborative Family Healthcare*, *33*(3), 283–284. doi:10.1037/fsh0000154.

Martin, G., Swannell, S. V., Hazell, P. L., Harrison, J. E., & Taylor, A. W. (2010). Self-injury in Australia: A community survey. *Medical Journal of Australia*, **193**, 506– 510.

McCarthy, L., & Gijbels, H. (2010). An examination of emergency department nurses' attitudes towards deliberate self-harm in an Irish teaching hospital. *International*

Emergency Nursing, *18*(1), 29–35. doi:10.1016/j.ienj.2009.05.005.

McHale, J., & Felton, A. (2010). Self-harm: What's the problem? A literature review of the factors affecting attitudes towards self-harm. *Journal of Psychiatric and Mental Health Nursing*, *17*(8), 732–740. doi:10.1111/j.1365-2850.2010.01600.x.

McLane, J. (1996). The voice on the skin: Self-mutilation and Merleau-Ponty's theory of language. *Hypatia*, *11*(4), 107–118. doi:10.1111/j.1527-2001.1996.tb01038.x

McLeod, J. (2013). Developing pluralistic practice in counselling and psychotherapy: Using what the client knows. *The European Journal of Counselling Psychology*. Retrieved from https://ejcop.psychopen.eu/article/view/5/html

McMahon, E. M., Keeley, H., Cannon, M., Arensman, E., Perry, I. J., Clarke, M. (2014). The iceberg of suicide and self-harm in Irish adolescents: A population-based study. *Social Psychiatry and Psychiatric Epidemiology*, *49*(12), 1929–1935. doi:10.1007/s00127-014-0907-z.

Merleau-Ponty, M. (1962) *The phenomenology of perception*. New York: Routledge and Kegan Paul.

Merleau-Ponty, Maurice. 1968. *The visible and the invisible.* Trans. Alphonso Lingis. Evanston IL : University of Illinois Press.

Mezirow, J. (1994). Understanding transformative theory. *Adult Education Quarterly*, *44*(4), 222–232. doi:10.1177/074171369404400403.

Miller, R. M., Chan, C. D., & Farmer, L. B. (2018). Interpretative phenomenological analysis: A contemporary qualitative approach. *Counsellor Education and Supervision,* 57(4), 240–254. https://doi.org/10.1002/ceas.12114.

Morrissey, J., & Tribe, R. (2001). Parallel process in supervision. *Counselling Psychology Quarterly*, *14*(2), 103–110. doi:10.1080/09515070126329.

Morrissey, J., Doyle, L., & Higgins, A. (2018). Self-harm: From risk management to relational and recovery-oriented care. *Journal of Mental Health Training, Education and Practice*, *13*(1), 34–43. doi:10.1108/JMHTEP-03-2017-0017.

Morrow, E. (2009) Teaching critical reflection. Teaching in Higher Education.Vol. 16.No. 2. pp 211-223. doi: 10.1080/13562517.2010.515022.

Muehlenkamp, J. J. (2006). Empirically supported treatments and general therapy guidelines for non-suicidal self-injury. *Journal of Mental Health Counselling*, *28*(2), 166–185. doi:10.17744/mehc.28.2.6w61cut2lxjdg3m7.

Murphy, C., Keogh, B., & Doyle, L. (2019). ‘There is no progression in prevention’ – The experiences of mental health nurses working with repeated self-harm. *International Journal of Mental Health Nursing*, *28*(5), 1145–1154. https://doi-org.dcu.idm.oclc.org/10.1111/inm.

Murphy, D., Cramer, D., & Joseph, S. (2012). Person-centered relational therapy as mutual encounter. *Person-Centered and Experiential Psychotherapies*, *11*, 109–123. Retrieved from: doi:10.1080/1477.

Murray, N., & Beglar, D. (2009). *Inside Track: Writing dissertations and theses*. England: Pearson.

Nash, C., & Basini, S. (2013). Just Whose Hand Rocks the Cradle? *Irish Journal of Management*, *32*(2), 129–156.

Nathan, J. (2010). Managing self-harm: Psychological perspectives. Edited by Anna Motz. Routledge. 2009. 248 pp. ISBN: 9781583917053. *British Journal of Psychiatry* a. Motz (Ed.). Routledge, 197(3), 250–250. doi:10.1192/bjp.bp.109.073528

National Collaborating Centre for Mental Health (UK). (2012). (NICE Clinical Guidelines, No. 133.) 4, EXPERIENCE OF CARE. Self-harm: Longer-term management.

Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK126796/. Leicester, UK: British Psychological Society.

National Institute for Health and Care Excellence. (YEAR) Self-harm. *NICE Quality Standard*, *34*. London: NICE. (2013). Retrieved from www.nice.org.uk/ guidance/qs34/chapter/ Introduction-and-overview.

NSRF. (2018). *National self-harm registry Ireland annual report*. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/nsrf-national-self-harm-registry-ireland-annual-report-2018. National Suicide Research Foundation. Retrieved from http://wwwnsrf.ie/statistics/suicide

Nafisi, N., & Stanley, B. (2007). Developing and maintaining the therapeutic alliance with self-injuring patients. *Journal of Clinical Psychology*, **63**(11), 1069– 1079.

Nielsen, E., & Townsend, E. (2018). Public perceptions of self- harm: Perceived motivations of (and willingness to help in response to) adolescent self- harm. *Archives of Suicide Research*, **22**(3), 479–495.

Nock, M. K. (2009). Why do people hurt themselves? New insights into the nature and functions of self- injury. *Current Directions in Psychological Science*, **18**(2), 78– 83.

Nock, M. K., Teper, R., & Hollander, M. (2007). Psychological treatment of self-injury among adolescents. *Journal of Clinical Psychology*, *63*(11), 1081–1089. doi:10.1002/jclp.20415.

O'Connor, S., & Glover, L. (2017). Hospital staff experiences of their relationships with adults who self-harm: A meta-synthesis. *Psychology and Psychotherapy*, *90*(3), 480–501. https://doi-org.dcu.idm.oclc.org/10.1111/papt.12113.

O'Donovan, A. (2007). Pragmatism rules: The intervention and prevention strategies used by psychiatric nurses working with non-suicidal self-harming individuals. *Journal of*

Psychiatric and Mental Health Nursing, *14*(1), 64–71. doi:10.1111/j.1365-2850.2007.01044.x.

O'Donovan, A., & Gijbels, H. (2006). Understanding psychiatric nursing care with nonsuicidal self-harming patients in acute psychiatric admission units: The views of psychiatric nurses. *Archives of Psychiatric Nursing*, *20*(4), 186–192. doi:10.1016/j.apnu.2005.12.007.

Ogrodniczuk, J., & Oliffe, J. (2010). Manning up for men's mental illness. *Australian Family Physician*, *39*(12), 931–932.

Owens, C, Hansford, L, Sharkey, S, et al. (2016) Needs and fears of young people presenting at accident and emergency department following an act of self-harm: Secondary analysis of qualitative data. The British Journal of Psychiatry 208(3): 286–291.

Owens, C, Sharkey, S, Smithson, J, et al. (2015) Building an online community to promote communication and collaborative learning between health professionals and young people who self harm: An exploratory study. Health Expectations 18(1): 81–94.

O'Reilly, M., Kiyimba, N., & Karim, K. (2016). 'This is a question we have to ask everyone': Asking young people about self- harm and suicide. *Journal of Psychiatric and Mental Health Nursing*, *23*(8), 479–488. doi:10.1111/jpm.12323.

Oxford English Dictionary. (2004). *Concise Oxford English Dictionary*. UK: University Press.

Parkes, J. H., & Freshwater, D. S. (2012). The journey from despair to hope: An exploration of the phenomenon of psychological distress in women residing in British secure mental health services. *Journal of Psychiatric and Mental Health Nursing*, *19*(7),

618–628. doi:10.1111/j.1365-2850.2012.01909.x.

Park, Y., Mahdy, J. C., & Ammerman, B. A. (2021; 2020). How others respond to non-suicidal self- injury disclosure: A systematic review. *Journal of Community & Applied Social Psychology, 31*(1), 107-119. doi:10.1002/casp.2478.

Patton, M. Q. (1990). *Qualitative evaluation and research methods*. London: SAGE.

Pembroke, L. (1994). *Self-harm: Perspectives from personal experience*. London: Survivors Speak *Out*.

Plant, B. (2018). Levinas in therapy. *Theory and Psychology*, *28*(3), 279–297. doi:10.1177/0959354318763120.

Pringle, J., Drummond, J., McLafferty, E., & Hendry, C. (2011). Interpretative phenomenological analysis: A discussion and critique. *Nurse Researcher*, *18*(3), 20–24. doi:10.7748/nr2011.04.18.3.20.c8459.

Ramcharan, P., & Cutcliffe, J. R. (2001). Judging the ethics of qualitative research: Considering the 'ethics as process' model. *Health & Social Care in the Community*, 9(6), 358–366. https://doi.org/10.1046/j.1365-2524.2001.00323.x

Ridley, S., Martin, R. & Mahboub, L. (2017). Consumer involvement in the tertiary-level education of mental health professionals: A systematic review. *Australian Social Work*, **70**, 372– 380.

Roberts-Dobie, S., & Donatelle, R. J. (2007). School counsellors and student self-injury. *Journal of School Health*, *77*(5), 257–264. doi:10.1111/j.1746-1561.2007.00201.x.

Robson, C. (2002). *Real world enquiry: A resource for social scientists and practitioner-researcher* (2nd Ed.). Oxford: Blackwell Publishing.

Rogers, C. (1967). *On becoming a person.* London, UK

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality

change. *Journal of Consulting Psychology*, *21*(2), 95–103. doi:10.1037/h0045357.

Rogers, C. R. (1980). *A way of being*. Boston, MA: Houghton Mifflin.

Roter, D. L., Frankel, R. M., Hall, J. A., & Sluyter, D. (2006). The expression of emotion through nonverbal behavior in medical visits: Mechanisms and outcomes. *Journal of General Internal Medicine : JGIM, 21*(S1), S28-S34. doi:10.1111/j.1525-1497.2006.00306.x

Ryberg, W., Diep, L. M., Landrø, N. I., & Fosse, R. (2020; 2019). Effects of the collaborative assessment and management of suicidality (CAMS) model: A secondary analysis of moderation and influencing factors. *Archives of Suicide Research, 24*(4), 589-608. doi:10.1080/13811118.2019.1650143.

Saunders, K. E. A., Hawton, K., Fortune, S., & Farrell, S. (2012). Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review. *Journal of Affective Disorders*, *139*(3), 205–216. doi:10.1016/j.jad.2011.08.024. Retrieved from https://doi-org.dcu.idm.oclc.org/10.1016/j.jad.2011.08.024.

Schon, D. (1983). *The reflective practitioner: How professionals think in action*. New York: Basic Books.

Self-harm in Irish Prisons (2017). *First report from the Self-Harm Assessment and Data Analysis (SADA) Project. Draft date: August 2018*.

Sexton, L. (1999). Vicarious traumatisation of counsellors and effects on their workplaces. *British Journal of Guidance & Counselling, 27*(3), 393-403. doi:10.1080/03069889900760341.

Simpson, A. (2006). Can mainstream health services provide meaningful care for people who self- harm? A critical reflection. *Journal of Psychiatric and Mental Health Nursing*, *13*(4), 429–436. doi:10.1111/j.1365-2850.2006.01000.x.

Sinclair, J. M., Hawton, K., & Gray, A. (2010). Six-year follow-up of a clinical sample of self-harm patients. *Journal of Affective Disorders*, *121*(3), 247–252. Retrieved from: doi:10.1016/j.jad.2009.05.027.

Slavin, M. O., & Kriegman, D. (1992). *The adaptive design of the human psyche*. New York: Guilford.

Smith, J. A. (2003). *Qualitative Psychology: A practical guide to research methods*. London: SAGE

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 39–54.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory method and research*. London: SAGE.

Smith, J. A. (2015). The phenomenology of Face- to- Face mindreading. *Philosophy and Phenomenological Research*, *90*(2), 274–293. doi:10.1111/phpr.12063.

Smith, J., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. Smith (Ed.), *Qualitative psychology: a practical guide to research methods* (pp. 51–80). London

Snorrason, Í., Smári, J., & Ólafsson, R. P. (2011). Motor inhibition, reflection impulsivity, and trait impulsivity in pathological skin picking. *Behaviour Therapy, 42*(3), 521-532. doi:10.1016/j.beth.2010.12.002.

Spinelli, E. (1989). The Interpreted World. An Introduction to Phenomenological Psychology, London: Sage Publications.

Stanley, B., Winchel, R., Molcho, A., Simeon, D., & Stanley, M. (1992). Suicide and the self-harm continuum: Phenomenological and biochemical evidence. *International*

Review of Psychiatry, *4*(2), 149–155. doi:10.3109/09540269209066312.

Stänicke, L. I. (2021). The punished self, the unknown self, and the harmed self - toward a more nuanced understanding of self-harm among adolescent girls. *Frontiers in Psychology, 12*, 543303-543303. doi:10.3389/fpsyg.2021.543303.

Swannell, Sarah V. (2014) Prevalence of Nonsuicidal Self-Injury in Nonclinical Samples: Systematic Review, Meta-Analysis and Meta-Regression *Journal:Suicide & life-threatening behavior* ISSN Volume: 44 Issue: 3 Page: 273-303 DOI:10.1111/sltb.12070.

Taylor, B. (2003). Exploring the perspectives of men who self-harm. *Learning in Health and Social Care*, *2*(2), 83–91. doi:10.1046/j.1473-6861.2003.00042.x.

Trepal, H. C. (2010). Exploring Self- Injury through a relational cultural lens. *Journal of Counseling and Development, 88*(4), 492-499. doi:10.1002/j.1556-6678.2010.tb00051.x

Tudor, K., & Worrall, M. (1994). *Congruence reconsidered*. Place of Publication: Taylor & Francis Group.

Turner, B. J., Baglole, J. S., Chapman, A. L., & Gratz, K. L. (2019). Experiencing and resisting non suicidal Self- injury thoughts and urges in everyday life. *Suicide and Life-Threatening Behavior*, *49*(5), 1332–1346. doi:10.1111/sltb.12510.

Turp, M. (1999). Encountering self-harm in psychotherapy and counselling practice. *British Journal of Psychotherapy*, *15*(3), 306–321. doi:10.1111/j.1752-0118.1999.tb00455.x.

Turp, M. (2003). *Hidden self-harm*. Narratives from psychotherapy. Jessica Kingsley Publishers, London.

Van Manen, M. (1990). *Researching lived experience, human science for an action sensitive pedagogy*. New York: State University of New York Press.

Van Manen, M. (2017). But is it phenomenology? Qualitative Health Research, 27(6), 775–779. https://doi.org/10.1177/1049732317699570.

Van Manen, M. (2018). Rebuttal rejoinder: Present IPA for what it is—Interpretative psychological analysis. Qualitative Health Research, 28(12), 1959–1968. https://doi.org/10.1177/1049732318795474.

Victor, S. E., & Klonsky, E. D. (2014). Correlates of suicide attempts among self-injurers: A meta-analysis. *Clinical Psychology Review*, *34*(4), 282–297. doi:10.1016/j.cpr.2014.03.005.

Wagstaff, C., Jeong, H., Nolan, M., Wilson, T., Tweedlie, J., Phillips, E., Senu, ….. (2014). The accordion and the deep bowl of spaghetti: Eight researchers' experiences of using IPA as a methodology. *Qualitative Report, 19(24), 1–15.*

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

Walsh, B. W. (2008). *Treating self-injury: A practical guide*. London, UK: The Guilford Press.

Warm, A., Murray, C., & Fox, J. (2003). Why do people self-harm? *Psychology, Health and Medicine*, *8*(1), 72–79. Retrieved from: doi:10.1080/1354850021000059278.

Williams, A. J., Nielsen, E., & Coulson, N. S. (2020). "They aren't all like that": Perceptions of clinical services, as told by self-harm online communities. *Journal of Health Psychology*, *25*(13–14), 2164–2177. https://doi.org/10.1177/1359105318788403

Whisenhunt, J. L., Chang, C. Y., Flowers, L. R., Brack, G. L., O'Hara, C., & Raines, T. C. (2014). Working with clients who self-injure: A grounded theory approach. *Journal of Counseling and Development, 92*(4), 387-397.

doi:10.1002/j.1556-6676.2014.00165.x

Williams, D., & Gilligan, R. (2011). Self-injury and the challenges of responding to young people in care:The experiences of a sample of social care workers. *Irish Journal of Applied Social Studies, 11*(1), 14-25.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham, UK: Open University Press.

Yakeley, J., and Burbridge-James, W. (2018). Psychodynamic approaches to suicide and self-harm. *British J Psych Adv* 24, 37–45. doi: 10.1192/bja.2017.6.

Yalcin, M., Tellioğlu, E., Yildirim, D. U., Savrun, B. M., Özmen, M., & Aydemir, E. H. (2015). Psychiatric features in neurotic excoriation patients: The role of childhood trauma. *Noro Psikiyatri Arsivi*, *52*(4), 336–341. doi:10.5152/npa.2015.9902.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*(2), 215 228. doi:10.1080/08870440008400302.

Yardley, L. (2008). *Demonstrating validity in qualitative psychology. Qualitative Psychology.* London: SAGE

Zayas, L. H., & Gulbas, L. E. (2012). Are suicide attempts by young latinas a cultural idiom of distress? *Transcultural Psychiatry*, *49*(5), 718–734. doi:10.1177/1363461512463262.

Appendices

Appendix A: Interview Schedule

Therapists' Experiences of Witnessing the Physical Manifestations of Self-Injury

- Please tell me about a time when you witnessed the physical manifestations of self-injury?
- What happened?
- What did you see?
- How did you feel?
- What did you think? What were your interpretations at the time?
- What did you do?
- How did the encounter develop?
- How did your understandings develop through the encounter? Since then?
- How do you judge the quality of your response to the self-injury?
- What else is significant about all of this?
- What else would you like to say?
- Please tell me about another situation like this.
- Is there anything else you would like to tell me about your experience of witnessing the physical manifestations of SI? Is there anything I have not asked you that you would like to add?

Appendix B: A sample of (Anna's transcript) demonstrating the first stage of analysis.

Data	Description	Language Use	Conceptual
A7. So, can you recall a time when you would have witnessed the physical manifestations of self-injury? And maybe tell us about it. Okay, I worked with a client, a young girl, 16, who had extreme borderline personality. And she would have had engaged in self-harm from the age of 13, and had been admitted into the hospital, maybe on a weekly basis with extreme self-harm. So that would be cutting, burning, she used to cut herself and measure blood, so that she would drop below a certain level that she would have to be admitted into the A&E, so she was able to calculate the percentage of blood loss. So, she would present in after doing that, so she'd be wrapped in bandages. And she would… her cutting was extremely intensive. **A8. So, what was it like for you to witness?** It was very, very difficult because she was adamant on showing the self-harm. So even though you'd boundary… but because I think she suffered from borderline personality, it seemed to be part of the presentation that she did have, is the need to show. And I think what she was looking for that, was like a parental response, like a nurturing, because there had been difficulties with her mother relationship. But for me, I've a strong stomach anyway, so… but it was just that she was young,	Anna describes a case of extreme self-injury. Cutting. Burning. Determined to show her wounds. Difficult Strong stomach. Urgent medical assistance required. The medical staff were impacted by her self-injury. She carried her. Reflection Visual images. Hard to forget.	Anna spoke in a factual matter. "She was able to calculate the percentage of blood loss". Boundaries disregarded. Is a strong stomach required? The injuries were extreme and very, deep, deep wounds. The repeated use of the word "deep" emphasis the extent of the wounds. Hard for others to comprehend. Rumination. Anna uses the term "we" as opposed to "I". Who does this refer to?	An element of respect that this young woman had mastered her craft so well. "It was very, very difficult" What is the "it"? She felt she was looking for a parental response. Does this conflict with a professional response? Mothers carry their children, and the client was looking for a parental response. The penny dropped. "over a period of time we began to identify that it was impacting on you", She starts with saying "we began to identify" and then shifts to saying, "impacting on you". Impacting on whom?

and that it was so intense. Like, I've had other clients who would present in, but they would be more superficial cuts, but these would have been cuts that would have needed urgent medical help, so there'd be a lot of stitches, and they'd be very deep, deep wounds. And they would be from the neck down, it wasn't any specific area. So, like, when I did see it, she produced her arm, so it was like something that had come out of a burning, it was so scarred. So, it was completely covered. And she had presented into the A&E department and she would talk about even the nurses that had worked there a long time would be very impacted by her, the intensity of her self-harm. **A9. And you said you had a strong stomach, so how would you say those… witnessing those cuts and those burns… how did it have… did it have no effect or…?** It would have an effect because I would think about it later on in the day. You know, I think when you're in the session you're kind of focusing on the client, but when you have time to drop down into yourself, and you go home of an evening and you're sitting, and you have your alone time, you're reflecting back over the day. And she would be the one client that I reflect back in, because it was very visual. So, I think over a period of time – because I worked with her for eight years – so I think over a period of time we began to identify that it was impacting on you, because you could create… you could see it visually.			

Appendix C: Developing Emergent Themes.

Emergent Themes	Original Transcript	Exploratory Comments	Researchers Interpretations
Mother-Daughter Relationship Blast from the past. Feeling the Fear but I'll Work with her Anyway Feeling the pain Fake it till you Make it. Going above and beyond	**A8.** "What she was looking for that, was like a parental response, like a nurturing, because there had been difficulties with her mother relationship". **A10.** "She was the same age as my own daughter at the time". " It definitely became a mother-daughter relationship". **A16.** "She had an intense attachment to me… … It definitely became a mother-daughter relationship. **A31.** "I would go over to her on a weekly basis and see her in the hospital – they asked me to go in to her. There was one time that she locked herself into the toilet and	The participant names the relationship as a mother-daughter relationship. The participant had a child the same age as her client. She states that she believed her client was looking for a maternal response. There had been difficulty with the client's initial attachment to her mother. The participant wanted to become the mother this girl didn't have. At various points throughout the text the participant speaks in terms of soothing, healing and how self-injury is this client's "soother". The language used supports/demonstrates the maternal transference that seemed to be at play. The participant speaks about making herself really available to this client and visiting her	The participant speaks about having an interest in attachment and how she is drawn to this area. She appears to contribute the success of her work to be based on the relationship she developed with the clients she spoke about. There seemed to be a strong desire to provide her client with a secure base and a different experience of attachment. This is evident throughout and the participant uses language like 'holding','nurturing','healing' and 'soothing'. She is confident in believing that this was what her client needed. She uses terms like "rebirthing". There was something more attached to this relationship it appears to have exceeded the normal realm of therapy and my sense making of this, is that it presented more like a mother-daughter relationship above anything else. The participant herself uses those very words. The participant speaks about another client she worked with and would have witnessed her wounds too. However, there is

Repairing ruptures in relationship Desire to nurture	she wouldn't come out, unless I would come over and talked to her. So I sat outside the toilet and coaxed her out". " It was never draining on me, no. And probably with other clients, I probably would have had that feeling of, oh you know, this is too much hard work, I'm not able to contain it. But my relationship with her was, it was never any trouble to go over to her". "If you're going to break this relationship, if this relationship is going to break, you're going to do it on your own, I'm not going to do it for you, or allow you to do it. And I think that was really important. I don't think she's ever experienced that before". **A49.** "I think it's the mother part of me comes out, the maternal instinct. It's the same as if your own child,	while she was in hospital. She was going above and beyond. Perhaps an underlying fear that the client would complete suicide. This relationship was different, possibly due to the mother-daughter relationship she describes it as. She said herself she may not do this for other clients. There also seems to be an element of being needed. Like she was the only person who understood this client. Difficult to forget what was witnessed. Thinking of the client beyond the therapy room. Hard to switch off and taking her home with her. There is fear and anxiety attached to working with this client. She could complete suicide. The participant appears confident in managing parents. Nonetheless, she does mention parents applying pressure and how they need to understand that this behaviour maybe keeping their child alive.	a different energy when she speaks about the first client who she describes as having a very, very intense relationship with self-harm. It presents as a very personal account possibly exaggerated by the extent of the injuries. As she said herself, this client was her best teacher, and nothing would shock her after that. The participant speaks about her challenges along with the rewards and her professional growth as a result of working with her clients. She attributes the strong empathic relationship being fuelled by seeing the extent of her client's wounds. Nonetheless she was not side-tracked by what she witnessed she continued to pay attention to the psychological distress that manifested in self-injuries behaviour. Despite describing herself as having a strong stomach, she felt sick when she could smell burning flesh and witnessing the print of an iron on her client's ankle. This subsequently led to recurring images of what she had witnessed, spilling into her personal life and thinking about this client when she was at home. There was a sense of no one knowing their child like their mother. This seemed to be the case in the therapeutic relationship too. She was

Ruminating S.I was her life boat.	when they're small and they fall and they graze their knee, immediately you're going to go and soothe it and soothe and soothe it. So, I think it's the mother part. Now, it could be completely different if I were never a mother, but I think the maternal instinct comes in straight away, is to heal it and make it better". **A9.** "And I remember going home that evening and visualising, I could see the print of the iron nearly, the wound was that shape". " I think when you're in the session your kind of focusing on the client, but when you have time to drop down into yourself, and you go home of an evening and you're sitting, and you have your alone time, you're reflecting back over the day. And she would be the one	This client is different to others. The participant seems to be operating from a mother's perspective. It was obvious from the participant's face and body language that this was difficult for her and the senses of sight, smell and hearing were all activated. The participant was aware that the client was testing the relationship, lashing out with the expectation of rejection. It appears the participant never faltered, never rejected and remained consistent throughout with this client. She was holding face to some degree, not wanting to show shock or judgement.	invited into meetings with the psychiatrist and advocated on the client's behalf. The relationship stretched far beyond the therapy room. Even though the first client she spoke about having a poor attachment to her mother and coming from a very dysfunctional family she shared different experiences with the other client and acknowledges that she came from a very supportive background. Although there was empathy for both there was an obvious difference when she spoke about the first client and the depth of the relationship. The participant offered a healing relationship to her clients. I think what the participant is describing is fitting of the stroppy teenager. The participant had stated that she is a mother herself. I think what she is saying is that she has experience of being a mother and dealing with teenagers and "the sulky child."

Being driven by fear Sensory overload	client that I reflect back in, because it was very visual”. **A20.** “Also, she would overdose. She would make suicide attempts”. “But I think the pressure, it mainly comes from parents, because their goal is that the child needs, and it’s natural reaction. But I think as you more educate parents in around it, they have an understanding then that the strategy may be keeping the child alive for that particular time”. **A27.** “So, I think if she didn’t have it, even though it was extremely intense, I think she’d have taken her own life”. “So, when it went to that level, it was then I was thinking, if she continues on with this form of self-harm, there could be an accidental death”. “There was an awful lot of risk-taking that came		

	alongside the self-harm". Anxious, I suppose anxious. You're waiting for the phone call; you're wondering will she come in for the next session? "So, yeah, you're waiting for the phone call. So that would be difficult. I'd have been, I suppose, very upset if I had lost that client, because I had that deep relationship with her". **A23.** "That was the first wound that I went, oh, I could actually feel the pain, you know if you burn your little finger. But the print of the iron was on her ankle, on the end of her leg. So that was the first time, because I could smell it, so it was the senses were aroused in that". **A24.** "Sick, I felt sick. There was a kind of sick… but I just wanted to kind of… my first instinct was to put some clean bandaging on it		

	and to cool it down." **A21.** "She was testing me a lot. So, it was the containment and not to be shocked by her, she was always looking for my facial expression". "So, she was looking for my shock response, but I never gave it. Now, in my tummy I could feel it, but I would never give it to her", "And even though she would say to me, 'Oh I hate you, I'm never coming back again' and I would say, 'Well I'm not going anywhere, I'll still be here". **A29.** "she'd get up and walk out and bang the door and tell me she wasn't coming back again. But it was I think, again it was a test".		
Feeling Excluded	**A38.** Yeah, there was a change of psychiatrist, she seemed to have a better relationship. And I was invited then to go over. When the previous		I think that the participant believed she was excluded and was frustrated with other professionals. Collaboration brought relief.

	psychiatrist was there when she was quite young, I wasn't invited.		
The Pay Off	A19. "Oh, I think there's great benefits of working with her, I think she was an expert. I was able to get into her head and see exactly how the relationship between a person in that much pain with self-harm, she taught me… she was my best teacher about self-harm". "So, she taught me more than any book".	Despite naming the challenges, the participant becomes animated when she states: "she was my best teacher" she states this more than once. My sense is that there is an attitude of gratitude for what she learned from this client, in particular. The participant mentioned using supervision to support herself when working with this client.	

Appendix D: Recruitment Flyer/Advertisement with IACP and IAHIP.

Study Title: Therapists' Experiences of Witnessing the Physical Manifestations of Self-Injury: An Interpretative Phenomenological Analysis. Are you an accredited counsellor or psychotherapist? Have you witnessed the physical manifestations of self-injury while working in clinical practice? Your experience is important to this research and I am inviting you to participate in a research study. The study aims to gain a better understanding of how witnessing the physical consequences of self-injury impacts psychotherapists. The goal is to provide information that can help to improve training and supports available to psychotherapists. The study you are invited to take part in is being conducted by Cindy O'Connor as part of a Doctorate in Psychotherapy and is completely independent of any organisation for which you work.

I am looking for participants who:

- Are accredited counsellors or psychotherapists?
- Have witnessed the physical manifestations of self-injury while working in clinical practice?
- Are willing to participate in an interview lasting one hour?

For further information, please contact Cindy O'Connor (MIACP), Doctorate in Psychotherapy student at Dublin City University at Jacinta.oconnor93@mail.dcu.ie or Tel. No. ##########

Appendix E: Plain Language Statement

Study Title: Therapists' Experiences of Witnessing the Physical Manifestations of Self-Injury: An Interpreted Phenomenological Analysis.

The study you are invited to take part in is being conducted by Cindy O'Connor as part of a Doctorate in Psychotherapy and is completely independent of any organisation for which you work.

Cindy is a Doctoral Candidate at the School of Nursing and Human Sciences in Dublin City University. This study will be supervised throughout by Dr. Evelyn Gordon and Dr. Mark Philbin, Dublin City University.

Dear Therapist,

Thank you for taking time to read this. You are invited to participate in a research project by sharing your experience of witnessing the physical manifestations of self-injury.

Study Purpose:

The main aims of this study are:

- To capture the lived, personal experience of witnessing the physical manifestations of SI.
- To gain an understanding of how this experience affects therapists' lives.
- To explore the perspectives of therapists on how this experience impacts their client work.
- To illuminate any strategies that therapists may have used to manage the presentations they witnessed.
- To uncover what therapists found most difficult when witnessing these presentations.

What will happen if I agree to participate?

If you decide to participate, you will be invited to take part in an interview lasting one hour. The interview will be conducted with the researcher at a location that is convenient to you.

How is privacy protected?

In order to protect the privacy of the participants, participants' names, their assigned pseudonyms and their interview data will all be stored separately, and audio files will be securely stored on Google Drive. Any paper data will be stored securely in a locked fireproof filing cabinet. No-one apart from the researcher will have access to her laptop or filing cabinets. Anonymity cannot be guaranteed, but every effort will be made to maintain it.

How will data be used and disposed of?

The data obtained from the interviews will be used as part of the researcher's doctoral thesis. The thesis may also be used as the basis for journal articles, presentations at conferences and workshops for practitioners. All the data will be deleted and destroyed five years after the study. You can receive a summary report of the research findings by email or post. The completed dissertation will be available on DORAS, DCU's open-access institutional repository, which provides free online access to research publications and theses from Dublin City University (DCU).

Will participation bring any benefits?

You may benefit from taking part in this study on an individual basis by having the opportunity to share your experience of witnessing the physical manifestations of self-injury. Your colleagues in the profession will also benefit by having an opportunity to read about fellow therapists' lived experiences of this phenomenon.

Does participation involve any potential risks?

There is a risk that you may become distressed during the interview while talking about your personal experience of witnessing these encounters. If this happens, some/all of the following measures may be taken:

- The interview may be paused to enable you to take a break from the interview.
- The interview may be postponed or discontinued.
- The researcher will establish if you require any support from your clinical supervisor or personal therapist. As a qualified therapist and supervisor, the researcher will also offer a sensitive de-brief. It is suggested that you discuss this with your clinical supervisor prior to taking part.
- Partaking in a study that will use a small sample size (eight participants) and will include direct quotes (all anonymised) in the reported findings may pose a level of risk to your anonymity, insofar as it is possible that you may be identified. However, it important to note that I (the researcher) will make every effort to protect your anonymity. I will make every effort to remove any data from the transcripts of your interview that may potentially identify you or any other third party (e.g., your clients), although I cannot guarantee that I will be able to catch all potentially identifying data.

Confidentiality is subject to the following limitations:

The researcher must adhere to legislation requirements. If you were to disclose a child protection issue, the researcher would have to comply with the Children First Act (2015).

The sample size of the study is small, and every effort will be made to preserve your anonymity. There is a remote possibility that you could remain recognizable, however, because direct quotations will be used in the writing-up of the study and in presentations. However, all quotations will remain anonymous. The dissemination of the research is every bit as important as the research itself since it is necessary to inform colleagues of the findings.

As a member of the Irish Association of Counselling & Psychotherapy (I.A.C.P), I am bound by the code of ethics and reference section 2.2 Self-Care to "provide consultation and assistance when warranted with colleagues showing signs of professional impairment and intervene as appropriate to prevent imminent harm to clients". Therefore, if at any point in the interview process, I become aware of unethical practice, you will be informed, and I will take advice from the I.A.C.P and from academic supervisors.

Who is organising this research?

The researcher is conducting this research as partial fulfilment of a Doctorate in Psychotherapy, Dublin City University. The researcher will be supervised by Dr. Evelyn Gordon and Dr. Mark Philbin, Dublin City University.
Has the study been approved by an Ethics Committee?

This is a draft provision subject to approval by the Dublin City University Research Ethics Committee.

Any other relevant information

It might be relevant for you to know that the principal researcher is also a working psychotherapist and supervisor. It is possible that we may meet in other working contexts in the future.

If participants have concerns about this study and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-7008000 or rec@dcu.ie

How do I take part in the study?

Contact: Cindy O' Connor: Tel. No.: ########## or email:
Jacinta.oconnor93@mail.dcu.ie

Thank you for your help with this research project.

Appendix F: Ethical Approval

Ms. Jacinta O'Connor School of Nursing and Human Science.
7th March 2019
REC Reference: DCUREC/2019/037

Proposal Title: Therapists experiences of witnessing the physical manifestations of self-injury: an interpretative phenomenological analysis.
Applicant(s) Ms. Jacinta O'Connor, Dr Mark Philbin, Dr Evelyn Gordon.

Dear Colleagues,
Further to expedited review, the DCU Research Ethics Committee approves this research proposal.

Materials used to recruit participants should note that ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee.

Should substantial modifications to the research protocol be required at a later stage, a further amendment submission should be made to the REC.

Yours sincerely,

Dr Dónal O'Gorman
Chairperson
DCU Research Ethics Committee

Appendix G: Informed Consent Form

INFORMED CONSENT FORM Dublin City University.

Therapists' Experiences of Witnessing the Physical Manifestations of Self-Injury: An Interpretative Phenomenological Analysis.

School of Nursing and Human Sciences, Faculty of Science and Health,
Dublin City University
Principal Investigators: Cindy O Connor, Dr. Evelyn Gordon, Dr. Mark Philbin

You are being invited to participate in an interview of approximately 60 minutes duration.
Please complete the following (Circle Yes or No for each question)
I have read the information sheet (or had it read to me) and I understand the information provided. Yes/No
I have had an opportunity to ask questions and discuss this study. Yes/No
I have received satisfactory answers to all my questions. Yes/No
I am aware that my interview will be audio-taped. Yes/No
I may withdraw from the research study at any point. Yes/No
I have read and understood the information in this form. My questions and concerns have been answered by the researcher, and I have a copy of this consent form. Therefore, I consent to take part in this research project. Yes/No
Advice as to the arrangements to be made to protect the confidentiality of my data (including advice on the legal limitations on the confidentiality of the information provided) is subject to DCU data protection guidelines. Such advice is also subject to the requirements of GDPR.
I understand that anonymised direct quotations will be used in the write-up of this dissertation and also presented at conferences. Yes/No
I understand the limits of confidentiality in line with regulatory. and ethical guidelines. Yes/No
I understand that signed consent forms and original recordings will be retained in the researcher's possession for five years following the completion of the study. Yes/No
I have read and understood the information in this form. My questions and concerns have been answered by the researcher, and I have a copy of this consent form. I agree to participate in this research study.

Participant's Signature:..

Name in Block Capitals:..

Witness:...Date:....................................

Researcher: Ms. Cindy O' Connor. BA Counselling & Psychotherapy, MA Supervisory Practice, (MIACP)

Tel: ##########. Email: jacinta.oconnor93@mail.dcu.ie

Appendix K: Information about the Debriefing Protocols/Schedule

The debriefing process will take place immediately after the research interview has been completed. Below is the proposed outline of the proposed debriefing schedule:

1) The researcher will begin by thanking the participant for taking the time to take part in the interview/study.

2) The researcher will ask the participant if they have any questions about the research interview that they have completed or any further questions about the research project. If there are any questions, the researcher will make every effort to answer these questions as comprehensively as possible (within legal and ethical limits).

3) In the event that a participant has experienced any distress by participating in the interview, the researcher will encourage the participant to access their supports (should they wish to avail of them). For example, their own supervisor, as part of the inclusion criteria for the study was that participants were currently availing of clinical supervision.

4) The researcher will remind the participant that a summary of the research findings can be posted or emailed to them when the research study is completed, if they so wish to receive them.

5) The researcher will thank the participant once again for contributing to the study by taking part in the interview.