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Exploring Self-Injury: An Art-Based Approach to Cultivating Empathy and Understanding in Mental Health Professionals

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EXPLORING SELF-INJURY:
AN ART-BASED APPROACH TO CULTIVATING EMPATHY AND
UNDERSTANDING IN MENTAL HEALTH PROFESSIONALS

A DISSERTATION

(submitted by)

DANA WYSS

In partial fulfillment of the requirements
for the degree of
Doctor of Philosophy

Lesley University
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Lesley University
Graduate School of Arts & Social Sciences
Ph.D. In Expressive Therapies Program

DISSERTATION APPROVAL FORM

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Cultivating Empathy and Understanding in Mental Health Professionals

Approvals

In the judgment of the following signatories, this Dissertation meets the academic standards that have been established for the Doctor of Philosophy degree.

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I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

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I hereby accept the recommendation of the Dissertation Committee and its Chairperson.

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SIGNED: 

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ABSTRACT

Self-injury greatly affects individuals, their families, and the mental health professionals who provide their care. This art-based research investigates the impact of clients' self-injury on mental health professionals. It addresses four research questions and applies a methodology that integrates body art, photography, poetry, and dialogue. Six participants (including the researcher) participated in three meetings wherein they artistically responded with temporary body art to two questions, sorted through their photographs, reviewed poetry created about their work, and discussed the study experience. The researcher navigated being a witness-researcher by personally and creatively engaging in the study.

The results present raw, distilled narratives, visual and verbal, as the process of discovery identified six prevailing characteristics: (1) Holding the space and relationship with the witness became a model and guide for participants to explore self-injury in the room and with their clients; (2) Sensory empathy allowed participants to increase appreciation of the body as a canvas. Experiencing art materials on the skin and in the mirror and photographic viewing of the art created a pseudo self-injury experience that deepened participants' connection to the behavior; (3) Cultivating a compassionate response is important in healing the client and the mental health professional; (4) The research provided insights into the role of ambivalence and the impact of overflowing emotions in the development of self-injury; (5) I examined the significance of self-injury as expression and communication. Through body art, participants metaphorically experienced potential power and influence of this communication; (6) I considered the surfacing sense of hope an integral treatment-related experience that can replace self-

injury as the resource of choice to feel alive and have hope in the professional's ability to treat and enhance healing. Body art, coupled with photography and poetry, can be a valuable resource upon which to build common language, understanding, compassion, and healing.

CHAPTER 1

Introduction

The mind is fighting body
both hostage to choices of hurt men
slowly exsanguinating her innocent breath

Hands hold the silky blade
tactile relief flows down her scarred skin
solace for the injured soul¹

Over the last 20 years, I witnessed the acts and aftereffects of children, adolescents, and adults who mutilate their bodies to express overwhelming emotions. I have often wondered what hurt could cause such destruction and isolation of the self. At a time when these individuals need to be most connected, they perpetuate disconnection through self-injury, which others often perceive as horrific. I have also witnessed how mental health providers and families respond to self-injury with shame, disappointment, horror, and helplessness.

1. Haiku-inspired poem about self-injury written by Dana Wyss on February 27, 2016 during a workshop by Ericha Scott exploring the use of art and poetry in trauma work.

These observations led me to contemplate how both self-injury and body art produce strong emotions that transcend bodily experience—whether created to excise personal demons, for ritual, to punish, or to offer a powerful demonstration of an individual’s internal world. Body modification and body art have developed as adaptive resources for communication and survival the general population more consistently accepts (Walsh, 2012). The study of body modification and art, self-injury, and scars intrigued me because it allows the exploration of another’s existence, including his or her pain, sorrow, and joy. It allows a journey beneath the skin and into a world that is often misunderstood.

Foundation of this Study

During my pilot study (Wyss, 2014), the literature indicated that major hindrances to the effective treatment of self-injury are a poor understanding of the behavior, inadequate assessment, and misdiagnoses by service providers (Walsh, 2012). Therefore, the focus of the pilot study became exploring the use of temporary body art with individuals who self-injure to help mitigate these hurdles. The pilot was a qualitative study conducted at a locked-down adolescent group home in Torrance, California. Two female youth who engaged in skin-orientated self-injury chose to participate and were approved for the study through the court, treating clinician, county social worker, and family. The participants used temporary body art to respond to two questions: (a) What do your scars or self-injury communicate? and (b) What do you wish you could tell others or yourself instead? I took photographs of their art, and the participants selected eight photographs to represent their life experiences.

As a researcher, clinician, and artist, I had the responsibility to allow the process to surface naturally. Through holding space and openness, the participants were willing to invite me into their private worlds. The fear and reality of injury often outweighs one's ability to sit with an individual who participates in self-injury; the pilot study provided evidence that body art can create an empathetic substitute experience with which a clinician-researcher and participant can safely and ethically explore the self-injurious behavior together.

Throughout the pilot study, the participants increased their ability to communicate their traumas, feelings, and reasons for self-harm. The participants, their primary therapists, dorm staff, and I (as the participants would seek me out to talk more) noted an increase in communication and openness to discuss past and current issues such as the triggers that led to their self-injury. Furthermore, the participants continued to report a propensity to use the body art, which they indicated was a safe way to communicate when words were inaccessible or could not fully describe their experience. The use of body art appeared to decrease self-injury in response to the need for communication or to gain attention. However, the use of body art did not ameliorate the participants' behavior when self-blame or a need to feel physical pain was the antecedent.

These outcomes indicated that body art could be a valuable tool to understand, assess, and treat self-injury. Directly studying individuals who self-injure helped me gain insight, empathy, and connection; unfortunately, these gains did not fully translate to all mental health providers. In the same way, the connection the participants felt to me, relative to being heard and understood, was not transferable to the treating therapist and staff (per post-reports from the staff and the participants). The pilot findings, the client

responses, and their requests for body art post-study indicated the need for body art with clients to be more a long-term therapeutic process than the focus of a short-term study.

A final concern raised throughout the pilot study almost led to the discontinuing the process—the body art and I, as the researcher-witness, became part of the participants' self-injury rituals. Throughout and directly after the study, the participants engaged in the act of self-injury in a way similar to the art represented. This process exposed the bias and fear this behavior evokes in those who care for and treat clients who self-injure, who began to blame the clients, me, and the study (Walsh, 2012). These responses and my own feelings of guilt during the study suggest training and supervision that is more specialized could better prepare mental health professionals to create safety in treatment and support for each other.

Embodiment

I was encouraged in my art-based research class to create body art to honor the participants' experience. Although it was not part of the original study, it helped further my understanding of the participants' experiences, as well as process my own feelings around the guilt and shame that arose during the pilot. This allowed me to explore what Moon (1999), McNiff (1998), and Fish (2017) discussed as a way to process and create knowing on another plane. As the dissertation committee sifted through my pilot results and considered this dissertation, it became important to ask, "What do I want to achieve?" The original goal of the pilot was to provide insight and build compassion for self-injury.

After a significant discussion with my doctoral committee, the focus of this dissertation became exploring the use of body art with the mental health professionals who provide service for individuals who engage in skin-orientated self-injury. The purpose of

this dissertation was to develop a richer understanding of self-injury and provide a space that allowed mental health professionals to explore their empathy and personal feelings about this topic experientially, in order to provide comprehensive treatment to their clients.

Assumptions

Through embodied knowing, this study aspires to close the gap between the mental health provider and the client's experience with self-injury and to build compassion, trust, and stronger communication skills within the therapeutic dyad. A secondary aim was to support self-care and compassion for the individuals, families, and the mental health professionals directly affected by self-injury. To increase awareness, develop compassion, and investigate this gap, I examine four main research questions in the current study:

RQ1. How can art that uses the body as a canvas help communicate the experience of self-injury?

RQ2. To what extent can body art help mental health professionals further understand the phenomenon of self-injury?

RQ3. To what extent might mental health professionals' use of body art influence treatment with their clients who self-injure?

RQ4. How does having a witness during the body-art experience of this study affect the participant?

CHAPTER 2

Literature Review

Nock's (2012) research implied that one of the greatest limitations in the investigation and treatment of self-injury is the inability to witness or directly observe the self-injurious behavior, which leaves an unexplored space that could greatly inform diagnoses, words, and behaviors. This literature review explored the extant literature related to self-injury, such as nonsuicidal self-injury (NSSI), self-harm, self-mutilation, body modification, body art, art therapy, vicarious trauma, and therapists creating art.

Specifically, the literature review examined the current knowledge about self-injury and body art and their effect on mental health providers. It explored the definition of self-injury and body art both in history and as a means to mitigate self-injury cultural and religious aspects through history; categories of self-injury (e.g., the impact on outpatient programs, residential treatment, and hospital settings; contagion; and adverse childhood experiences); and current treatment methods, including art therapy. In addition, it reviewed mental health workers' use of art to mitigate vicarious trauma and improve overall treatment. An important focus was exploring the effectiveness of art-based supervision and treatment for mental health professionals to increase empathy and understanding. This literature review highlights challenges in both research and treatment, including treatments most pertinent to this self-injury epidemic.

Importantly, many art therapy studies related to self-injury were limited to case-study research or had small sample sizes. These limitations echoed in the lack of findings in the self-injury literature regarding the usefulness of a consistent treatment method for the various motivations and types of self-injury. Similarly, whereas there was significant

research on contagion and the frequency of self-injury, there was limited research on mental health workers' self-care, increasing empathy, or managing feelings about clients' self-injury. Additionally, researchers such as Cook and Gorraiz (2016) and Muehlenkamp (2006) recognized the lack of statistically significant empirical research, in that most self-injury studies consisted of anecdotal evidence and reports that were highly subjective regarding the usefulness of a specific treatment model. There were well-designed research studies specifically related to treatment; nonetheless, their small sample sizes (e.g., $n < 10$) and lack of control groups limited the ability to estimate effect size and treatment efficacy (Cook & Gorraiz, 2016). However, all these studies indicated the importance for future research.

Significance of Study

The act of shedding blood creates an immediate sense of connection to the inner body because blood is considered the essence of life (Hewitt, 1997). Favazza and Conterio (1989) established that self-injury typically begins in early adolescence but can become more frequent over time. Documented self-injury occurrences have increased in recent years from 400 per 100,000 in the late 1980s (Favazza & Conterio, 1989) to 1,400 per 100,000 in 1998 (Conterio & Lader, 1998). Based on their review of research studies, Kerr, Muehlenkamp, and Turner (2010) estimated that 4% of adults, 15% of adolescents, and 17% to 35% of college students reported some form of self-injury. Currently self-injury-related Internet sites, such as Healthy Place (Gluck, 2016) and Center for Discovery (Mahoney, 2018), estimated that one in five females and one in seven males engage in self-injury. The increase in these self-injury rates presents a major source of concern for families, service providers, and mental health professionals (Walsh, 2012). Furthermore,

lack of trust and misunderstandings in the therapeutic relationship generate barriers to a client's ability to receive effective treatment (Brown & Kimball, 2013).

Numerous restrictions have led to difficulty identifying effective treatment options (Nock, 2012). These factors include a high rate of self-injury, the dangerousness of the behavior, lack of trust in the treatment, inability to cope with less dangerous means, and caregiver and provider concern and judgment (Walsh, 2012). Many individuals who participate in self-injury indicated a high rate of dissatisfaction with the mental health services they received. Favazza and Conterio (1989) speculated that the number of individuals who self-injured would greatly increase due to increased public awareness and the inability of mental health facilities to meet the treatment demands of these patients.

Misunderstanding the precedents to self-injury, combined with the inability to conceptualize proper treatment and the high rates of injury, increase the likelihood of misdiagnosis, serious injury, hospitalization, and possible death (Conterio & Lader, 1998). Furthermore, this behavior and the difficult and lengthy treatment that follows lead to significant incidents of vicarious trauma and burnout in mental health professionals (Jones & Hastings, 2003). Because art therapy has been useful in understanding, treating, and exploring feelings about self-injury (Cooper & Milton, 2003), body art specifically may provide concrete means for body-based exploration and assessment (Masters, 2011).

Definition of Self-Injury

While respected groups such as the National Alliance on Mental Illness (NAMI) define self-injury as "hurting yourself on purpose," (NAMI, n.d., line 7), there are many definitions and terms for self-injury. It has been termed NSSI (Nock, 2009), self-harm (NAMI, n.d.), self-injury (Walsh, 2012), and self-mutilation (Hewitt, 1997). Clinically,

Nock (2009) defined it as “a prevalent, but perplexing behavior problem in which people deliberately harm themselves without lethal intent” (p. 78). It has also been described as “deliberate, direct, nonsuicidal destruction or alteration of one’s body tissue” (Favazza, 1998, p. x). Nonclinical definitions included self-injury being a resource (Freeman, 2012), way to reclaim the body, expression of inner pain (Hewitt, 1997), reflection of unmet and unheard needs, or attempt to stay alive (Strong, 1998). Along with more commonly known methods of self-injury, such as cutting or carving, scratching, burning, and hair pulling, less common methods, such as inserting objects into the body, limb removal (Favazza, 2011), ingestion of foreign bodies, self-poisoning, and substance abuse (Ougrin et al., 2012) have been noted.

Individuals who engage in self-injury do not often have the intention of death; however, they are at higher risk of death due to the nature of these dangerous behaviors (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). Compared to suicide, self-injury behaviors are markedly distinct—they occur with greater frequency than suicidal behaviors and, because there is no intent to die, the behaviors are usually nonlethal (Walsh, 2012). Walsh (2012) reported that in clinical practice, he frequently encountered clients who self-injured 20 to 150 times a week. The high rate of injury and crisis in these individuals greatly affected the providers’ ability to gain insight and understanding into root cause, intention, and internal experience, which are important factors in developing rapport and navigating treatment with isolated or alienated clients (Scott, 1999). The need for therapeutic rapport where there is repeated misunderstanding (Conterio & Lader, 1998) underscored the importance of cultivating understanding in and for the mental health professionals working with this behavior (Walsh, 2012).

Body Art and Modification in History

The use of body art has ancient, global continuities as a form of communication and ritual (Favazza, 2011). Anthropologist Schildkrout (2004) noted that the skin was the earliest form of communication for identity and culture. Such body art consisted of painting on the body, henna tattoos, scarification, tattooing, branding, and piercing. Schildkrout further suggested that some scholarly references addressed cosmetic surgery as a form of body art. There is an ambiguous relationship between body and society; therefore, the skin has been of theoretical relevance in many academic, social, religious, and therapeutic practices.

In her analysis of body modification and mutilation, Hewitt (1997) discussed their historical importance in different cultures as rites of passage. Some cultures used body painting, scarification, and piercing to create a specific demeanor or role in communicating with the gods, preparing for war, or deflecting evil forces. Schildkrout (2004) explored how acts of inscribing on the body, wearing masks, or donning shoulder-length wigs have been referred to as “social skins” (Turner, 1980) and “second skins” (O’Hanlon, 1992). These anthropologists associated the experiences with dreaming, creating a relationship with subject and the world, ancestral healing, and transcending the boundaries of the past and present. The use of piercing, tattooing, body painting, and scarification in these cultural settings did not equate to a form of anger or negative body image, but to tradition, culture, rites of passage, and religious ceremonies (Schildkrout, 2004).

Carroll and Anderson (2002) examined the importance of body piercing and tattooing in adolescent females’ attainment of identity and mastery over the body. Their sample

included only at-risk youth who were in special programs due to self-injury and other aggressive behaviors; over half had participated in some form of body modification. The researchers concluded that anger and negative attitudes about the body were strong predictors of body piercing and tattoos. In contrast to Antoszewski, Sitek, Fijałkowska, Kasielska, and Kruk-Jeromin's (2010) study, which examined the general population, Carrol and Anderson (2002) emphasized that major factors of body ornamentation in teens and adults were their desires to enhance individuality and increase sexual attractiveness. Although studies such as theirs correlated body modification with crime, alcohol use, self-injury, and aggressive behavior, the findings focused on samples that already had an increased risk of those behaviors, regardless of body modification. Antoszewski et al.'s (2010) findings represented different worldviews and suggested there was no singular predictor or reason for individuals' choices to modify their body through tattoo or piercing. In addition, the studies suggested that the choice to modify one's body did not, in and of itself, indicate future behavior.

Walsh (2012) noted a significant shift in professionals' views of body modification (tattooing and piercing) from the 1980s to the 2000s. However, there can be underlying self-injury tendencies in individuals when they are participating in body modification. This is apt to be particularly true when the body modification relates directly to psychological distress, as opposed to ritual, symbolic meaning, or beauty enhancement. Walsh (2012) therefore suggested that assessing for both direct and indirect self-injury is essential to avoid mistaking socially acceptable body modification for pathological behavior or vice versa.

Categorizing Self-Injury

Self-injury has been documented in medical journals since the 1800s. Gould and Pyle (1901) recognized several types of self-mutilation and self-injury reported by medical professionals. They attributed this behavior at the time to temporary insanity resulting from hallucination, extreme sadness with or without suicidal intent, or religious frenzy as a means of devotion or self-punishment. The medical professionals in Gould and Pyle's book outlined several examples—from men who broke their bones and amputated their own limbs to women who stuck themselves with sewing needles repeatedly and bound their feet to change their shape and size, thus causing great pain.

Similarly, Klonsky (2007) presented several theories about the function of self-injurious behavior, including interrupting a dissociative state or shocking oneself back to the “here and now” to feel the body numb, an anti-suicide method, a cry for help, communication to receive needed attention, an attempt to avoid abandonment, self-punishment, or seeking excitement or exhilaration. Muehlenkamp, Bagge, Tull, and Gratz (2013) proposed a relationship between self-injury and individuals less connected to bodily experiences because they tend to devalue their bodies and are indifferent toward protecting or caring for their bodies.

According to Nock and Prinstein (2004), some adolescents reported engaging in self-injury to reinforce the self to provide immediate emotion regulation, or for social reinforcement (e.g., attention, avoidance, or escape). Nock and Prinstein's four-function model of self-injury classified and treated behaviors according to antecedents and consequent contextual influence. The model is important because treatment cannot occur without proper assessment of the mitigating motivations. It outlined the necessity of

service providers practicing individualized approaches to match treatment to the identified function of the individual's self-injurious behavior. Identifying that function can be difficult because it typically relies on self-reporting or observation of preceding events (Walsh & Doerfler, 2009). This procedure presents several limitations, because clients' verbal reports often lack validity and the individual may not know or be able to express the reason for the actions (Walsh, 2012). Additionally, without proper support, education, and guidance, an outside observer is likely to misunderstand or mislabel the etiology of the behavior.

Ritualistic Customs of Body Modification and Self-Injury

Self-injury has been documented throughout history as part of human ritual (Favazza, 2011). Rituals foster transition from one state of being to another. Not only does pain lend meaning to the ritual process, but also the self-injury or modification creates a marker of the transition. Ancient cultures inscribed symbols on the body to communicate with the gods (Hewitt, 1997). Tattooing in Polynesia is considered meditative; it manifests sacred properties that connect the past and the future (Schildkrout, 2004). Further, van Blommestein (2012) explored the intersections of religiously motivated mortification on the flesh (common in medieval times) and modern self-injury as important to one's capacity to achieve empowerment, agency, and control. Throughout history and across the world, the skin has been manipulated, adorned, and hidden in an effort to communicate (Strong, 1998).

Although many cultures embraced the use of the body in ritual, other religions and cultures banned body manipulation as a communication tool. Schildkrout (2004) referred to North American slaves and the use of scars, branding, and marking on the skin to

denote the slave's origin or status. The Standard King James Version Bible referred to self-injury in the New Testament concerning a demon-possessed man who "always, night and day, was crying and cutting himself with stones" (Mark 5:5, The New King James Version). Further scriptures stated, "You shall not make any cuts on your body for the dead or tattoo yourselves: I am the Lord" (Leviticus 19:28, The New King James Version). Similarly, the Torah pronounced, "Ye shall not make any cuttings in your flesh for the dead, nor imprint any marks upon you: I am HaShem" (Leviticus, 19:28, Jewish Publication Society of America, 1963). Although these passages seemed to indicate that tattooing, body modification, and cutting were forbidden, debate over the translation speaks to the prevalence of these behaviors—there would not be a need to forbid them if they were not commonly occurring.

Koch, Roberts, Armstrong, and Owen (2004) examined responses from college students ($N = 450$) on religious beliefs and attitudes toward piercings and tattoos. Their results suggested that modern Christians were more open to considering and accepting tattoos and piercings. Truesdell (2015) discussed the history of tattoos both in Jewish law and because of the Holocaust. He contended that the belief began to gain stronger support after the Nazis at Auschwitz forcefully tattooed Jews who passed through the camp. However, in recent years, young Jews have explored tattooing to connect to their history and identity. Despite the debate, these instances signified how the skin can become a "canvas" of religious, social, political, and racial identity.

Residential Treatment and Hospital Settings

Residential treatment (community-based group homes and psychiatric inpatient facilities) and hospital settings have the highest concentration of patients who use self-

injury as a resource (Favazza, 2011; Walsh & Doerfler, 2009). As a result, mental health providers experience multiple situations that can result in their burnout and vicarious trauma. Furthermore, many clients receiving outpatient therapy and engaging in severe self-injury required hospitalization or received intensive outpatient or inpatient treatment at some point. Although empirical research on this population continues to be underrepresented, the number of children, adolescents, and young adults receiving care in hospitals and residential treatment facilities has reportedly grown significantly since the 1980s (Walsh, 2012). Hospitalizations, the need for medical treatment, multiple losses, placement changes, and heightened interventions such as physical restraints affect treatment, potentially rapport between client and clinician, and client motivation (Klonsky, 2007).

The growth of such programs has led to an increase in potential burnout and vicarious trauma in providers who work in these facilities (Klonsky, 2007). Walsh (2012) identified that consistent exposure to clients' self-injurious behaviors and a perceived lack of ability to stop the behavior can lead to negative biological and psychological reactions. Not only does this affect the providers' own health, but it can also lead to increased responses of punishment, removal of privileges, and imposing control over an individual who needs safety, enhanced self-esteem, and encouragement to gain agency.

Contagion and Self-Injury

Contagion is a crucial concern in the treatment of self-injury (Walsh & Doerfler, 2009). Social contagion of self-injury can occur when two people engage in self-injury together or within a 24-hour period using the same method or instrument or when a group of people has a significant increase in self-injury behavior (Walsh, 2012). Whether in

residential programs, hospitals, high schools, college campuses, or Internet message boards and social media, contagion has led to substantial increases in self-injury and in the specific type of self-injury inflicted (Richardson, Surmitis, & Hyldahl, 2012). Situations in which individuals with emotional dysregulation spend a great deal of time together can exacerbate maladaptive coping. Walsh and Rosen's (1985) seminal work, which originally identified the significance of contagion in a review of daily reports completed by the staff on each client at a residential center, continues to provide the foundation for future studies on contagion. Of nine domains studied, they eliminated four due to low occurrence rates and four (aggression, suicidal talk, substance abuse, hospitalization) that occurred more often but did not show significant results. However, self-injury was noted as yielding significant results. One concern of the study was the reliability of the daily reports. Due to personal feelings and perceptions about the self-injurious behavior of clients, staff reportedly struggled to explain the facts objectively and accurately in reports. This was a major concern in residential programs and the treatment of self-injury in general (Favazza, 2011).

In addition to the impact on staff and therapist, reactions to self-injury may inadvertently increase the behavior (Charles & Matheson, 2007). Conterio and Lader (1998), Favazza (2011), and Walsh (2012) examined the impact of countertransference on treatment of self-injury. Although strong reactions to self-injury are understandable, it is important to provide strategies that prevent its occurrence in order to maintain empathy and work within the framework of the clients' treatment needs. Furthermore, expressions of shock (Charles & Matheson, 2007) or desires to stop children or clients from self-injuring could inadvertently increase the behavior (Walsh, 2012). The daily written reports

in the Walsh and Rosen's (1985) study of 25 adolescent subjects with self-injury behaviors in residential treatment indicated the staff's lack of understanding of countertransference, or the need to stop clients from engaging in self-injury, affected the increase of the behavior, causing it to be contagious. Finally, the victim or caregiver roles that often play out in this process may magnify the effects of both contagion and countertransference, because the desire to help and receive help are strong needs that may continue the self-injury cycle (Walsh, 2012). As noted earlier, Charles and Matheson (2007) identified that the staff response to a client's self-injury was critical to increases or decreases in the behavior.

Connection to Adverse Childhood Experiences

Traumatic experiences that occurred in childhood or adolescence often lead to increased negative behavioral, social, and emotional outcomes (Thompson et al., 2012), which can manifest in increased physical and mental health risks if not addressed (Felitti et al., 1998). Illustrating this experience, Freeman (2012) wrote a personal reflection about her childhood, self-injury history, and scars: "My arms reflect the silence of a darkened mind due to the subjective and horrific terror brought by one human being to another, a silence that went unsaid, that stayed unspoken in the mind of the child" (p. 10).

Children who experienced complex trauma often develop maladaptive coping strategies, ongoing interpersonal complications, difficulties building and sustaining healthy attachments, and diminished abilities to reciprocate social relationships (Kinniburgh, Blaustein, Spinazzola, & Van der Kolk, 2005). According to Hussey, Reed, Layman, and Pasiali (2007), for example, the ability to navigate relationships and trust appropriate figures were major factors in an individual's use of more adaptive coping. In

return, this dynamic affects a caregiver's or mental health provider's ability to sustain and maintain a safe and healthy environment. Van der Kolk (2014) outlined that as a child constantly pushes the bounds of the relationship, replaying abuse and using maladaptive coping (such as self-injury), the caregiver or provider is often left unable to elicit change and becomes stuck in a cycle of the individual's trauma. Kaess, Parzer, Mattern, Plener, Bifulco, Resch, and Brunner (2013) provided evidence that a client's experiences of antipathy in the caregiving system and neglect had a significant impact on the use of self-injury to cope.

Long-term effects of childhood losses and disruptions due to the death of a parent, foster care, or residential treatment can lead to poor self-esteem, lack of self-regulation, and poor functional outcomes (Coholic, Lougheed, & Cadell, 2009). Additionally, these factors can trigger self-injury behavior (Walsh 2012) because the experience of continuous loss and abandonment reinforces negative views of self and in turn increases the use of maladaptive need attainment (Charles & Matheson, 2007).

Although to my knowledge a direct connection has not been documented between inadequate attachments (i.e., a healthy bond was not created between caregiver and child during the formative years of zero to five) and self-injury, Ougrin et al. (2012) and Yates (2009) found overrepresentation of a history of insecure attachment (an ambivalent, neglectful, or avoidant caregiver) and significant losses or abandonments in the studies of adverse childhood experiences for adolescents who engaged in self-injury. Van der Kolk, Perry, and Herman (1991) found histories of childhood abuse and trauma present in the majority of participants and linked the severity of the abuse and trauma to the severity of the self-injury. In addition, they found that lack of secure attachment led the client to

maintain the behavior for a longer period. Although these studies suggested a strong correlation between insecure attachment and self-injury, many participants either resided in group-home settings or had significant histories of trauma. Thus, this correlation did not fully account for the number of teenagers and adults who had secure attachments but participated in self-injuring behavior. However, it shed light on the complexity of the treatment and the impact of these attachment styles on healthcare providers.

Treatment Models for Decreasing Self-Injury

According to many researchers (e.g., Charles & Matheson, 2007; Muehlenkamp, 2006; Nock & Prinstein, 2004; Walsh, 2012), self-injury behavior is difficult not only for mental health professionals and caregivers to understand, but also to treat. When assessing self-injury, there is a lack of ability to witness the ritual of the behavior (Nock, 2012). Most assessments are written post-behavior and lack of knowledge of the event itself. Furthermore, the caregiver or the service provider might unintentionally reinforce the behavior through the secondary gains of extra attention, emotional and physical support, and sense of being heard inherent in the assessment and reporting process (Walsh, 2012). A therapist's duty to provide care and avoid harm limits the likelihood the clinician will witness the self-injurious behavior, despite the fact that this behavior—which often results in a significant injury or wound—is most informative (Lloyd-Richardson, Lewis, Whitlock, Rodham, & Schatten, 2015). Even if confidentiality does not need to be broken, it is considered unethical to allow even low-level injuries to occur in the presence of a professional or a caregiver.

According to Nock, Joiner, Gordon, Lloyd-Richardson, and Prinstein (2006) and Trepal, Wester, and Merchant (2015), another major challenge for service providers and

mental health workers is distinguishing self-injury from suicide attempts. Researchers, service providers, and families often superficially categorize these as similar behaviors (Muehlenkamp, 2006), and the behaviors were diagnosed under the same category until the recent publication of the DSM 5 (American Psychiatric Association, 2013; Zetterqvist, 2015). However, the two behaviors are markedly distinct. Suicidal acts are categorized by the intent to die (Ougrin et al., 2012), whereas an individual who engages in self-injury often uses the act as an attempt to self-preserve and heal (Charles & Matheson, 2007). Due to their inability to communicate unspeakable and horrific experiences, those who self-injure may use this behavior as a metaphor for their internal experience or as a resource to alleviate their history of pain and suffering (Scott, 1999).

Treatment Therapies

The four consistently used approaches to treating self-injury are psychotherapy, cognitive behavioral therapy (CBT; Conterio & Lader, 1998), dialectical behavioral therapy (DBT; McKay, Wood, & Brantley, 2007), and group therapy (Conterio & Lader, 1998). Psychotherapy is insight oriented and traditionally addresses underlying needs and conscious or unconscious conflicts using talk therapy. Favazza (2011) suggested a transition from psychodynamic theory to CBT and DBT, which are targeted and more effective with fewer visits needed. The CBT incorporates the premise that the way an individual feels influences actions; therefore, treatment focuses on changing and addressing automatic thoughts, underlying assumptions, and cognitive distortions that increase the self-injury (Conterio & Lader, 1998). The DBT addresses specific skills such as identifying and labeling emotions, increasing positive events, mindfulness, distress tolerance, and identifying obstacles (McKay et al., 2007). Outpatient and inpatient

programs use both psychotherapy and CBT (Walsh, 2012); outpatient and specialized treatment centers often use DBT (McKay et al., 2007). Whereas CBT focuses on stopping the behavior, DBT allows for the acceptance or need of the self-injury (Zervas, 2014). Group therapy is also commonly used in specialized programs such as SAFE (self-abuse finally ends) alternatives and is recommended in all settings to help increase support and connection in safe ways (Conterio & Lader, 1998).

Although these modalities are commonly used in treatment and have anecdotal support for their benefit, Cook and Gorraiz's (2016) meta-analysis of the effectiveness of DBT for NSSI found a significant lack of solid research. In their review of 315 abstracts, only 12 met criteria for inclusion in the meta-analysis due to small sample sizes, lack of pre- and post- measures, and lack of control groups. Likewise, Muehlenkamp (2006) conducted a review of research on CBT and DBT and found limited empirical studies outlining the effectiveness of any particular model. Again, most studies had small sample sizes, included both self-injury and suicide, were case-study based, or did not include randomized trials. Furthermore, due to safety factors, fear, and variation in behavior function and length, conventional therapy methods alone often failed to ameliorate self-injury (Charles & Matheson, 2007). Thus, many clinical approaches were used in combination with medication and adjunctive therapies, thereby making it difficult to assess which approach or combination of approaches caused any positive changes (Walsh, 2012).

Potential fear, hopelessness, physical risk, and perceived feelings of loss of control often lead mental health professionals and caregivers to tighten control or retreat from the individual and his or her behavior (Walsh, 2012). Hoffman and Kress (2010) proposed

that the stages-of-change model could be effective in managing feelings of fear and the need for control while supporting the client, family, and therapist to assess treatment from a harm-reduction perspective. Irrespective of the therapy method used, the mental health provider's reaction to the behavior of the client was arguably the most critical aspect of treatment (Charles & Matheson, 2007).

Role of Empathy and Compassion

Regardless of the therapeutic model, forming a strong therapeutic alliance is paramount to treatment with a client who engages in self-injury (Muehlenkamp, 2006). Long, Manktelow, and Tracey (2016) used a grounded theory approach to study 10 client interviews regarding their experiences treating self-injury. They found that trust, seeing beyond the cutting, human contact, and integration were keys to effective treatment. Therapeutic empathy includes mirroring, accurate understanding, reflecting the client's experience, labeling emotional experience, and feeling with the client without being overwhelmed by emotion (Paivio & Laurent, 2001). Empathy and authentic engagement are delineated by the mental health professional's acceptance of the client's suffering and need for self-injury as a resource (Norton, 2011).

Charles and Matheson (2007) and Walsh (2012) recognized the need for a sensitive yet nonreactive approach that offers straightforwardness and sincerity, provides the individual a safe space and sense of empowerment, and decreases the individual's need to exert power or control via self-injurious behavior. This compassionate response would allow a therapist to join the client in a way that demonstrates acceptance as opposed to repulsion, fear, or shock (Muehlenkamp, 2006). Equally, self-compassion is essential in the face of difficult and challenging clients and behaviors because there is a need to let go

of pain and feelings of failure, connect to common humanity, and cultivate a balanced awareness of feelings (Neff, 2003).

Art Therapy

Nonverbal forms of therapy are important because many children, adolescents, and adults who self-injure have been exposed to multiple stressors and traumas. They may be unable to verbally access memories or unwilling to recount their experiences verbally (Hussey, Reed, Layman, & Pasiali, 2007). Van der Kolk, Greenberg, Boyd, and Krystal (1985) and Van der Kolk (2014) discussed the hypothesis that the body holds trauma, and the trauma remains in the body until one is able to release it. Re-exposure to traumatic events increases endorphins that create an illusion of control. Similarly, some people reportedly felt the same release of release of endorphins after an act of self-injury. This idea supports the use of art therapy in response to trauma as well as self-injury. Malchiodi (2011) theorized that experiences of self-regulation might occur through art and experiential activities because they stimulate balance by activating both the left and right hemispheres of the brain.

Ougrin et al.'s (2012) study of female adolescents ($N = 70$) assessed the clinical characteristics of self-injury and response to therapeutic assessment. They found a direct connection between adolescents who self-injure and past adverse childhood experiences. Cohen and Mills (1999) theorized that art plays a significant role in cognitive and emotional supports for severely traumatized and disassociated clients. It assists their communication of thoughts, experiences, and self-perceptions. In addition, the body is the main conductor of communication (Hewitt, 1997). Thus, when trauma cannot be

expressed verbally, other methods of communication—such as the body—become necessary (McLane, 1996).

Art therapy may provide a channel for growth, healing, and understanding for clients who self-injure. For many individuals, artistic expression provides a nonthreatening method by which the therapist can introduce body image and emotional regulation and identity issues in a safe and supportable way for the individual (Cohen & Mills, 1999). Cooper and Milton (2003) also demonstrated art therapy's effectiveness and ability to add a "deep dimension" (p. 194) by studying the artwork of several women engaged in self-injury compared to other self-destructive behaviors. They concluded that reactions and responses to one's own artwork could lead to a high level of understanding and connection between thoughts and actions. Additionally, Kozlowska and Hanney (2001) posited that creating art on paper surfaces provides a place to externalize experiences and gain mastery over associated affect and memories.

Body Art to Heal from Self-Injury

Body art provokes a strong response in both the viewer and the artist (Hewitt, 1997) and could prove a powerful tool in the treatment and assessment of self-injury. Although there were limited peer-reviewed studies on the use of body art and painting specifically in the therapeutic setting, grassroots operations and websites supported and encouraged the use of body art to reduce self-injury and heal from the scars. The Butterfly Project (2011) encouraged those who self-injure to draw butterflies on their bodies in the places they wanted to injure. They could then write, or have others write, messages of hope where they drew the butterfly. The goal was that the person would allow the butterfly to fade naturally and avoid metaphorically "killing" the butterfly by resisting the

urge to cut. The website posted guidelines for the person to follow, as well as pages of support and poems uploaded by those who had drawn the butterflies. Many people reportedly used this project to help reduce their self-injurious behaviors.

Similar to the Butterfly Project, Masters (2011) used temporary tattoos in a 60-bed child and adolescent residential setting to assist in diminishing self-injury and help the clients heal. Although there was limited formal information about how data were collected and analyzed in this study, it was the closest documented use of body art as a way to explore and heal self-injury. Seven female and three male clients with skin-orientated self-injury behavior were selected to participate. The program used nontoxic body markers and temporary tattoo decals with designs or words that promoted healthy coping, self-esteem, and positive feelings. The researchers reported decreased self-injurious behavior throughout the five-year trial. It is difficult to assess whether the results were due to concurrent therapies, such as eye movement and desensitization reprocessing (EMDR), DBT, and CBT; the use of temporary tattoos; the change in staff response to their self-injury; or a combination. Some barriers that arose throughout the study were the staff responses to incidents of self-injury during the trial. Staff often attempted to remove the markers and decals for client safety, even when the client had not used the marker or decal in a harmful or inappropriate way. This connects to what Walsh (2012) described as reinforcement of the behavior. Masters (2011) intended for the staff to focus on why the client did *not* use the tattoo and on encouraging them to use it even after a self-injury act, versus focusing on why they self-injured or on removing items from them. Although this reportedly took a great deal of support and staff supervision, the clients who participated

and program staff reported a marked decrease in self-injury with an increase in self-expression and self-esteem throughout this study.

Whereas the Butterfly Project (2011) and Masters' (2011) work were meant as a temporary use of art that allowed the art to be removed or altered to suit mood, emotion, occasion or desire, Project Semicolon, created by Amy Bleuel (Shields, n.d.), encouraged those who suffered long-term effects of mental illness, self-injury, and suicide to tattoo a semicolon on their body as a metaphor for their life being incomplete (Steyer, 2015). Although tattoos were not originally part of the movement, the tattooed semicolon came to be a permanent reminder of a temporary problem (Olya, 2015). This movement had several followers who claimed the project saved their lives, including 253,553 followers on their Facebook page and thousands of tattoos and stories available through a Google search of *semicolon tattoo* on the Internet.

According to these websites, another important feature was that these projects encouraged those who support someone who self-injures to participate in creating art on their bodies or on the individual who self-injures. This action constitutes a nonverbal show of support. For example, The Butterfly Project (2011) encouraged non-self-injuring supporters to draw a butterfly and write messages of hope on their own body as a sign of a safe place to talk or get a hug without the need to explain. Further, Freeman (2012) had family members draw and write on her body about her scars to help the family heal and understand her long battle with the behavior. These processes represented a social art-based method to help a community of people who are suffering.

An Internet search of tattoos and self-injury revealed several newspaper, web, and magazine articles on tattoo artists such as Poppy Segger in Norwich, England (Gladwell,

2016), Brian Finn in Ohio (Donovan, 2016), and Whitney Develle in Brisbane, Australia (Bruk, 2017), who used their talents to cover or enhance scars from self-injury,. Segger (www.spring.st/self-harm-scars-tattoo-cover-up), Finn (<http://www.iatattoo.com/artists/10/2/Brian-Finn>), and Develle (<https://westsidetattoo.wordpress.com/tattoos/whitney-develle/>) offered discounted or free tattoos to people with self-injury scars. Segger asked people fill out an application or essay about their self-injury scars and their healing processes, whereas Finn and Develle accepted submissions and requests via email or on social media. Some people revealed their scars were a sign of having lived; but the scars haunted others, serving as a constant reminder of trauma and pain. The tattoos offered a way to embrace, salvage, or hide the scars (Solomon, 2015). Many tattoo artists reported difficulty tattooing over scar tissue, because it is an unpredictable medium (Solomon, 2015), but these artists embraced the challenge to help individuals heal (Gastaldo, 2016).

Addressing Vicarious Trauma

Shepard (2013) found that most of his supervisors and colleagues working in the mental health field had suffered several psychosomatic, physiological, and mental health symptoms because of their work. Human service occupations, specifically with long-term and self-destructive clients, can lead to burnout, decreased confidence in one's work, emotional exhaustion, and feelings of low personal accomplishment (Gibb, Beautrais, & Surgenor, 2010). Over time, the effects of working in acute environments, coupled with low wages and daily stresses outside of the job, led to more serious outcomes such as developing *vicarious trauma* (the physiological and psychological impact of hearing and witnessing trauma's effect), anxiety, and depression (Shepard, 2013). Additionally,

according to Conterio and Lader (1998), safety and serenity were important aspects of the therapeutic dynamic for both the therapist and the patient. Individuals who self-injure challenge these relational aspects of the work by creating an unpredictable and potentially dangerous relationship or environment (Conterio & Lader, 1998).

Due to the immediate risks, longevity, and graphic nature of this behavior, many therapists find it difficult to manage and control their personal reactions, which may lead professionals and family members to respond ineffectively to the self-injury, thereby continuing the cycle (Walsh, 2012). If mental health professionals are unable to manage their countertransference, treatment may begin to address the therapist's—rather than the client's—agendas and treatment goals (Hoffman & Kress, 2010). Walsh (2012) outlined three categories of negative responses: (a) anxiety, fear, and related avoidant emotions; (b) frustration and related aggressive emotions; and (c) sadness, discouragement, and related hopeless and helpless emotions.

Although many systems focus on coercive and prohibitive means to reduce self-injury, proactive skills training is a more effective and important treatment method (Walsh, 2012). For example, while in a four-point restraint (wherein wrist and ankle straps are attached to an individual and then tied or attached to a bed railing or restraint bed) for ingesting foreign objects, one woman bit a mouthful of her flesh, communicating “[I] can harm myself no matter how much you try to control me” (p. 322). This type of behavior often leaves staff and therapists dejected and overwhelmed. Staff members need support and validation from higher-level management and outside entities to decrease stress and burnout while managing these clients and building more adaptive coping tools. Walsh implied that working with clients who self-injure could burden even the most ethical

therapist's morals and intentions. Finally, Brown and Kimball (2013) outlined the importance of vigorous training and discussion of self-injury to be rooted in the education and supervision of all mental health professionals.

Mental Health Workers Creating Art

Many creative arts therapists and supervisors have supported the use of a therapist's own art personally and professionally for self-care and as a way to deepen their empathy and understanding of their clients (Fish, 2006, 2017; Mazloomian & Moon, 2007; McNiff, 2011; Moon, 1999; Purswell & Stulmaker, 2015). Fish (2006) further supported this idea by identifying the term *harm's touch*, which refers to events witnessed either within the session or outside the therapy time that often have a significantly detrimental impact upon the therapist. According to Fish, the effects of our own and our clients' trauma, self-injury, and other behaviors become trapped in our bodies. Image-based outlets are essential to make sense of these experiences. In the same way, words are often insufficient to describe the experiences of trauma and self-injury for the client and the mental health professional. Therefore, art-based supervision provides a safe space for self-care, self-reflection, and self-awareness (Purswell & Stulmaker, 2015). Furthermore, the use of art and poetry can help articulate unknown, subconscious, and overwhelming thoughts or emotions that transcend words (Fish, 2012).

Self-injury is a powerful method to communicate graphically what is customarily a silent anguish words cannot define (Strong, 1998). Nock (2012) and Walsh (2012) described the experience of assessing and processing self-injury after the fact as a secondary assessment and thus potentially inaccurate because research relies on primary assessment in the moment. Similarly, McNiff (1998) addressed the use of verbal language

to describe and assess a nonverbal act as “translating from a primary to a secondary medium” (p. 44). By relying upon these secondary levels, a substantial amount of information and knowledge may be lost or overlooked.

Several art therapy scholars (e.g., Fish, 2017; McNiff, 1998; Moon, 1999; Schreibman & Chilton, 2012) proposed that the therapist’s use of creative outlets (such as art and poetry) in processing their own reactions could deepen understanding and connection with their own role and their client’s experience and behavior. Therefore, experiences that allow for verbal and nonverbal investigation into this phenomenon may lead to greater outcomes for the mental health professionals, families, and individuals who self-injure.

Similarly, Moon (1999) found that images created in reaction to these experiences with clients could be useful in establishing empathic relationships and providing therapists with an expressive outlet for imaginative, interpretive dialogue with clients. However, the ability to immerse oneself deep into an artistic experience and then translate it into more linear thinking is essential (Forinash, 2016). Creating and sharing art and poetry in supervision or consultation can allow a space to process psychological struggles and decrease professional isolation (Fish, 2017).

Summary

As noted throughout the literature, humans for centuries have communicated through skin in the form of tattoos, ritual scarification, and body art (Favazza, 2011). Similarly, a person who self-injures is sending a message (Charles & Matheson, 2007). Researchers such as Nock (2012), Van der Kolk et al. (1991), and Walsh (2012) recognized a gap between an individual’s self-injurious act and current assessment and

treatment models. Mental health providers and families are beginning to understand this behavior as meaningful and separate from suicidality (Zetterqvist, 2015). As they develop compassion and support for themselves and those suffering with self-injury, more effective treatments—accompanied by less judgment and frustration over the behavior—will hopefully emerge. This literature review examined the importance of art-based inquiry on the body as an important method to understanding the choice of self-injury as a resource (Freeman, 2012), embodying one's knowing (McNiff, 1998), and providing a safe place to artistically explore the phenomenon in the presence of a witness (Fish, 2017). Art-based inquiry may offer those who do not self-injure a safe catalyst to explore the behavior, as well as provide creative alternatives that support individual differences and increase control for the client and the therapist. Specifically, body art might be an important and uniquely meaningful tool for understanding and communicating emotional pain, which manifests somatically but cannot be easily verbalized.

Overall, the existing literature indicated a need to support those who provide care for individuals who self-injure by increasing empathy, connection, self-compassion, and insight. A therapist or researcher is unable to witness or engage in the client's behavior due to its dangerous nature and the ethical concerns of allowing someone to harm himself or herself (Nock, 2012). In addition, transference and countertransference in the relationship affect the treatment provider's perspective and own self-care. Together, these effectors lead to disconnection and potential for misdiagnosis and misunderstanding of the behaviors and the need behind it. They also lead to increased burnout, vicarious traumatization, and compassion fatigue (Walsh, 2012). The body art study described in the

following chapters attempted to explore a resource by which the mental health providers could begin to sit in “their clients’ skin” in a creative and meaningful way.

CHAPTER 3

Methods

The use of body art related to self-injury is relatively underrepresented in scholarly research (Masters, 2011) despite numerous documented examples of body art as a source of healing, communication, and understanding on Internet Boards (Butterfly Project, 2011; Shields, n.d.). Other sources document the work of tattoo artists (Bruk, 2017; Donovan, 2016; Gladwell, 2016), anecdotal research (Freeman, 2012), and my colleagues' and my personal work with clients, which together guided this research. I adapted the research design to discover the possibilities of utilizing body art as a method to explore and understand the client in a way that is generally unavailable via other research methods (McNiff, 1998). Art-based research arguably allowed for a deeper and more comprehensive investigation of the research questions due to art's ability to explore metaverbal experiences (Moon, 1999) and connect to the nuance and impact of communicating through the skin (Hewitt, 1997). Furthermore, this methodology created a multisensory relationship between the art, artist, researcher, and subject (Fish, 2017).

The Office of Human Research and Institutional Review Board at Lesley University reviewed a detailed overview of the research design and purpose, and returned approval to conduct this study (Appendix A). All participants signed written consent to participate in the study (Appendix B) and share their photographs, written and verbal responses (Appendix C), and self-identified demographics. The administrator of the locked facility, the company president, clinical training consultant, and director of research and program practices for my employer supported this research and the use of their facility.

Research Questions

This study was designed to examine the following questions:

- RQ1. How can art that uses the body as a canvas help communicate the experience of self-injury?
- RQ2. To what extent can body art help mental health professionals further understand the phenomenon of self-injury?
- RQ3. To what extent might mental health professionals' use of body art influence treatment with their clients who self-injure?
- RQ4. How does having a witness during the body-art experience of this study affect the participant?

Assumptions

- a. Body art can increase empathy and understanding for the mental health professional, which will lead to insight and growth in treatment for clients who self-injure.
- b. Body art can provide an experiential way to understand self-injury by allowing the professional to embody the behavior in a safe way.
- c. The mental health professional's use of body art may increase rapport and help decrease the power and control dynamics that occur in and out of sessions related to self-injury.

Study Location

The facility in Torrance, California was comprised of a locked psychiatric facility (16 clients), a locked group home (44 clients), and a special education school to serve the clients. The facility employed 220 staff. The administrator provided use of the facility's large conference room, which had a dedicated entrance, a private bathroom, and limited

access, allowing the privacy and security preferred for the meetings. The participants came from different sites to the location to take part in the study.

Participant Selection

Participants

Participants included six mental health professionals currently working with clients who self-injure in the greater Los Angeles area. I served as primary witness to the first five participants and participated as one of six professionals who completed the experience. A seventh professional served as an alternate witness and a guide during my experience to keep time, maintain validity, and provide an authentic process. The alternate witness was also a mental health professional with experience in self-injury work. Participants selected a pseudonym to further reflect their experience and allow some level of anonymity.

Recruitment and Selection

I sent an invitation email (Appendix D) to a list of identified mental health professionals (e.g., art therapists, marriage and family therapists, clinical social workers, and master and doctors of psychiatry). Two local art therapy schools, as well as several local therapeutic nonprofit organizations, forwarded the email to their alumni and employees. After expressing interest, potential participants completed a questionnaire to assess suitability for the study and possible concerns that would limit their ability to participate. Criteria for inclusion in the study included: (a) clinical experience working with clients; (b) familiarity with clients who participate in some form of skin-oriented self-injury; (c) willingness to participate in the use of body art; (d) willingness to have the experience photographed, recorded, and videotaped; (e) participation in three meetings—

the first two in person and the third in person or on Skype; and (f) willingness to sign the informed consent (Appendix B) and consent to use the artwork (Appendix C) . There was no cost to the participants of this study. Although not a question directly asked, if disclosed, previous personal self-injury experience was neither a requirement nor an exclusionary factor. I did not allow my previous or current clients or my previous or current supervisees or supervisors to participate in the study, in order to prevent dual relationships.

Of 14 identified potential participants (not including the researcher), four did not return the questionnaire, the only male scheduled to participate removed himself, one was ineligible due to being a past supervisor, and three due to being past or current supervisees of the researcher. Thus, the final sample size was five recruited participants plus the researcher.

Demographics

Although it was not an inclusion requirement, four of the six participants had both art therapy and marriage and family therapy degrees. The remaining two had no previous art experience—one had a social work background, and one was a licensed clinical psychologist. The participants were all females, ranging in age from 25 to 50 years. The witness and the participants were encouraged (but not required) to identify their gender as well as their ethnic and racial background. All participants, the alternate witness, and I identified as female. The first participant self-identified as of Japanese and Norwegian descent; the second as of Japanese and American descent; the third a mix of European and Hawaiian descent; the fourth as Asian American; and the fifth participant, the alternate witness, and I as Caucasian.

Primary Witness (Researcher)

It was important for me as the primary art-based researcher to not only witness the experiences of the participants, but also become a participant. This dissertation committee approved and supported the approach, which allowed my full immersion in the investigation, deepening my experience, and increased my empathy and understanding of the participants' experiences.

Alternate Witness

Two mental health professionals were selected to be witnesses for the researcher based on their knowledge of the study and previous research experience. The witness who participated had a doctorate in clinical psychology and was familiar with research methods and process. The alternate witness had no art background.

Exploration Design

All participants completed a questionnaire to assess their ability to participate in the study, willingness to do the body art, and willingness to be photographed. Each participant then attended three individual meetings, which were audio- and video-recorded. (In addition, I provided the participants with a list of recommended professional resources, Appendix E). After the meetings, the audio recordings were transcribed. The videotapes, used as a supplemental mode of documentation, were not transcribed. Photography was the primary mode of documenting the process and the completed body art, a permanent record of the body art created during the meetings. The photographs were shot with an Apple iPhone camera using the Hipstamatic app (creating photos with a torn-edge look), a Canon EDS Rebel T3, and a Sony NEX-5R. The Canon and Sony cameras

took black and white, as well as color, photographs. Several photographs were taken using all cameras. The sessions were video recorded with a JVC HD GZ-HM40 camcorder.

Meeting Design

Each participant was scheduled for three individual meetings. The initial meeting was one hour to two hours long and focused on an art-based inquiry of self-injury. In response to two questions, the participants created art on their arms, necks, face, and legs by painting, drawing, and writing with body crayons and body paint. The first question for exploration was, “What do you think your clients or those who self-injure are communicating or expressing through this behavior?” The participants spent 30 to 60 minutes reflecting on the first prompt. The second question was then asked: “What do you wish you could tell your clients or yourself before, during, or after a self-injury incident?” The witness then photographed the process and the final art per the participant’s request. All participants asked the researcher to take photographs and made some specific requests throughout the process. The witness photographed from different angles to ensure the participants’ experiences were captured and to decrease photographer bias. In addition, as further empowerment, each participant briefly examined the photographs throughout the process to ensure their experiences were adequately captured. Only two participants chose the option to photograph themselves, each taking approximately 10 photographs.

In the second individual meeting one to two weeks later, the participants assisted in the review of photographs by selecting 12 to 25 pictures that most significantly represented their experience. These meetings lasted 30 to 90 minutes. The photographs were used as documentation of the participants’ experience and as a prompt to elicit

discussion and insight into the body-art experience and its relation to self-injury (Pink, 2013). The participants were invited to sort through the photographs to make meaning, identify significant features and visual qualities, and create field notes for the researcher to explore and investigate further. The participants made piles of *no* (this does not represent my experience), *yes* (this represents my experience), and *maybe*, going through the photographs several times until they were confident in their selections. The participant then titled each piece and shared any significant observations with the researcher. After the second meeting, the researcher created a poem using the participant's images, titles, and significant words to further explore and enhance understanding of the experience.

The final individual meeting occurred one to two months following the second meeting. It was a semi-structured interview aimed at identifying overarching thoughts or insights about the experience. Each final meeting lasted 30 to 60 minutes. The participants reexamined their chosen photographs one more time and used word association to further understanding. Then they were presented with the poem the researcher wrote for them and asked to share any thoughts or feelings about the poem and the experience as a whole. Finally, they were asked how they would like to be identified in the study and which photograph best represented their experience.

Art and Other Source Material Collection

Photography, transcripts, field notes, and poetry provided the source material to be examined later. Photography was important to both create a tangible record and allow the participant and the readers to bear witness to the experience. Transcripts were read and used to fact check information noted about the photography. In the same way, field notes provided a way to fact check, assess for ideas, and identify emotional changes as observed

in the moment. Finally, poetry served as a representation of the individual's experience and a way to create meaning, as well as a way to understand and explore the material from the literature review.

Accuracy and Trustworthiness

Multiple approaches were expended to establish accuracy and trustworthiness. The participants were active contributors in identifying significant characteristics of the photographs and the experience as a whole. This exploration relied on visual, tactile, and physical enactment; therefore, it was paramount that the participants contributed in the identification of distinguishing features, patterns, and areas of personal identification. After selecting their photographs, the participants were also encouraged to provide a title that represented each photograph selected and share any significant thoughts or insights about the photograph. In addition, the participants reviewed the poem I created for accuracy, and were presented an opportunity to make changes or suggestions. Consistency of the experimentation was also ensured through audiotaping and transcribing the meetings verbatim, as well as photographing the participants' body art. Finally, an art therapist/marriage and family therapist with experience and knowledge related to both this research and work with self-injury assisted in reviewing the transcripts, poems, and photographs for distinguishing features, patterns, and meaning, further reducing researcher bias.

Investigation of Materials

Transcripts

Tape recordings were listened to and subsequently transcribed by an associate who was provided the following sequence: (1) Listening to the tape and stopping as needed to

capture the communication. This step allowed the transcriber to capture most of the communication; (2) A second listen, allowing for a detailed transcription that captured more of the spoken dialogue, noting overlaps, interruptions, and unintelligible utterances. The transcriber noted movement, outside noise, mutterings, and places where the subjects were too quiet to be heard. (3) The meetings were listened to again to assess for lapses in verbal communications and silences. This allowed noting the amount of time that lapses and silences occurred.

Once the meetings were transcribed, a colleague with knowledge of this study and self-injury and I independently examined the transcripts for common elements. Because I was also a participant, this was an important review to help decrease bias and cross-check themes. First, we reviewed the transcripts as a whole and noted any first impressions. Then, we read them more thoroughly, one by one highlighting and noting phrases and statements that recurred, surprising phrases or words the participant identified as important, and concepts or phrases that connected back to the literature reviewed (Denzin & Lincoln, 2013). We paid special attention to both the participants' and my emotional reactions to the art. This review helped explore the emergence and development of common issues, themes, and patterns. Although word, *theme*, is common in qualitative research, it did not capture the depth of the experience of embodiment, art, photography, and words; instead, the findings will be referred to as *prevailing characteristics*.

After we completed this process independently, the reviewer and I came together to analyze findings and compare them to the poems and photographs. First, we noted our thoughts about the process, significant characteristics, or participant comments, as well phrases participants repeated in the meetings. Then my colleague and I reviewed our

identified prevailing characteristics. We compared and contrasted to solidify our prevailing characteristics and created a comprehensive outline that honored the findings.

Field Notes and Video

In addition to the transcriptions, I reviewed the field notes created during the process. I looked for comments, statements, words, or doodles that reinforced the transcript findings, as well as phrases and statements about emotional responses in the moment of the art making. I then reviewed the videotapes from the meetings to explore further the sections of emotional change and response to art. Although the videotapes were not transcribed, I could watch them to assess accuracy in researcher perspective and audio-recorded transcriptions. After I had written the bulk of the results and discussion sections of this dissertation, another review of the video recordings allowed me to fact check specific details and correct any misquotes or misrepresentations.

Reflection on the Art

I used several methods to examine the art artifacts within the study.

Body Art

The first source of exploration occurred in the first meeting using body art in response to the two questions. “What do you think your clients or those who self-injure are communicating or expressing through this behavior?” and “What do you wish you could tell your clients or yourself before, during, or after a self-injury incident?” The body art was the foundation of the entire study and allowed for experiential response to the questions. To explore and process the questions on the body, I offered participants nontoxic, professional-quality products: Wolf brand character make-up, which included crayons, paint, and foam brushes; Tulip brand body markers (in different colors);

Maquillage brand cream makeup (in different colors); Snazaroo brand face sponges; a standard small paint brush; and Q-tips. These materials were chosen due to their professional quality, ease of use, consistency, and availability. Participants were able to clean off the art throughout the process, as desired. They were specially instructed to clean off the artwork between their response to the first and second questions. For cleaning off the makeup, they were offered CVS sensitive unscented body wipes, CVS sensitive skin cleansing towel makeup remover, and the use of the onsite bathroom with a sink and hand soap.

Photography

Photographs of the process and the body art were taken from a variety of angles as an artifact of the experience (Pink, 2013). These photographs were taken throughout the art process under the participant's agreement and direction. The photographs taken once the artwork was completed (as identified by the participant) allowed for more posed and emotionally poignant shots directed by the participants. As the photographer, I also took photographs throughout and after the process in an attempt to capture different moments, angles, and stories during the exploration.

At the onset and throughout the study, there was significant discussion about the choice to remain anonymous and options where the photography allowed either choice. We took photographs of all participants without identifying features, and participants had the option to crop and alter their photographs to hide or change identifying features. In addition, participants had the final choice about which photographs were selected as part of the study. All participants chose to allow their full body and faces to be shown in order for their pictures to be used in the study.

There were 150 to 200 photographs per participant; all photographs were printed at 8” x 10” and separated into categories based on artwork and the parts of the body used. As previously described, participants separated and sorted the artwork corpus into *yes*, *maybe*, or *no* piles. After the first sorting of the photography, the participants again selected photographs into *yes*, *maybe*, and *no* piles, continuing at the participants’ pace until each had selected 10 to 20 photographs. Once they selected the final photographs, the participants went through them one by one to title the photos and verbalize any comments or thoughts they wanted to share about each piece or the process of creating it. I then reviewed the photographs and titles the participants selected for distinguishing features, patterns, words, and significant elements of the body art.

Poetic Interpretation

Similar to the use of visual art as a way of knowing, poetry as a method of interpretation and understanding can uncover new aspects of the subject (Leavy, 2018). I transformed the participants’ titles, words, silences, images, and photographs into a poetic representation of each individual’s experience. I then shared the response poetry I created as the researcher with the participant for confirmation of emotional resonance and attunement to the individual’s process and experience. In addition, we examined the poems to elicit a deeper meaning into self-injury and the participant’s experience. This method of inquiry allowed more discoveries and a deeper level of empathy, and promoted a positive learning experience for the participant and the witnesses (Fish, 2017).

Artistic Participation by the Researcher

I took part as a participant in all phases of the inquiry as a way to make meaning of the other participants’ process as well as to explore my own experience with a client

exhibiting self-injury during the time of the study. This allowed for the full experience of the investigation, deepened my own experience, and increased my empathy and understanding of the participants' experiences. Additionally, my knowledge of self-injury, extensive work both in treatment and supervision related to the topic, and photography skill lent itself to my participation as the researcher. A witness was chosen to help keep time, interview, take notes, and add insight, as well as take photographs of me as participant. In addition to contributing as a participant, I created a poem after the second meeting in response to each participant and to the witness, as part of the inquiry as noted above. This aided to me further to embody and understand each individual's experience and story.

CHAPTER 4

Results

The participants' complete experiences in picture and poem form are available to review in Appendix F, Presentation of Artwork and Poetry.

Discovery of Prevailing Characteristics

Question 1: What do you think your clients or those who self-injure are communicating or expressing through this behavior?

The participants referred to this section as “raw and opening,” “powerful and intense,” and having “created a deeper connection to the whole experience of self-injury.” Several similarities were found throughout the participant responses. The expression of feelings was an important concept that echoed throughout the work. Faith represented this in Photograph 4 with words written on her head; Hope exhibited it through her works entitled “Muffled” and “Leaking out” (Photographs 30–32); and Hana represented guilt in Photograph 42. Additionally, I titled one of my pieces “Lopsided Twisted Guilt” (Photograph 94). Unicorn showed it through her Photographs 73, “Shame,” 74, “Mixed Messages,” and 76, “Negative Thoughts.” Arthur represented the images of the overflow of emotions (Photograph 14–15, 17), and in Photographs 19–20 represented the emotions that come before and after a self-injury incident.

The desire to be heard and understood also became an overarching experience represented by Faith (Photograph 9); Hope (Photographs 25–26, titled “Presenting to Another”); and Hana (Photographs 43–44, 50). Unicorn represented this through Photograph 69, titled “I Felt Like No One Cares,” and Photograph 70 with the words “Trying,” and I through Photograph 92, titled “Reaching Out.”

A fear of abandonment or being left also arose as significant. Faith wrote, “Don’t leave” next to the image of a baby (Photograph 8). Although Arthur did not draw about the fear of abandonment, it arose in the conversation related to the overflow of emotions. Every participant used red and black as main colors during their response to the first question.

Although there were several similarities among the participants at and photographs, there were also some unique features. Faith (Photographs 6–9) was the only one aside from me (Photographs 85, 87, 97) to use the mirror as part of the artwork. Additionally, Faith was the only participant to use music during her response to the first question or to bring in a prepared drawing to use as a reference (Photographs 3, 6, 8). Whereas Faith, Hope, and Arthur considered several clients or the concept of self-injury as a whole during their response, Hana, Unicorn and I identified one specific client as we responded.

Question 2: What do you wish you could tell your clients or yourself before, during, or after a self-injury incident?

In contrast to the first question, the participants experienced this question as “a sewing up of their rawness,” and “cooling and peace,” as well as “cathartic.” Feelings and expressions related to being noticed, heard, and understood permeated the answers to this question. The words, “I hear you,” were represented in Faith’s Photographs 10 and 12 and my Photograph 104. Hana titled Photograph 49, “Send Loving Energy” and Photograph 50, “Noticing,” representing the importance of these connections. Photograph 83, titled “Progress,” and Photograph 84, where Unicorn wrote on her body, “Wanted keep trying,” represented the hope of being noticed and understood. All participants used blue or white

colors in their responses to the second question. Regardless of their treatment model, all participants verbalized the importance of trust, compassion, hope, and sincerity in the therapeutic relationship.

All participants had different specialties. Faith specialized in clinical art therapy, CBT, and aggression replacement training; Arthur used DBT, motivational interviewing, and the recovery model in treatment; Hope specialized in art therapy; Hana specialized in trauma resolution through clinical art therapy and EMDR; and Unicorn identified as a psychologist with a strong attachment focus. These different modalities led the participants to explore different aspects of self-injury and create unique art. For example, Arthur was the only participant to choose a specific manta to help her and her clients. Additionally, Arthur and Hana discussed their own scars and their importance in their lives. Hana circled her scars as part of her art (Photographs 56–61), while Arthur shared about a recent experience rock climbing that left a fresh wound (Photograph 24).

Process of Discovering: Presentation of Prevailing Characteristics

Sanctuary

Embodiment

holds the space

for sensory empathy

to cultivate a compassionate response

Trapped in ambivalence

drowning in the overflow

bad and good, wanted and unwanted

absorbed in a battle for power and control

Truth exposed

uncovering expression

silence, words and images

shelter hope²

The body art, photography, and poems melded into a symphony of powerful experiences. In the accumulation of these components, connections and insights were formulated. Through the process of examining the body art and photography with the participants, alone, and through poetry, prevailing characteristics arose as integral pieces of information that helped paint a visual representation of the participants' experiences. Although I do not discuss the poems and videotape review in detail herein, they were fundamental to the process of making meaning. The poems allowed further depth and prevailing characteristics to arise, and the videotapes allowed a sense of support and connection to the writing and the inferences made. While the prevailing characteristics began to be formulated through the poems, the participants reviewed them for accuracy. In the next section, the six main prevailing characteristics identified are illustrated with photographs that best represent each characteristic to help illuminate the findings. The

2. Poem written on January 20, 2017 by Dana Wyss to reflect upon the prevailing characteristics identified throughout the research.

photographs labeled “figures” in the section are only selected examples; the corpus of the photographs is included in Appendix F.

Holding the Space: Impact of Having a Witness

It was critical to the process of this study to have included a witness who could provide safety in the midst of at-times overwhelming content and facilitate the exploration of the body art. The attunement of the witness to the participants (Figure 1) became a crucial part of creating the holding space, which allowed us to build rapport and enabled the participants to ground themselves through artwork and processing the experience (Van der Kolk, 2014). As a main witness, I found this experience a profound, intimate, and raw event. The bravery and willingness of these professionals to be so vulnerable in their exploration was powerful and humbling. I originally embarked on the journey of this study to help those who self-injure; however, this experience outlined the need to support and allow space for the mental health professionals to explore their thoughts, feelings, and reactions (Fish, 2017).



Figure 1. Photograph 85, “Witness” (Blue).

Although there was no direct inquiry about the impact of having a witness, the participants shared an overwhelming sense of gratitude for having someone guide them through the experience. Initially during the pilot (Wyss, 2014), I undertook my own body-art painting experience as part of an art-based class without a witness. I spent more than 10 hours playing with the body art and taking pictures. I found myself absorbed in the art and the experience. In contrast, the witness during my participation in this study grounded me in the questions, helped me stay on track, and provided needed containment during the art making (Forinash, 2016). In addition to containment, the witness captured the body art, photographing throughout the art creation to ensure the participant's experience was represented through a variety of angles (Leavy, 2018). Hana expressed gratitude for having a witness who could guide her and honor her by accurately capturing everything in photographs.

An interesting component was that the holding space was maintained differently for each individual. In particular, playfulness and humor emerged as essential factors to alleviate tension and maintain safety. The participants, the alternate witness, and I recognized these elements throughout the study, even though they were only evident in a few photographs (e.g., Photographs 12, 61, 80–81, 108). During the meetings, jokes and laughter aided in coping and grounding in the face of disheartening and, at times, overwhelming content (Figure 2).



Figure 2. Photograph 61, “Revisiting History Through My Scars” (Hana).

There was also significant variation in the way the space was held regarding verbal and nonverbal communication. Some participants remained silent during parts of the art process while others were verbal. Arthur told a story through her words, accompanied by artwork that illustrated her experience with her clients and the processes she used. Hana led me through the work with her client and her own experiences using image and voice simultaneously. In contrast, Faith listened to music, allowing the lyrics and music to remind her of her clients and to tell that story as she completed her art. Unicorn, Hope, and I remained silent for the majority of the art making, relying on the art to speak on behalf of our experiences. It was important to allow the participant to identify the need for silence, communication, music, and so forth to support the organic flow of the process.

Unicorn, Faith, Hana, and I commented that there is not a safe space to share feelings about clients who self-injury, because it is often an ongoing behavior and the profession may or may not afford effective safe-place resources or support (Brown &

Kimball, 2013). For example, many participants were licensed and the supervisors of students and interns who work with cutting behavior. That role added another level of support the participants had to provide, even though they often lacked similar support from a superior. This study's art process allowed the participants to not only honor the clients, but also experience the importance of holding the space for the clinicians and professionals we supervise. This became a safe place to explore and reflect on feelings and thoughts with a witness (McNiff, 1998).

The photographs were originally a way to document the art, but they became the art, as well as a way to hold the space and provide a sense of control for the participants. The ability to distance oneself from the art emerged as an intervention to protect the self and regain power and control instead of feeling overwhelmed by the experience (Fish, 2017). Additionally, there was a strong sense of agency in being able to select the pictures used for the study. For example, Faith discussed the photography in the moment and how the review of photographs allowed a safe distance from what she had done. She described it as a way of "externalizing" the experience to help her explore it objectively. The photographs served as a pause button after an extremely emotional moment. The use of photography allowed the participant to guide the witness or to take control of the camera herself. Additionally, it allowed the participant to pause from the artwork and the intense feelings related to it (Fish, 2017).

Another important consideration that surfaced was the ability to hold multiple spaces for different treatment units, including the individual who self-injures, the family that deals with the behavior, and the mental health professionals who try to help the client and the family heal. The definition of the holding space could be significantly different for

each person. Hana and Arthur, who both worked with adults, identified the holding space as acceptance of the client's self-injury. For example, Hana discussed that her client continued to self-injure as a resource or coping mechanism; they had established rules around safety in and out of their sessions in an attempt to extend the holding space beyond therapy sessions. As exemplified in Figure 3, Hana explored this dynamic throughout her art, representing the growth her client experienced through acceptance of her condition and herself in the treatment (Photographs 51–55).



Figure 3. Photograph 53, “Bring It Closer” (Hana).

Unicorn was unable to allow any level of self-injury to occur due to the policies of the residential treatment facility in which she worked. When her client was cutting or banging her head, the rules and regulations of the treatment program and the client's age required that program staff interrupt the behavior, regardless of the level of

dangerousness. In addition, her client often used significant force and caused damage when cutting or banging her head. Thus, Unicorn had to manage and provide the sense of control that Hana was able to provide her client in other ways. The mental health professionals who worked with adolescents in outpatient settings reported the clients hid the injuries and did not self-injure in their presence. It would be interesting to explore how someone in outpatient could help the parents or caregivers manage this experience. This emphasized the many ways that holding space, empathy, and a compassionate response must be maintained (Walsh, 2012).

Faith wrote in a post-study email, “Looking back on participating in this study, I find myself ruminating on its richness, on the content it evoked, and how it cultivated a deeper sense of empathy and self-compassion in me than I had before” (January 16, 2016). All participants and witnesses echoed this thought, reporting a significant increase in empathy and compassion for the self and others in general, which in turn further supported work with their clients. Specifically, the participants felt the study directly influenced and increased their ability to hold the space for their own experience with self-injury and in working with their clients and the clients’ families. For me, this exploration cultivated empathy for not only the individuals who self-injure, but also the mental health providers (Fish, 2017).

Sensory Empathy: Understanding the Body as a Canvas

Empathy was defined in the literature as the ability to accept and reflect the client’s suffering (Paivio & Laurent, 2001), understand their need for self-injury (Norton, 2011), and authentically engage to create healthy human connection (Long, Manktelow, & Tracey, 2016). Figure 4 depicts how sensory empathy was the physical sensations created

through feeling the paint and instruments on the skin (also see Photographs 5, 27, 56, 100), and Figure 5 shows the reflection of this in the mirror or the pictures (also see Photographs 7–8, 85, 87, 97), which allowed a deeper connection to the whole experience of self-injury. The sensory empathy identified in this study allowed the participants to reach past understanding “why the person self-injured” to feeling with their own bodies why the injury is integral to the clients. Hope discussed how the experience was about not just *realizing* that the scar has a story, but *experiencing* that the scar has a story.



Figure 4. Photograph 68, “Cut” (Unicorn).



Figure 5. Photograph 9, “Silent Tear” (Faith).

During the cleanup process, Unicorn had difficulty wiping the residual turquoise marker off her body. While trying to clean it off, she mentioned she was rubbing her skin so hard it turned red. She joked, “Is it part of the process to have me self-injure to get the marker off?” This led to a discussion creating a parallel between the art process and the process of an individual who self-injures. Unicorn was not able to remove the marker from her skin, much as someone who self-injures is unable to remove the scars. These parallel

examples of sensory empathy arose through the study. Mental healthcare professionals and researchers have a detached relationship to the physical role self-injury plays for those who self-injure (Nock, 2012). The process of undergoing the ritual of creating art, feeling the sensations of the art materials, brushes, and cleaning materials on the body, as well as seeing the body in this way, provided a profound sense of physical sensation that allowed for embodied knowing (McNiff, 2011).

Art making on the body created a powerful first-person experience (McNiff, 1998). Faith described drawing on the body during the first question as raw and as opening of a wound, while the second question allowed for “sewing” up and closing the wound. There was a visceral response to the art materials on the flesh. Faith (Photographs 2–3), Hope (Photographs 31–32, 36), and I (Photograph 89–93, 95, 97, 99) experienced a tightness or heat around our necks when we painted flames (Figure 6).

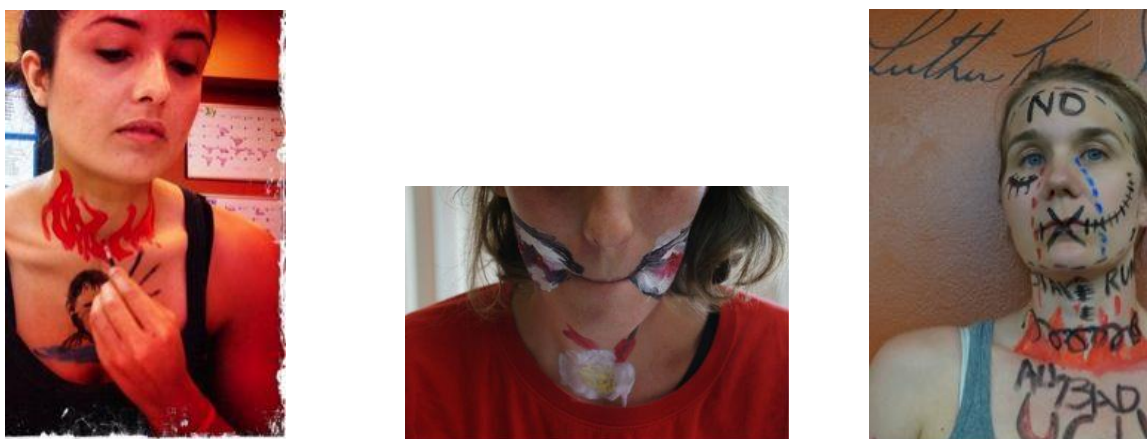


Figure 6. Photograph 2, “Choked” (Faith); Photograph 31, “Muffled Two: Leaking Out” (Hope); Photograph 93, “Seriously Disturbed” (Blue).

In contrast to feeling heat, Hope (Photographs 37–39) and I (Photographs 100, 103, 104) felt coolness when we painted the blue color on our foreheads while responding to the second question (Figure 7).



Figure 7. Photograph 37, “Owl Eyes: Cooling the Heat” (Hope); Photograph 100, “Resources” (Blue).

After completing my art, I looked in the mirror and was surprised how much of my body I had covered (Figure 8). I imagined this as similar to the experience of someone who engages in cutting behavior. They would start with one small wound, and it would grow from there. This reminded me of a client who said that the first cut was the one that opened the door for them all. The client often actively and passively tried to have her arm removed by creating wounds and infections. When I wrote, “Take my arm,” I had a strong consciousness of wanting to wipe it off, as if something would happen because I wrote it on myself.

Faith described being able to respond to both questions as a cathartic and emotionally charged experience that helped increase insight. In addition, the idea of the

body as a canvas was liberating to her personally and with her clients. She found a new freedom in allowing herself to use the body in a different way. After her participation in the study, Faith began writing a positive word on her body to keep her grounded and get her through the day. Similarly, Hana explored her own scars during the second question, examining the importance of scars to her life, how they tell the stories that keep her in line, remind her of specific moments, and signify she is living a full life (Figure 9). Unicorn explored the idea of sensory empathy in a different way. She referred to the process being similar to when someone is pregnant, and the husband has sympathy pains. Unicorn described after participating that when her client cut, she winced as if she felt it.



Figure 8. Photograph 89, "Guilt: The Aftermath" (Blue).

Contrary to Hope, Hana, Faith, and Unicorn, during the first session Arthur noted that while putting an image to her clients' pain was helpful and encouraged her to think

more deeply about her clients and their self-injury, she did not feel that putting those images on her body made much of a difference. Specifically, she commented that by thinking about how to put it into a picture, she was able to use a different part of her brain, which helped her feel and experience what her clients may experience in a safe way. By the third session, Arthur had begun working with a client who was actively cutting. She verbalized that, through this study, she was able to have an experience of self-injury to connect to that was not too personal. This allowed Arthur to hold the space for her client in a new way. By connecting to her experience in the study, she reported an increased unspoken ability to connect to her client, which then guided the treatment. This insight was similar to Fish's (2017) findings regarding the impact of art-based supervision.



Figure 9. Photograph 58, “Scars Telling Stories II” (Hana).

After reviewing the videos, I observed (and the witness for my experience described) that there seemed to be a significant shift in the participants' moods and energies from the first to the second question. While the participants reflected on their bodies about the first question, "What do you think your clients or those who self-injure are communicating or expressing through this behavior," there appeared a drowsiness and sadness in their eyes. Most participants were quiet, somewhat solemn, and used fewer words. Their focus was on creating and reflecting. While responding to the second question, "What do you wish you could tell your clients or yourself before, during, or after a self-injury incident," the participants seemed more alive, laughed, and held a lightness in their tone and words. Each participant and witness described the experience of the first question as intense and expressed gratitude and relief for the second question.

The importance of seeing, noticing, and witnessing the truth of the behavior, feelings, and stories behind self-injury became evident throughout the exploration of the participants' experiences. It appeared vital for the professionals to be able to join with the persons they were working with to offer support in moving past the need to self-injure. It was essential for the participant to embody the experience of self-injury with the body art in order to connect with something related to the behavior. This in turn cultivated a true sense of empathy and connection to the client's internal experiences, which Norton (2011) found to be fundamental. For many people who have not experienced a desire to harm themselves, it may be difficult to empathize with the behavior. For professionals who have histories of self-injury, connecting with their own feelings about it could possibly lead to overidentification and overwhelming feelings. Some participants discussed that this

process allowed a way to distance from their personal experience of self-injury and connect to their experiences of this study instead.

Compassionate Response

These moments of sensory empathy cultivated a new level of compassion for self and the client. A compassionate response is defined as the “ability to feel with another” (Siegel & Hartzell, 2014, p. 260) as well to accept one’s own feelings of pain, failure, and success (Neff, 2003). This occurred for the participants with their clients and for the witnesses with the participants. Echoed through this exploration was the awareness of the importance in honoring the truth of the individual. The use of body art allowed a space for cognitive restructuring by acknowledging and addressing the positive and negative reactions related to client’s self-injury that Walsh (2012) identified (Figure 10). Participants not only discussed this as important in the process of the research, but also reported mirroring it in their work with their clients. Furthermore, this process helped participants move away from the pejorative language often used to describe clients who harm themselves. All participants reported the compassionate response led to a more “out of the box” way of looking for available and alternative resources and contributed to the holding space in therapy. In the same way, they identified a compassionate and open dialogue about self-injury and scars as an important part of their work with the individuals who self-injure.



Figure 10. Photograph 11, “Hope” (Faith).

The art process exemplified the importance of healing words for the clients and the professionals, similar to The Butterfly Project (2011) and Masters (2011). Unicorn, Faith, and I wrote healing words on our chests in response to the second question, purportedly to counter the negative comments and images represented on that part of the body in response to the first question. Faith wrote the words “You’re not alone” (Photographs 11–12). Unicorn wrote, “Kind, funny, loveable, smart, and brave” (Photographs 78–79, 82–83). I wrote, “Love yourself” (Photographs 100, 102, 104–105). Hana used a physical expression and artistic representation; that is, she created an image on her hand and then pressed her hand over her heart to imprint the image (Figure 11). She titled her pieces, “Bring it Closer” (Photograph 53) and “Heart Chakra” (Photograph 54).



Figure 11. Photograph 54, “Heart Chakra” (Hana).

No participants noted whether these messages were just for the clients they worked with or for themselves as well. I believe the need to hear all these messages, as a therapist working with clients who self-injure, and to project these messages to the clients is what was so salient. Furthermore, the importance of self-care and self-compassion provided through the process and the use of the healing words was an essential element in treating and supporting someone who engages in self-injury—specifically to counter the experience of “harm’s touch” (Fish, 2006).

Insights into Those Who Self-Injure

Throughout the exploration of this study, there was an overwhelming sense of the participant’s connection to and understanding of the power of positioning words, scars, and wounds on one’s body. This led the participants to gain new insights about their clients and why they chose self-injury as a resource. The idea of self-injury as a resource

and the impact this resource had on the professionals and people who supported them was prevalent throughout the art.

During the study, body art emerged as a mechanism to assist the participants in understanding the phenomena of self-injury. Faith discussed the impact of creating the artwork on the body. She had never witnessed a client self-injure; she had only seen the scars and wounds after the fact. This process of creating art provided a window into the experience and to the wound or scar represented by the photographs. The characteristics suggested by these observations have been divided into two main categories: ambivalence and overflow of emotion: bad, negative, or unwanted.

Ambivalence. Self-injury produces mixed feelings about both the person who self-injures and the act itself (Walsh, 2012). Ambivalence surfaced in many ways in this study. Several images (e.g., Faith's Photographs 6 and 8; Unicorn's Photographs 72–74; and my Photograph 92) represented how the person who self-injures might fear abandonment, rejection, or people moving on without them (Figure 12). Additionally, we all discussed the inability for our clients to stop the self-injury, which leads to further rejection (Conterio & Lader, 1998). Hana did not have a specific photograph that represented abandonment; she discussed her client's fear of abandonment and fear of not being good enough that led to the self-harm. She further discussed the shame and guilt the client feels after the self-injury occurs.



Figure 12. Photograph 72, “Trauma” (Unicorn).

Additionally, there was strong representation of wanting to be left alone or pushing people away. Hana represented the wounds as a sense of pride and not caring if people did leave (Photograph 44). Faith (Photograph 3) represented herself as a doll to create an image of someone who was living to please someone else, hiding her true self, and, in turn, not getting her basic needs met. In essence, she was pushing her own image or self away to please others. Unicorn (Photographs 62–63, 75) wrote the words “all bad” on her chest to show not only how she felt about herself, but also that her self-injury was a warning to fear her. It was a way to push people away so she did not have to care or get hurt by being “left behind.” Photographs 95–96 and 99 represented the immediate and more expressive ways clients push us away to self-protect and avoid caring about others.

Although Photograph 90 is an example of the refusal to speak and ask for help, the dichotomy of leave-versus-stay was exhibited most specifically in my work, wherein I wrote “stay/run” on different sides of my neck (Photographs 91–93). My client and

Unicorn’s client, in particular, would scream out for us to come help them and then emotionally or physically hurt us and push us away in the same moment (Figure 13).



Figure 13. Photograph 91, “Faceless” (Blue).

This dichotomy was also presented in the photographs of darkness Hope (Photographs 33–34), Hana (Photograph 42), and Unicorn (Photograph 71) chose. There seemed to be a paradox of desiring to be seen or noticed and needing to hide in the shadows or the background. Darkness represented loneliness, being left behind, and a desire to hide. Hope commented, “The image represents keeping people away; it’s like trying to hide in the shadows or like I don’t want to come out of the light” (July 20, 2015 transcript, p. 9, lines 15–19). Unicorn noted that darkness epitomized the belief of being undeserving of love, that no one cared, and then giving up by showing others how bad one can be (Photograph 71). Hope exhibited the experience of wanting to hide or fade away in

Photograph 33, “In the Dark One: In the Shadow, Burning Fire on the Neck,” and Photograph 34, “In the Dark Two: Trying to Hide” (Figure 14). Hope wrote on these photographs, “These represent trying to keep away the feelings and other people hiding in the shadows and the darkness.” However, in direct contradiction, she represented in Photograph 25, “Presenting,” and Photograph 26, “Presenting to Another,” the desire for someone to see the pain and offer help. The wound became a concrete representation of an elusive emotion and intangible pain.

Hana, Faith, and Hope expressed ambivalence about washing off the paint. As part of the research design, they were instructed to wash off the art between questions to allow for a fresh canvas. However, they all had reasons that made it difficult for them or made them want to hold onto the art longer. Hana talked about wanting to walk into the world with her body art and explore how people would respond to her.



Figure 14. Photograph 34, “In the Dark Two: Trying to Hide” (Hope).

Faith said it felt bad to wash off the baby image she drew on her chest (Photographs 1–4, 6, 8). She struggled with feeling that by washing off the paint, she was also abandoning the baby (Figure 15). Hope identified the process as being messy and somewhat of a difficult transition. She described the intensity of looking at herself in a bigger mirror and watching the paint drip down her body. She suggested being able to clean up everything in the room to maintain the safety of the space for the participants and for clients, if using this process with them. Hope indicated the space felt very safe, but leaving broke the safety and left her alone with this overwhelming information. Before her cleanup process, she was offered wipes or the sink and chose the sink. This spoke not only to the ambivalence of enjoying the process, but also struggling with the aftermath. It reflected the difficulty those who self-injure may have when they are not with the people or in places that hold the space and create safety for them. They may want to stop, but when their coping systems are not present, they revert to what works immediately and struggle to trust that they will be okay.

Overflow: Feeling Bad, Negative, or Unwanted. Self-injury was discussed throughout the study as the result of a need to release an overflow of strong emotions (Conterio & Lader, 1998). In particular, feeling bad, negative, or unwanted arose as potential reasons for the behavior. Furthermore, this idea surfaced as outcomes of the aftermath of self-injury. Favazza (2011) underscored the truth of these beliefs: “Put simply, no one loves self-mutilators. Their very presence seems to threaten the sense of mental and physical integrity of those around them” (p. 244). The artwork and discussions

in the present study indicated these feelings can occur for those who self-injure and for those trying to help them.



Figure 15. Photograph 1, “The Babies’ Multigenerational Cry” (Faith).

Several words and images illustrated the clients’ experiences with these emotions and thoughts. Unicorn also related to feeling bad, negative, and unwanted in the representation of “all bad” (Photographs 62–66, 71–73, 75). In my response to the first question, I also wrote on my chest, “all bad” and “ugly” (Photographs 85, 87–93). My

witness, Nicole, chose two photographs with those words on my chest (Photographs 106–107). These images seemed to represent the shame, sadness, and fear our clients feel (Figure 16).



Figure 16. Photograph 106, “The Live Corpse” (Nicole, witness).

In the same way, this overflow of feelings, as represented consistently throughout the first question with the depiction of water, was what led to the lack of available resources. The participants described water in response to the first question as “drowning,” “overflowing,” and “overwhelming.” Faith drew a picture of a baby in water

and stated the baby was drowning and abandoned (Photographs 2–3, 6, 8). Arthur drew a picture of a glass overflowing with water (Photographs 13–17). She said the water represented the overwhelming and overflowing emotions of the clients she works with who self-injure—unable to handle the emotions that build up, they spill out all over the place (Figure 17). For me, tears in my art represented loneliness and sadness at being emotionally overwhelmed (Photographs 85, 88–93, 96, 98–99). My witness Nicole chose one photograph that represented the tears (Photograph 106).



Figure 17. Photograph 17, “The Compassionate Alternative” (Arthur).

A parallel of the clients’ experience with feeling bad, negative, and unwanted occurred throughout the study, as all the participants commented and discussed fearing they would negatively affect the study in some way. There seemed to be a sense of “doing something wrong” or “not being good enough” in the process of the art or in choosing

photographs. Hana expressed concern that she was providing too much work for me and had chosen too many pictures. She needed reassurance and guidance to allow her to tell her story and select the images that best represented her journey. Arthur discussed being worried she would ruin the study because she was not an artist. Hope continuously apologized for wanting to select pictures that were similar and explained each time why it was important, even when I reassured her that it was *her* story to tell in whatever way she wanted. Unicorn apologized for crying during the third meeting and commented that she should not cry. Faith also verbalized that she almost cried in the third meeting, but stopped herself, saying she worried it would be inappropriate. She remarked on the intensity of the study in parallel to the intensity of emotions in working with self-injury.

I remember thinking over and over that I, too, did too much, could have been more creative, chose too many pictures, and could have thought of more poignant titles. It seemed these emotions were intense for those who self-injure, and elicited in mental health providers and caregivers a fear that they were not “good enough.” Favazza (2011) discussed his own struggles with helplessness and hopelessness in relation to the treatment of clients who self-injure and the ongoing necessity to educate himself to gain insight and avoid being emotionally overwhelmed.

Self-Injury Is Expression and Communication

The participants strongly believed their body art and images told a story. They reflected on the importance of having the choice in which pictures were used because, depending on which ones were chosen, they could tell significantly different stories. In addition to the story of the experience and the photographs, the poems allowed a deeper

exploration of the content of the titles, pictures, and experience. They became a guide to the participant's truth.

Hana was verbal throughout the process and used the first meeting to tell a story through her words and artwork. She discussed her client as having a relationship with self-injury; the longer she was in it, the harder it was for her client to leave the relationship. Whereas the beginning of the first meeting was more a story of Hana's client, during her response to the second question, Hana progressed into the story of her own scars and their meanings. In addition, during the second meeting, she focused on the process, emphasizing the story of her experience participating in this study. Hana enjoyed the process of sorting through the pictures and spoke about it as being very personal (Figure 18).



Figure 18. Photograph 43, “Embracing and Nursing” (Hana).

Hope used her photographs as the story. She arranged them based on her story and often chose similar pictures, stating that each one was important to the story's meaning. She also discussed the idea of the deepening layers of self-injury and reflected upon the pictures as scars. The pictures told a story, as did the scars and the act of self-injury. Similarly, the pictures had a different story than did the body art, and the scars had a story different story than the act. Most participants agreed it was an intense experience to participate in and view the artwork and pictures, but their participation deepened their perceived understanding of self-injury and solidified their understanding that cutting is about much more than just the act or behavior.

Truth and the authentic voice. As Hewitt (1997) identified, there is great power and catharsis in using self-injury and body art as a form of communication. By positioning one's pain, anger, sadness, and loss on the body, the individual and others unavoidably observe this communication. In addition, the wounds and marks often create an immediate reaction (Walsh, 2012). These reactions feed the feelings of power and control over oneself and others.

Furthermore, self-injury often becomes part of one's identity (Favazza, 2011). For example, while creating her art, Hana mused over what it would be like to step into the public with all her drawings to see people's reactions. In the same way, she discussed the idea of her client and herself being warriors because of their scars and histories. By creating the art, the participant metaphorically "tried on" the identity of self-injury, and then washed it off, thus experiencing the potential power and influence this behavior can have over an individual.

Although self-injury is an emotional form of communication, excessive attention is often given to the self-injurious act due to overwhelming fear and potential need for medical care (Favazza, 2011). This behavior is upsetting and provocative, but it seems essential to understanding how the behavior fits into the individual's soul and heart (Conterio & Lader, 1998). The importance of seeing beyond the behavior to hear the truth was evident throughout the participants' work and titles, such as "The Babies' Multigenerational Cry," "Hear Me," "Act with Compassion," "The Underlying Feelings," "Warrior" (Figure 19), "Scars Telling Stories," "Revisiting History Through My Scars," and "Reaching Out."



Figure 19. Photograph 44, "Warrior" (Hana).

The individuals in the study began to further understand and explore the use of self-injury as a resource to manage overwhelming feelings and thoughts related to pain,

trauma, loss, and feeling misunderstood. They explored the importance of being heard, believed, validated, and connecting with another person as they shared their story. The alignment of the witness to the individual emerged as an important parallel process because many participants discussed needing a space in which they could have the experience of being heard, believed, validated, and connected with others for their own wellbeing (Fish, 2017).

Nonverbal and verbal communication. Artistic expression, images, nonverbal gestures, body language, words, and their written use emerged as important to the process. No form of communication was more important than another, and each told a different section of a story. All participants and witnesses noted that at times the words felt more removed from the process, while witnessing or completing the artistic acts were visceral (Fish, 2017). Often, words could not fully explain the experience. Every participant partook in some type of mark that was non-word oriented. The artistic expressions in this study were a first and primary mode of communication, while the words were secondary attempts to understand and experience (McNiff, 1998). The words used were powerful and carefully placed to connect the feeling, emotion, and sensation of this primary mode of communication. The artistic expressions led toward development of an authentic voice, whereas the words emerged as equally powerful and important in the construction of a common, reflective language for the experiences (McNiff, 1998).

The experience of wanting to talk but not being able to get the words out arose throughout the artwork and the discussion (Figure 20). I painted an “X” over my mouth during the body art (Photographs 89–90, 92–93, 96, 98–99, 106). The witness Nicole reported that after I painted the “X,” I did not talk for a significant amount of time. She

also stated that, if I needed anything, I would point or motion. I had no memory of this and thought I had been communicating with words. Hope positioned her mouth shut or wide open (represented in Photographs 27–34, 36) during her art process, yet spoke no words while she created her art. She referred to the open mouth as representing a scream or a purging, but only silence filled the air. In addition, she titled Photographs 30–32, “Muffled.” Faith was also more quiet and focused on the process but used music to fill the space. She allowed her art and music to speak for her and tell her story.



Figure 20. Photograph 90, “Silenced: Won’t Talk” (Blue); Photograph 30, “Muffled One: So Good at Keeping it Closed” (Hope).

Self-injury can be a way to seek attention. Therefore, many people including clinicians attribute the behavior to negative attention seeking and thus dismiss it as manipulation (Walsh, 2012). Many participants believed, as did their clients, that self-injury was a form of communication modified to help other people accurately understand

what was happening when the clients do not have the verbal words to communicate. Some self-injury could be just for shock value; it could also be ornamentation, a memorial of different life events, or to show an inner world (Strong, 1998). There are vast arrays of messages being exhibited when someone self-injures, many of which were represented throughout this study. Some participants were proud of their scars, whether self-made or gained through life events. For example, Hana presented her scars as part of her art (Photographs 57–61). Arthur came into the meeting with a current wound (Photograph 24) and discussed her life experience of rock climbing. Her wound and scars were badges of honor from her rock-climbing adventures. This further supported and represented how powerful those memories and those marks can be in someone's life (Figure 21).

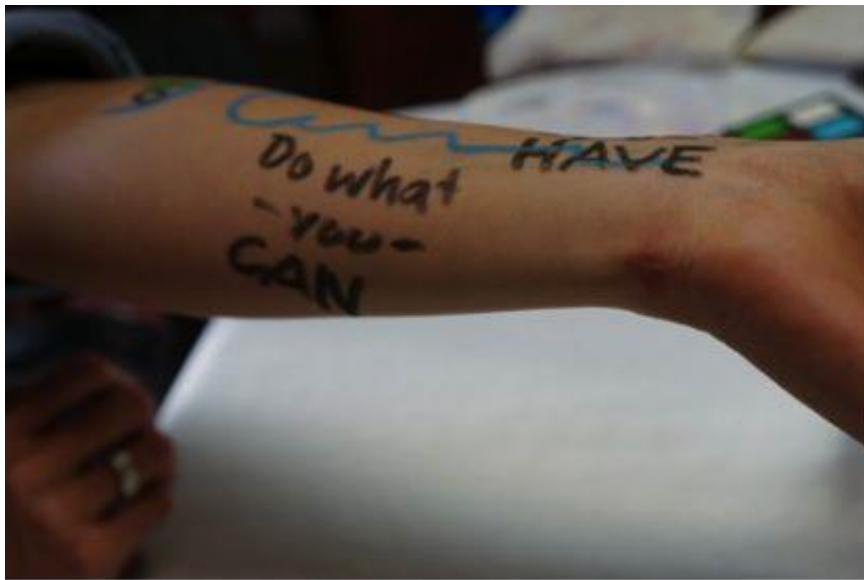


Figure 21. Photograph 24, “Patience” (Arthur).

A Sense of Hope: Influencing Treatment

One constant characteristic was demonstrated throughout the art in response to both questions posed to the participants during the first meeting. This was the importance of the client's sense of hope, which related to the experience of self-injury as a resource to stay alive and feel, as well as the need to have hope as the professional provides treatment and influences healing. This characteristic directly connected to the concept of positive psychology discussed by Wilkinson and Chilton (2018).

The idea of hope emerged in several ways. Faith's work, with the words "You are not alone" (Photographs 11–12) presented a hope for connection (Long et al., 2016); Arthur discussed resources and connecting to what one already has (Photograph 23); Hana represented the importance of connecting to her heart and scars (Photographs 51–61); Unicorn wrote on her forehead, "We won't leave you" (Photographs 80–81); and, as shown in Figure 22, I wrote "Love yourself" on my chest (Photographs 100, 104–105). Faith (Photograph 10) and I wrote, "I hear you" (Photograph 104) to denote a hope that others would listen and understand (Norton, 2011). The hope in trying was represented in both the first and second question by Unicorn's (Photographs 67, 70, 74, 84) and my images (Photographs 85, 87, 96, 99, 102–103) of a heart. In discussing the heart represented in her work, Unicorn mused about the meaning of the tattoo for her client. While her client carved, banged her head, or cut when she was in a dark place, tattooing a heart represented a belief that healing was an option and she was worthy. Her body modification was a positive healing ritual, while head banging, creating carpet burns, and cutting were forms of self-torture.



Figure 22. Photograph 105, “Finding Peace” (Blue).

In contrast to participants using the imagery of water in question one to represent being overwhelmed, in responses to question two they presented water as hope, a resource, letting go, flowing, acceptance, and cooling (Figure 23). In addition, they examined the idea of water or the color blue to cool. For example, Arthur created an image of a wave to symbolize the importance of learning how to ride the wave of overwhelming emotion by using resources (Photographs 21–24). Hope stated, “This picture represents water and tears and letting them flow to cool the heat” (Photograph 38). The idea of letting go and cooling the brow was also represented in Photographs 37 and 39. I created a similar image to Hope’s (Photographs 100, 102–104, 109). It seemed, as Hope stated she needed to cool it down, there was a visceral feeling of cooling while putting the materials on the brow.



Figure 23. Photograph 38, “Owl Eyes: A Stronger Force” (Hope).

Similar to Photographs 102, 104, and 105, the words of many participants in response to the second question countered what they had represented in the first question (Figure 24). For example, Photograph 104 had the words, “I can hear you,” where I had written, “Why didn’t I talk?” I wrote, “Heal,” where “take my arm,” had been inscribed. Over the heart that was originally represented in Photograph 87, I wrote in Photograph 102, “Keep trying.” “Love yourself” was on the chest where “All bad” and “Ugly” had been written. This further supports the importance of hope and the influence of healing words and symbols as an alternative way to communicate, comparable to the works of The Butterfly Project (2011), Freeman (2012), and Masters (2011).



Figure 24. Photograph 12, “Undertaken with Painstaking Excellence” (Faith).

CHAPTER 5

Discussion

This research project is visceral and visually striking. It transforms internal psychological and physical pain and experience into artistic form (Fish, 2006).

Throughout this journey, I attempted to guide the readers through the immersive, profound experiences the participants and I carried from working with self-injuring clients in its authentic narrative, providing a detailed collection of materials without editing any major aspects. The preceding presentation of artwork and Appendix F allow the reader to experience a fuller understanding of challenges in dealing with self-injury and provide some insight into opportunities body art might provide the therapist or clinician by sharing images, stories, and poems in their entirety as they emerged. Throughout the body of the paper, I attempted to distill the main lessons learned from this exploration. This section provides a summary of these discoveries and connects them to the literature review and original research questions:

RQ1. How can art that uses the body as a canvas help communicate the experience of self-injury?

RQ2. To what extent can body art help mental health professionals further understand the phenomenon of self-injury?

RQ3. To what extent might mental health professionals' use of body art influence treatment with their clients who self-injure?

RQ4. How does having a witness during the body-art experience of this study affect the participant?

Summary of Prevailing Characteristics

Holding the Space: Impact of Having a Witness

Holding the space is defined as the moments of compassionate response the witness provided throughout the study. These moments create a connection in which the participant can be seen, heard, and valued without judgment, similar to what Conterio & Lader (1998) recognized as paramount to the treatment of self-injury. This discovery begins to answer RQ4, which discussed the impact of the witness on the study and experience. The witness response is essential in creating a safe holding space to guide the experience and allow a deeper sense of connection and support, similar to Walsh's (2012) findings that identified a neutral but supportive response as vital to creating a safe environment. Having a witness who could hold the space allows the participants to immerse themselves in the art and subject matter while maintaining emotional and physical safety. This directly links to the findings of Wilkinson and Chilton (2018), Fish (2017), Forinash (2016), McNiff (1998), and Moon (1999) regarding creating art with a witness and the use of art-based supervision.

Sensory Empathy: Understanding the Body as a Canvas

Creating art on the body provides the powerful first-person experience McNiff (1998) identified; it exemplifies the meaning of sensory empathy. This discovery answers RQ1, "How can art that uses the body as a canvas help to communicate the experience of self-injury?" Awareness of sensory empathy emerges as participants begin to experience the influence of the body as a canvas. As Jones and Hastings (2003) acknowledged, it demands to connect to the feelings of pain and hurt, as well as to physical sensations of self-injury. The body art, photography, and poetry allow for a deeper investigation that

provides participants insight into individuals who self-injure (Cooper & Milton, 2003) and creates a pseudo self-injury experience for the participants. For the participants, the first question felt raw, as if opening a wound; the second question allowed them to “sew” back up and close the wound. The participants reported a visceral response to the art materials on the flesh. As affirmed by Fish (2017), through these art-based experiences of sensory empathy, combined with the subsequent ability to communicate them with a witness, mental health professionals begin to develop deeper insight into the phenomenon of self-injury and their clients’ motivations.

Compassionate Response

The experiences of sensory empathy, gaining insight, and telling their story guided the participants to understand the importance of a compassionate response, which, as Walsh (2012) identified, is fundamental to treatment. The extent to which mental health professionals’ use of body art affects treatment with their clients is evident in several ways. Through body art, photography, and poems, the participants could connect with a tangible experience that further affected their compassion for themselves, their clients, and the clients’ families. This experience is similar to Neff’s (2003) findings that regarded connection to the greater human experience as necessary to avoid isolation and depression.

The participants noted that they became closer to the clients they were working with through this process. Similarly, Norton (2011) identified acceptance of the client’s suffering and need for self-injury as a resource as vital to treatment. In the current study, the therapeutic relationship became stronger through authentic engagement with the art, which led to first-hand embodiment of the client’s suffering and need for self-injury as a resource. Following the body-art experience, participants expressed a sense of calmness,

an ability to create a stronger therapeutic alliance, and a new sense of curiosity about the body, self-injury, and what it represented for each client, all of which Muehlenkamp (2006) identified as a necessary to treatment.

Insights into Those Who Self-Injure

Participants reported, experienced, and artistically represented several insights into those who self-injured. These insights begin to answer RQ2, “To what extent can body art help mental health professionals further understand the phenomenon of self-injury?” Throughout the study, body-art emerges as a tool that helped the participants further understand the power of communicating with their body, similar to the observations of Hewitt (1997) and Masters (2011). Understanding the client, a strong nonjudgmental relationship, and connection to others arose throughout the study as important, regardless of the mental health professional’s chosen modality or specialization. Although there are numerous insights into the reasons and impact of self-injury, two stand out consistently and support the functions of behavior outlined by Klonsky (2007), Nock (2009), and Walsh (2012)—ambivalence and the overflow of feelings.

Ambivalence. Ambivalence, for the purpose of this study, is defined best by Walsh (2012) as mixed or contradictory feelings about oneself and self-injury. Some examples of ambivalence in this study are the desire to harm oneself versus staying safe, wanting to talk versus not being able to speak, and wanting to be seen or loved versus hiding or pushing people away.

Overflow of feelings: Bad, negative, or unwanted. Overflow emerges as an overarching characteristic in the work. As Favazza (2011) noted, the overflow of feelings often occurs and represents the reason for self-injury and the result of the behavior. The

need to communicate, understand, and explore these feelings are significant factors that lead to self-injury. In addition, as Walsh (2012) and Favazza (2011) recognized through their research, all participants acknowledged experiencing feelings of being “not good enough” after a client self-injures. Thus, this characteristic arises as important in treatment planning, finding appropriate resources, and ensuring self-care for the professional.

Self-Injury Is Expression and Communication

The body art, photography, and poetry related to participant experiences, along with the existing literature in the field, support the hypothesis that self-injury is a powerful form of expression and communication. This finding partially answers RQ2 and RQ3, “To what extent can body art help mental health professionals further understand the phenomenon of self-injury?” and “To what extent might mental health professionals’ use of body art affect treatment of their clients?” As participants began to understand the importance of this communication, they connected to the influence of the behavior and the individual’s need to be heard. Strong (1998) wrote, “Cutting is a primitive yet powerful form of communication . . . a language written on the body, through blood, wounds, and scars” (p. 44). The participants lived the meaning of these words first hand through the art materials. The current results demonstrate the power and command of the expression and communication of cutting, and body art as a surrogate for it. Once the participants understood self-injury’s importance to their clients, the concept of how it relates to these different methods of communication emerged (Favazza, 2011).

Truth and the authentic voice. The participants used many forms of expression (i.e., artistic, written, verbal, body language, music) to share their experiences and those of their clients. An authentic voice through verbal and nonverbal communication sets the

stage for their stories and expressions to emerge. The body art, photography, and poems then become guides to the participant's sense of truth. Through body art, the participants metaphorically experience the potential power and influence this behavior can have and, therefore, begin to have the courage to explore their reactions to the behavior and their self-injuring clients. This expression mirrors the finding of Long et al. (2016), who concluded that trust, seeing beyond the cutting, human contact, and integration were keys to effective treatment.

Nonverbal and verbal communication. The words and images in this study combine to create a stronger depth of knowledge. No form of communication is more important than another, and each form tells a different segment of the story. Integration of all forms of communication is essential to the research, the participants, and their work with clients. The role communication and expression play throughout this study parallel the findings of Bandalli (2011) and Sternudd (2014), who asserted the act of self-injury, the blood, and the wounds are symbolic expressions that tell an important part of the individual's story.

A Sense of Hope: Influencing Treatment

The participants' sensory experiences of being understood and heard for their truth indicates the influence of hope in treatment and further answers RQ3, "To what extent might mental health professionals' use of body art affect treatment with their clients?" A sense of hope is important for the individual who self-injures, the mental health professional, and the family or caregivers in order for healing to occur. This need echoes Walsh's (2012) work, reasoning that the reaction of staff and family is more important than the intervention or treatment modality. In my study, this idea presents itself in the

artwork in numerous ways, such as a hope for connection to self and others, of being wanted and accepted, and of others hearing and listening. A sense of hope seems to relate to the experience of self-injury as a resource to stay alive and to feel, and for the need to have hope as the professional provides treatment and influences healing.

Equally, participants report a sense of hope in reconnecting with their own bodies through this experience. They identify a sense of freedom to use their bodies in a new way (from writing healing words to trying a unique hair color), as well as a healthy reconnection with the meaning of their scars. Furthermore, the idea of a more adaptive way to explore and communicate pain on the body may provide hope to all involved. Pre- and post-study, the use of writing healing words on the body became a resource the participants used in their therapy with their clients and for their own self-care. The use of healing words on the body creates a safe way to be witnessed and to communicate needs rather than pain, similar to the Butterfly Project (2011) and the work of Masters (2011).

Personal Reflections

Reflecting on the overall journey of this research, I am surprised by how immersed I became in the process. I am grateful for the various people who supported me and continued to pull me out of the abyss. Although it is disheartening to realize how many people of all ages struggle with acts and ideation of self-injury, it is affirming to create and view the art and poetry. Although this journey was long and, at times, arduous, each moment, learning lesson, and misstep was integral to the final evolution.

From the pilot study to the dissertation meetings to the countless drafts, immersing myself in the study as a researcher, witness, and participant allowed for a robust depth of knowing (Forinash, 2016). At times, it was overpowering to hold all these roles, which

may explain the increased time spent processing the results and finding the words to describe these experiences.

Full immersion illuminates the intensity of the experience of self-injury, the experience of witnessing, and the experience of being witnessed. As a witness, I focused on holding the space and managing the study. I felt confident and in control. Being witnessed myself created a sense of anxiety. Although I felt contained and supported, the process of having someone there also created a sense of loss of control. I found myself wavering between the world of researcher and participant. The more I paid attention to those feelings, the more insight I gained into the clients and my participants. Through the art, I embodied the experiences and gained knowledge and a sense of knowing that would not be available otherwise. Through poetry, I provided transparency and expressed my sense of the truths addressed throughout the study.

I allowed myself to be in pain, to be vulnerable, to be creative, and to understand from a place of knowing in my body and mind. I could only connect to the participants' authentic voices and intensities by allowing myself to own them and express them through who I am as a creative and passionate human being.

Difficulties, Limitations, and Areas for Growth

Many difficulties and areas of growth presented themselves throughout the study. The art-based style of research allowed engagement of these concerns and delineated areas that should be addressed, if this research is continued. A significant and recurring issue was technology. This barrier occurred in every meeting. At times, the video cameras shut off, interrupting the meetings and creating a potentially inaccurate source of documentation. Review of the video recordings revealed the depths and importance they

could provide; however, as many of the second and third meetings did not record properly, full cataloging of this potential resource was incomplete. Similarly, while the audio tape recorder was accurate most of the time, it did not record during the first 15 minutes of one meeting and, when someone was whispered in the room or when there were loud noises outside the meeting room times, the words were difficult to decipher.

While capturing the experiences, it was difficult to see the photographs on the camera screen. At times, participants wanted to check and make sure they had captured the image correctly. Having a computer available to review photographs in real time may help decrease the number of photographs taken and ensure the participant's experience is properly captured. Finally, having a tripod available for the photography camera would have allowed the participants to take more of their own photos. Another solution to this may be to have two witnesses—one to hold the space and keep time, and the other to observe and work the technology. However, due to the intimate nature of the work, it is likely that two witnesses would overwhelm the participant. This is an area for further exploration.

With regard to the art process and holding space, having the participants go to the bathroom by themselves to wash off the art was brought up as a concern. The participants felt it broke the safety of the space and allowed for potential overstimulation, both because they left the safety of the space and because there was a larger mirror. This may be especially true when reviewing Faith's imagery, which often contained words such as, "Don't leave me" (Photograph 8), "I can hold your pain" (Photograph 10), and "You're not alone" (Photograph 11). Furthermore, the witness was a great support during my

meetings; however, it would be interesting to investigate the difference between a witness with no art background and one with a studio art or art therapy background.

Another limitation was having a vast range of evidence to review—long transcripts, videotape, several photographs per person—and my own difficulty limiting how many they could choose. There was significant discussion back and forth, in all parts of the process, on what to use versus what to leave behind. This preponderance of rich and robust evidence created difficulty in the process of reflecting on the research and drawing conclusions (Forinash, 2016). With so much art, photographs, video, audiotape, transcripts, notes, and memories to organize and explore, it was challenging to narrow down characteristics pertinent to the study. In addition, I had a hard time limiting people to a certain number of photos and found, as the study went on, that I allowed participants to choose more pictures. I originally had a number of 15 to 20 as a guide; nevertheless, I did not require people to limit themselves, if they chose more. Although this did not appear to be an issue for those participating, it potentially affected the process. It is also important to consider other possible implications; for example, whether this aided in creating a holding space or took away by allowing too much freedom when perhaps containment was needed.

Implications for Art Therapy and Self-Injury Treatment

The inability to engage in verbal therapy and disclose experience generates difficulties in treatment, especially related to individuals who self-injure (Hussey et al., 2007). Most clients and families are surrounded by fear and secrecy. Art-based research, art therapy, and other expressive modalities offer not only alternatives, but also a catalyst to spoken language. In the same way, the use of body art can visually, physically, and

metaphorically offer access to this often-secret world that neither the clinician nor the client initially understands (McNiff, 2011). The use of the body to create art is an active tactile process (Cohen & Mills, 1999), and review of the photography allows a safe and necessary distance from the lived experience of self-injury (Pink, 2013), together with a tangible affirmation of how it can be positively transformed into artistic expression. Similar to the findings of Long et al. (2016), the use of body art in this study allowed the therapists to gain trust in themselves and their clients, see beyond the self-injury and scars, increase their ability to connect with their clients, and integrate the reason and importance of their clients' self-injury.

This is a potentially powerful activity for therapists and family members who struggle to gain control, overwhelmed with emotions and the need to be heard. Exploring self-injury on the body may allow them to express themselves and gain further insight into their loved one's behavior. As attunement of the witness to the participants became a crucial part of creating the holding space, attunement of the therapist or family to their own emotions and feelings about self-injury and their connection to the individual are equally important to creating a healing environment (Muehlenkamp, 2006). This process can be a powerful experience for therapist and family to explore those feelings and gain the compassion and personal support they need to maintain the healing environment. It is important to note that much support and screening is necessary because the body art could trigger or induce a trigger to self-injury or be overwhelming for people.

Limited peer-reviewed studies directly implied the effectiveness of any particular model of treatment for self-injury over another (Nock, 2012). That literature and this study suggest such a relationship and understand the individual function of behavior is critical to

effective treatment. Similarly, there is a substantial need for mental health professionals who work with self-injury to receive special training and supervision (Brown & Kimball, 2013). This study suggests that art-based supervision, namely body art, is an effective resource in the supervision and treatment of self-injury. Faith wrote in an email, “Their resilience to survive the horrors and injustices of this world continue to shock me and remind me daily that hope, however small, is powerful” (January 16, 2016). Evidenced by this rich art work, poems, and participant insights, this study suggests more research should be conducted on the use of body-art for self-injury treatment and as a resource in supervision for mental health providers to explore their feelings about self-injury and their clients. Additionally, it supports the work of Freeman (2012), the Butterfly Project (2011), Masters (2011), and Project Semicolon (Shields, n.d.) as resources of understanding and instruments of healing.

Conclusion

long, arduous, powerful
the journey has just begun
uncovering pain and exposing truth
inscribed compassionately on the skin
a powerful experience of hope
seen, heard, felt³

3. Poem written on January 20, 2017 by Dana Wyss to reflect upon the dissertation process as a whole.

Self-injury is a palpable manifestation of pain, sorrow, and experience. All participants mirrored this as they told their story verbally during their meetings, represented the experience in their art, organized the pictures and titles, and discussed the importance of self-injury related to their clients. The participants were able to explore their fear, frustration, hopelessness, anger, and hope regarding this behavior.

The use of body art, photography, and poems in this study allowed development of compassion of self and client through replication of the client's imagery, self-injury, and scars (Fish, 2017); clarified feelings about the client's experiences and self-injury (Favazza, 2011); and provided a safe place to explore relationships between the study participants and their respective clients (Kozlowska & Hanney, 2001). Similarly, the experiences in this study were reportedly meaningful and in-depth. They relate a great deal to what Moon (1999) described as "the starting place for imaginative interpretive dialogue" (p. 79).

Although many professionals have been exposed to self-injury over the last two to three decades, the violent, challenging, and demanding nature of this behavior continues to present difficulties for service providers to manage (Walsh, 2012). Muehlenkamp (2006) noted the importance of creative and innovative treatments in response to increasing reports of self-injury and clients seeking treatment. By increasing compassion, understanding, and a safe space to explore this topic, the hope is that mental health professionals will feel more comfortable exploring this topic to support their own processes, as well as provide therapy that is more effective for their clients.

It emerged throughout the course of the literature review, pilot study, and dissertation that people approach this behavior from vastly different perspectives. How

mental health providers view the behavior is crucial to increasing compassion and understanding in the larger sense (Nock, 2012). Additionally, I discovered that the journey for someone who works with self-injury is as important as the individual who self-injures. This behavior has a powerful impact on those who love and support the individual who uses self-injury (Conterio & Lader, 1998). To help the healing process, it is essential to understand why people put themselves through so much pain and suffering to be heard, connect to others, or cope. It is equally important for the mental health professionals and families to have a space to explore their feelings and experiences (Fish, 2017).

The participants in this study brought the experiences of self-injury and their therapeutic work to life through body art, photography, and poems. These discoveries demonstrate the potentially important changes that personal experiences in body art can produce in the clinician, in understanding both the pathogenesis of self-injury and potential methods to more effectively ameliorate such activities and their consequences for the self-injuring individual and their family and friends.

APPENDIX A:
LESLEY UNIVERSITY IRB APPROVAL

APPENDIX B:
INFORMED CONSENT FORM



29 Everett Street
Cambridge, MA 02138
Phone: +1.617.868.9600

Informed Consent Form:

**Exploring self-injury: An art-based approach to cultivating empathy and
understanding in mental health professionals**

Principal Investigator: Shaun McNiff Professor of the PhD program in Expressive Therapies, Lesley University; Dana Wyss, co-researcher.

You are being asked to volunteer in this study to assist in my PhD dissertation research on the exploration of self-injurious behaviors through body art. The purpose of this research is to develop a richer understanding of self-harm behaviors and provide a space that allows for the mental health professionals to explore their empathy and personal feelings about this topic in an experiential way. This will also lead to increased and more appropriate treatment for the individual and the family. Another goal is to further understand these harmful and dangerous behaviors to increase proper assessment, reaction from service providers, and treatment.

Conditions of participation:

I will participate in two 1:1 meetings and one follow up meeting. We will utilize body paint, body crayons, and theater makeup to paint/draw on their bodies (arms, legs, neck, face). I will instruct the researcher how to photograph body art to provide a record of the work.

I will be personally interacting with the principal researcher and co-researchers.

This research project is anticipated to be finished by approximately January 2015.

I, _____, consent to participation in this study.

I understand that:

I am volunteering to participate in two 1:1 meetings about one hour in length, and one follow up interview

Sessions will be recording, videotaped and transcribed.

Photographs will be taken of the body art.

My identity will be protected, unless anonymity is waived.

Information will be kept confidential and used anonymously only for purposes of the doctoral research and its inclusion in the dissertation and academic/professional presentation. Study information will be kept in a password locked computer. The information will not be used in any future study or publication without my written consent. The meetings will include verbal discussion about my experience with the body art and my reflection on clients who engage in self-injurious behaviors.

The meetings may bring up feelings, thoughts, memories, and physical sensations. Therefore, possible emotional reactions are to be expected, however, I am free to end the meeting at any time. If I find that I experience severe distress, I will be provided with resources and referrals to assist me, and will not lose any benefits that I might otherwise gain by staying in the study.

This study will not necessarily provide any benefits to me. However, I may experience increased self-knowledge and other personal insights that will be useful in my career and daily life. The results of the study may also help to increase public and

professional awareness of the needs and experiences of patients and clients engaged in self-injury and art therapy.

Participation in this research poses minimal risk to the participants. The probability and magnitude of harm or discomfort anticipated in the research are no greater in and of themselves than those ordinarily encountered in daily life.

The researchers are ethically bound to report, to the appropriate party, any criminal intent, or potential harm to self.

I may choose to withdraw from the study at any time with no negative consequences.

You will be given a copy of this consent form to keep.

a) Investigator's Signature:

Date

Investigator's Signature

Print Name

b) Signature of Parent/Guardian:

I am 18 years of age or older. The nature and purpose of this research has been satisfactorily explained to me and I agree to participant in the study as described above. I understand that I am free to withdraw from this study at any time if I so choose, and the investigator will gladly answer any questions that arise during the course of the research.

Date

Participants' Signature

Print Name

There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Dean of Faculty or the Committee at Lesley University, 29 Everett Street, Cambridge Massachusetts, 02138, telephone: (617) 349-8517.

APPENDIX C:
CONSENT TO USE AND/OR DISPLAY ART



29 Everett Street
Cambridge, MA 02138
Phone: +1.617.868.9600

Consent to Use and/or Display Art

CONSENT BETWEEN: Dana Wyss LMFT, ATR and _____ -

Expressive Arts Therapy Doctoral Student
Artist/Participant's Name

I, _____, agree to allow Dana Wyss, LMFT, ATR.

Artist/participant's name
Student

Expressive Arts Therapy Doctoral

to use and/or display and/or photograph my artwork, for the following purpose(s):
Reproduction and/or inclusion within the research currently being completed by the expressive arts therapy doctoral student.

Reproduction and/or presentation at a professional conference, workshops, or gallery exhibitions to raise awareness of the topic.

Reproduction, presentation, and/or inclusion within academic assignments including but not limited to a doctoral work, currently being completed by the expressive arts therapy doctoral student.

It is my understanding that neither my name, nor any identifying information will be revealed in any presentation or display of my artwork, unless waived below.

☐ I DO ☐ I DO NOT wish to remain anonymous.

This consent to use or display my artwork may be revoked by me at any time. I also understand I'll receive a copy of this consent form for my personal records.

Signed _____ Date _____

I, Dana Wyss LMFT, ATR, agree to the following conditions in connection with the use of artwork:

Expressive Arts Therapy Doctoral Student

I agree to keep your artwork safe, whether an original or reproduction, to the best of my ability and to notify you immediately of any loss or damage while your art is in my possession. I agree to return your artwork immediately if you decide to withdraw your consent at any time. I agree to safeguard your confidentiality.

Signed _____ Date _____

Expressive Arts Therapy Doctoral Student

APPENDIX D:
RECRUITMENT LETTER TO PARTICIPANTS

Exploring self-injury: An art-based approach to cultivating empathy and
understanding in mental health professionals

Dear ____,

My name is Dana Wyss. I am a doctoral student in the Expressive Therapies Department at Lesley University. I am conducting a research study as part of the requirements of my degree, and I would like to invite you to participate.

The purpose of this research is to develop a richer understanding of self-harm behaviors and provide a space that allows mental health professionals to explore their empathy and personal feelings about this topic in an experiential way. If you decide to participate, you will be asked to commit to attend two face-to-face meetings and one follow up interview either in person or via Skype.

In particular, you will be asked to create body art (using theater and Halloween makeup) on your arms, hands, neck, or face to help explore your thoughts and feelings about self-injury. The meetings will take place at a private practice office in Torrance, California, and should last about 60-90 minutes. The meetings will be audio and video taped so that I can accurately reflect on what is discussed. The tapes will only be reviewed by members of the research team who will transcribe and analyze them. They will then be destroyed.

Participation is confidential. Study information will be kept in a password locked computer. Your identity will not be revealed unless you have waived your right to maintain anonymity. So, please do not write your name or other identifying information on any of the study materials if you would like to remain anonymous.

I am requesting volunteers and you will not receive reimburse for your time or for the artwork created as part of the study.

Taking part in the study is your decision. You may also end your involvement in the study at any time or decide not to answer any question you are not comfortable answering.

I will be happy to answer any questions you have about the study. You may contact me at 213-841-0799 and danablue1@gmail.com or my faculty advisor, Shaun McNiff, smcniff@lesley.edu if you have study related questions or problems. If you have any questions about your rights as a research participant, you may contact the Office of the Provost at the Lesley University at (617) 349-8517.

Thank you for your consideration. If you would like to participate, please respond back to this email answering the following questions.

--What are your professional experiences with self-injury? Body art?

--Are you willing to create your own body art (using Halloween make-up and theater makeup) and have that art photographed?

--How long have you worked with clients who self-injure?

--What do you hope to gain from this experience?

You may also email to discuss any other questions or concerns about participating.

I will call or email you within the next week to see whether you are willing to participate and finalize details.

With kind regards,

(Signature)

Dana Wyss

dwyss@lesley.edu

213-841-0799

APPENDIX E:
RECOMMENDED RESOURCES

Recommended Resources

Exploring self-injury: An art-based approach to cultivating empathy and understanding in mental health professionals

These meetings may bring up feelings, thoughts, memories, and physical sensations. Both the content of this study and the use of the body can be triggering. It is important to have a plan if you become activated or overwhelmed by the artwork or the process. Below are suggested reading, hotlines, and websites that may help you. Please have a plan for yourself or friends, colleagues or your own therapist to speak with in the case that you are triggered by the material and feelings resulting from this study.

Books for Professionals

Treating self-injury (second edition): A practical guide (Walsh, 2012)

Nonsuicidal self-injury: Advances in psychotherapy, evidence-based practice (Klonsky et al., 2011)

Self-injury in youth: The essential guide to assessment and intervention (Nixon & Heath, 2009)

Understanding nonsuicidal self-injury: Origins, assessment, and treatment (Nock, 2009)

Identifying, assessing, and treating self-injury at school (Miller & Brock, 2010)

Books for Parents/Youth

Bodily harm: The breakthrough healing program for self-injurers (Conterio & Lader, 1998)*

Freedom from self-harm: Overcoming self-injury with skills from DBT and other treatments (Gratz & Chapman, 2009)*

Helping teens who cut: Understanding and ending self-injury (Hollander, 2008)

Skin game: A memoir (Kettlewell, 1999)

Cutting: Understanding and overcoming self-mutilation (Levenkron, 1998)

A bright red scream: Self-mutilation and the language of pain (Strong, 1998)*

The scarred soul: Understanding & ending self-inflicted violence (Alderman, 1997)

Inside a cutter's mind: Understanding and helping those who self-injure (Clark & Henslin, 2007)

*Excellent resource for professionals as well

***The full bibliographies for the dissertation and/or the pilot study are available upon request.

Websites

<http://sioutreach.org/>

<http://www.selfinjury.com/>

<http://www.recoveryourlife.com/>

<http://www.selfharmony.co.uk>

<http://www.twloha.com>

<http://butterfly-project.tumblr.com/>

24-hr National Crisis Lines

800-273-TALK (1-800-8255) www.nmha.org

800-SUICIDE (1-800-784-2433)

800-799-SAFE (1-800-799-7233) Domestic Violence Hotline

866-4-U-Trevor - for LGBTQ youth (www.thetrevorproject.org)

800-799-4889 Deaf Hotline

714-639-4673 New Hope Line 24 hrs, 7 days/week

877- 727-4747 (877-7CRISIS)- Suicide Hotline Only - DIDI Hirsh

310-390-6612 Service / Intake and Administration: DIDI Hirsh

APPENDIX F:
PRESENTATION OF ARTWORK AND POEMS

Process of Discovering: Presentation of Artwork and Poems

The Offering

The inquiry begins
 brave souls heed the call
 empty canvases of pristine skin
 ripe for exploration into this secret world
 to embody the depths of hearts transformed
 led deep into the underground
 with paint and flesh as guide
 to honor truth⁴

The artwork and poems are presented in order of participation and in order of completion during the individual meetings. This ordering allows the reader to join as a witness and honors the story of the participants' and witnesses' experiences. The depths of our experience cannot be fully captured through verbal expression (Forinash, 2016); therefore, in this section, I invite you to explore personally the world the participants and witnesses created through experience, poetry, art, and words.

Participants

The artworks are presented in the order participants completed them during the meetings. Attention is given to what the participants said about their specializations, work

⁴ Poem written by Dana Wyss on April 23, 2016, to honor the participants.

experience, and connection with self-injury. After a brief introduction of the participant, the photographs are presented with specific remarks or quotes about the photograph or experience of creating the artwork. The photographs are organized in the order they were completed during the meeting and by response to Question 1, “What do you think your clients or those who self-injure are communicating or expressing through this behavior?” and Question 2, “What do you wish you could tell your clients or yourself before, during, or after a self-injury incident?” At the end, the poetic reflection created for the participant using their words, titles, and images is presented.

Faith

Faith was a Japanese-Norwegian clinical art therapist. Faith was Christian. Her specializations included clinical art therapy, CBT, and aggression replacement training with at-risk youth ages seven to 19 years. She had worked in the residential milieu as an adjunct art therapist with adolescent males on probation and in rehab with adults coping with chronic mental illness, and was currently in outpatient community mental-behavioral health with youth and their families. Most of her clients came bearing pain from trauma, abuse, and domestic violence, often carried from one generation to the next. Faith brought her own drawing to the meeting, to create on her body. She was the only participant to use music during the art-making process. Regarding the choice of Faith for her name identification in the study, she stated, “If it wasn’t for faith, I would not be alive.”

Response to Question 1. “What do you think your clients or those who self-injure are communicating or expressing through this behavior?”

At the onset of the review of photographs during the second meeting, Faith commented, “I have been thinking about this since I did it, anticipating how the pictures will look” (June 20, 2015).



Photograph 1. The Babies’ Multigenerational Cry. Faith.

At the first meeting, Faith was prepared with both a drawing she had created at home and a music playlist she asked to use during the meeting. The playlist was a collection of songs her clients listened to during sessions and she listened to for self-care.

Faith commented that when she was drawing the picture, she started at the heart, the core from which all the injury stemmed. This picture represented the strong fear of abandonment she felt in her life and saw in her clients. Although several photographs were taken using black-and-white as well as color, Photograph 1 was the only black-and-white photo she selected.

When Faith drew the flames shown in Photograph 2 and the barbed wire shown in Photograph 3 (the black on her neck around the top of the flames), she reported feeling as though she were choking and feeling tightness around her throat.



Photograph 2. Choked. Faith.



Photograph 3. Downcast eyes. Faith.

Specifically related to the writing on the forehead (Photograph 4), I remember Faith experiencing a strong sense of competency for being able to write and spell correctly backwards.

When reviewing photographs similar to Photograph 5, Faith commented on the realism of the experience and the pictures. She said she was grateful it was just a body crayon and paintbrush, which speaks to the intensity of the experience and witnessing of the pictures. It was so intense that she had to remind herself it was only a benign object and could not hurt anyone.



Photograph 4. On the Forefront of Their Minds. Faith.



Photograph 5. Blue. Faith.

Faith shot Photographs 6–8. She was interested in exploring the photography for herself as a means to capture her experience. Although she did not comment on the impact of this specifically, she chose these pictures as her story.



Photograph 6. Hear Me. Faith.



Photograph 7. Backwards Love. Faith



Photograph 8. Don't Leave. Faith.

It was very important to Faith to have pictures of the reflections in the mirror (Photograph 9). She felt the mirror was a powerful symbol to illustrate and communicate the first person point of view of experience she and her clients share and that onlookers and others in the outside world cannot see; hence, the need for them to offer the reflection they saw on their bodies.

Response to Question 2. “What do you wish you could tell your clients or yourself before, during, or after a self-injury incident?”

As opposed to her responses to first question, Faith’s choice in songs reminded her of her clients, her own faith, and self-care in the second question. She chose to work in silence during the second question. In addition, the anxiety she reported while responding to the first question was not present in her face, words, or need for music during her response to the second question (Photographs 10–11).



Photograph 9. Silent Tear. Faith

On the wall in the background (Photograph 12) was a Martin Luther King quotation: “All labor that uplifts humanity has dignity and importance and should be undertaken with painstaking excellence.” Faith and I found that quotation ironically appropriate for the work we were exploring and the need for compassion and a new form of excellence to help the individuals represented through her artwork.



Photograph 10. New Skin. Faith.



Photograph 11. Hope. Faith.



Photograph 12. Undertaken with Painstaking Excellence. Faith.

Poetic Response to Faith

Faith

The intensity of a backwards love
sends a silent tear from downcast eyes
as the flames tightened around the neck
choking the babies multigenerational cry

HEAR ME,

LOVE ME,

DON'T LEAVE ME lost in blue
the pride, perfectionism, and narcissism
written on the forefront of their minds

New skin emerges for the most vulnerable

gaining patience for the unknown
 a chance for hope
 a chance to fight
 a chance for love
 undertaken with painstaking excellence

Arthur

Arthur was a Japanese American female. She was a clinical social worker currently working in a county outpatient mental health clinic with adults diagnosed with severe and persistent mental illness. Her specialties included DBT and crisis intervention, motivational interviewing, and case management. She worked with several clients who participated in passive self-injury related to drug use and refusal of medications and support. At the onset of the study, she reported not having a client with body-based self-injury. By the second meeting, she was treating one client actively participating in body-based self-harm. She chose the name Arthur due to her connection with an Arthur Ashe quote represented in her artwork, “Start where you are, use what you have, do what you can.” She described this quotation as her own serenity prayer and place of connection with her clients.

Response to Question 1. “What do you think your clients or those who self-injure are communicating or expressing through this behavior?”

Arthur stated at the onset, “My lack of artistic ability is not going to damage your study, right?” She commented several times that she was not an artist and was concerned about the effect of this on the study. I reassured her each time that all expression was

integral to the study, and the focus was on her own personal experience. Despite her original trepidation, Arthur was insightful and expressive throughout the process. Upon reflection and review of the photographs, Arthur wrote several statements on the photographs, along with the title. She wrote, “The trigger sets off the escalation towards an act of self harm” (Photograph 13).



Photograph 13. The Escalation Begins. Arthur.

Arthur wrote, “The crisis or act of self-harm often brings other people in. I try to be the person slightly distanced, keeping an outside perspective but maintaining compassion” (Photograph 14).



Photograph 14. The Overflow. Arthur.

Arthur (Photographs 15–18) also wrote:

It is important for the professional to model a compassionate response in order for the person to start to have hope, faith, and resilience and to instill these into themselves. Through exploration of resources, finding what works, searching for a compassionate alternative to the self-injury, and for both the mental health provider and the person to allow the wave to ride its course and try not to fight it.



Photograph 15. Helping the Person Find What Works. Arthur.



Photograph 16. Focused on the Individual Interventions. Arthur.



Photograph 17. The Compassionate Alternative. Arthur.



Photograph 18. Act with Compassion. Arthur.

Arthur wrote, "Each experience someone has will be triggered by an individual and unique feeling, thought, or perspective" (Photograph 19).



Photograph 19. The Underlying Feelings. Arthur.

Arthur wrote, “The individual may not be entirely aware of the internal experience. Patience is the key” (Photograph 20).



Photograph 20. The Unknown. Arthur.

Response to Question 2. “What do you wish you could tell your clients or yourself before, during, or after a self-injury incident?”

Arthur wrote, “A lot of my work is about helping people learn how to cope with feeling overwhelmed. To go with it and not to fight it. It is like surfing. You have to learn to ride the wave” (Photograph 21).



Photograph 21. The Wave. Arthur.

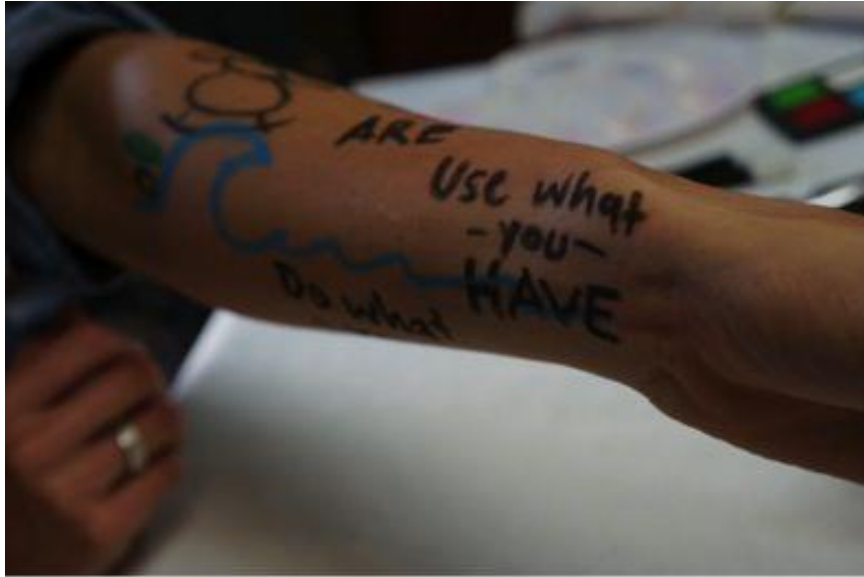
“For myself and my clients, I use this quote from Arthur Ashe: ‘Start where you are, use what you have, and do what you can.’ I help them to pay attention and validate thoughts and feelings in the moment” (Arthur, Photograph 22).



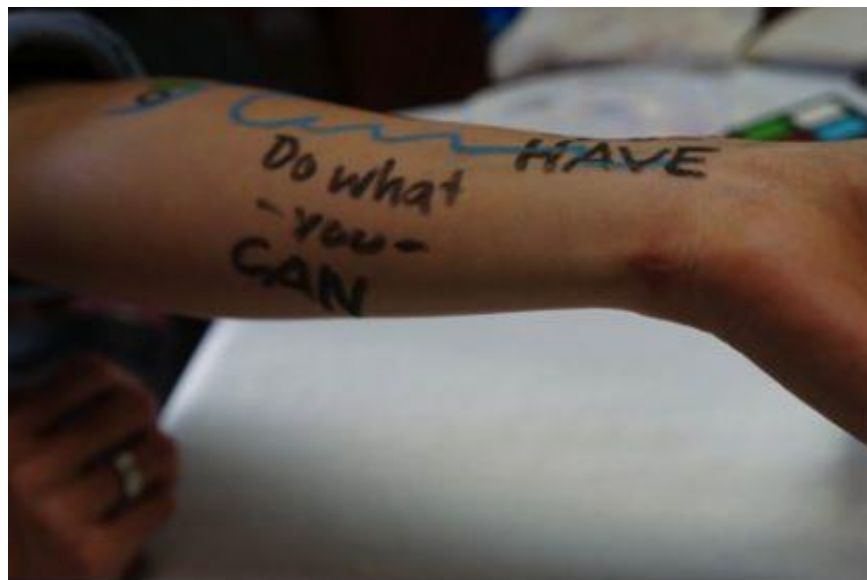
Photograph 22. My Serenity Prayer. Arthur.

Arthur wrote, “Focus on all available resources” (Photograph 23). She discussed that she strove to be like the lifeboat helping her clients to their resources. While the helicopter represents the hospital, the surfboard represents the individual being able to use their coping skills to get through the crisis. She wrote (Photograph 24):

Be okay with the possibility of an unresolved issue or problem. Be okay with the self-harm or destructive behavior continuing. We can only do what we can and if we take too much of the problem, we lose our ability to help the person who is suffering.



Photograph 23. Arthur Ashe is the Man. Arthur.



Photograph 24. Patience. Arthur.

Poetic Response to Arthur

Ride the wave with Arthur Ashe

The escalation begins

an overflow of crisis and emotion
overwhelming the delicate system
How can I help without getting
swept away
swallowed by the underlying feelings
fear
anger
pain
depression
rage
Explore the resources
find what works
search for a compassionate alternative
Don't fight the wave
hold on tight
have patience
slow down
remember the serenity prayer
and ride the wave to peace

Hope

Hope was an art therapist and MFT intern in Los Angeles. She was a 33-year-old female of European and Hawaiian descent. She had been working with children in a

special education school for two years. Throughout the study, she did not reference any clients specifically. She did express that she had experience with self-injury behavior and a current client who engaged in the behavior at the onset of the study. She chose the name Hope to represent the opportunity and ability to look for a positive outlet, solution, or connection. Hope stated of her experience, “I am so glad there were two directives, because if it were just the first one, I think I would have left in a puddle. It was helpful to reflect on both” (July 19, 2015).

Response to Question 1. “What do you think your clients or those who self-injure are communicating or expressing through this behavior?”

Hope’s work was more abstract, and she did not use words on her body. Similar to Arthur when reviewing the photographs, she wrote on them; however, in her body art, she refrained from the use of words. The words she wrote when reviewing the photographs are in quotations along with her photographs.

Hope wrote, “Hand on hand, inflicting pain” (Photograph 25), and “Showing the wound is like an offering, asking for help. The wound becomes something concrete to show that represents an elusive and non-concrete pain” (Photograph 26).



Photograph 25. Presenting. Hope.



Photograph 26. Presenting to Another. Hope.

Hope wrote, “Trying to find the words” (Photograph 27). She described that while “Vomit One” (Photograph 28) represents helplessness, “Vomit Two” (Photograph 29) represents the helplessness of disgust and trying to get the “ick” out. Hope felt very

strongly that these two pictures where important to the story she was telling through her work and she needed to have both to complete the story.



Photograph 27. Open Mouth. Hope.



Photograph 28. Vomit One. Hope.

Hope commented several times throughout the review of pictures that she saw a story in the photographs. She had a very clear vision throughout the process. Even though Hope chose pictures that were very similar (Photographs 30–32), she felt they were all integral, each sharing another piece of her story.



Photograph 29. Vomit Two. Hope



Photograph 30. Muffled One: So Good at Keeping It Closed. Hope.



Photograph 31. Muffled Two: Leaking Out. Hope.



Photograph 32. Muffled Three: Leaking Out What Have I Done. Hope.

Hope wrote, “These represent trying to keep away the feelings and other people. Hiding in the shadows and the darkness” (Photographs 33–34).



Photograph 33. In the Dark One: In the Shadow, Burning Fire on the Neck. Hope.



Photograph 34. In the Dark Two: Trying to Hide. Hope.

“These photographs represent the clinical cold feel the client may experience as the therapist assesses and catalogues the client’s injuries” (Hope, Photographs 35–36).



Photograph 35. Clinical Shot One: Documentation and Assessment of the Damage. Hope.



Photograph 36. Clinical Shot Two: Documentation, Assessment of the Damage. Hope.

Response to Question 2. “What do you wish you could tell your clients or yourself before, during, or after a self-injury incident?”

Hope wrote, “Unfurrow the Brow. This picture reminds me of a wise owl”
(Photograph 37).



Photograph 37. Owl Eyes: Cooling the Heat. Hope.

“This picture represents water and tears. Letting them flow to cool the heat”
(Hope, Photograph 38).



Photograph 38. Owl Eyes: A Stronger Force. Hope.

“This picture is a representation and a reminder to ‘let it go.’ To let go of the pain, the sadness, the need to fix things, etcetera.” (Hope, Photograph 39).



Photograph 39. Owl Eyes: Can Hold. Hope.

Poetic Response to Hope

Hope

In the dark

in the shadows

burning fire on the neck

trying to hide

STAY AWAY

Open mouth

trying to find the words
muffled
so good at keeping it closed
but it leaks out anyway

What have I done
helpless
disgusted
purged
must get the ick out

Presenting
hand on hand
inflicting pain
showing the wound
a concrete representation
years of aching silence

Assess the damage
document
your clinical cold feel
removed
disinterested

scientific

But the wise owl eye

cools the heat

letting the pain go

water flowing

unfurrow your brow

a stronger force

can hold the pain

Hana

Hana was a California-based marriage and family therapist in private practice. For the previous 15 years, she had specialized in trauma resolution through clinical art therapy and EMDR with adults and children. She identified herself as a one-and-a-half-generation Asian American. She focused her exploration throughout the study on one adult client who actively engaged in cutting behaviors. She chose the name Hana, which means flower in Japanese, to represent growth, blossoming, and hope.

Response to Question 1. “What do you think your clients or those who self-injure are communicating or expressing through this behavior?”

Although Hana was verbal and descriptive throughout the process, she chose not to use words in her artwork. Referring to Photograph 40, Hana explained: “She [referring to her client] cuts her tights a lot. The marks don’t bother her actually, you know? It’s like a

badge of honor in a way because she is able to hurt herself and be able to withstand the pain” (July 19, 2015).



Photograph 40. Initiating. Hana.

During the process of creating and exploring the representation of the cuts on the thighs (Photographs 41–42), I inquired, “If her scars could speak, what would they be saying?” Hana responded, “That I’m hurt” (July 19, 2015).



Photograph 41. Smearing. Hana.

Hana was intrigued with the thought of wearing her “wounds” or “art work” all day to see how people responded to her or how it changed the way she felt. Photograph 43 also represents the idea of embracing the scars in order to become whole.



Photograph 42. Sitting with Guilt. Hana



Photograph 43. Embracing and Nursing. Hana.

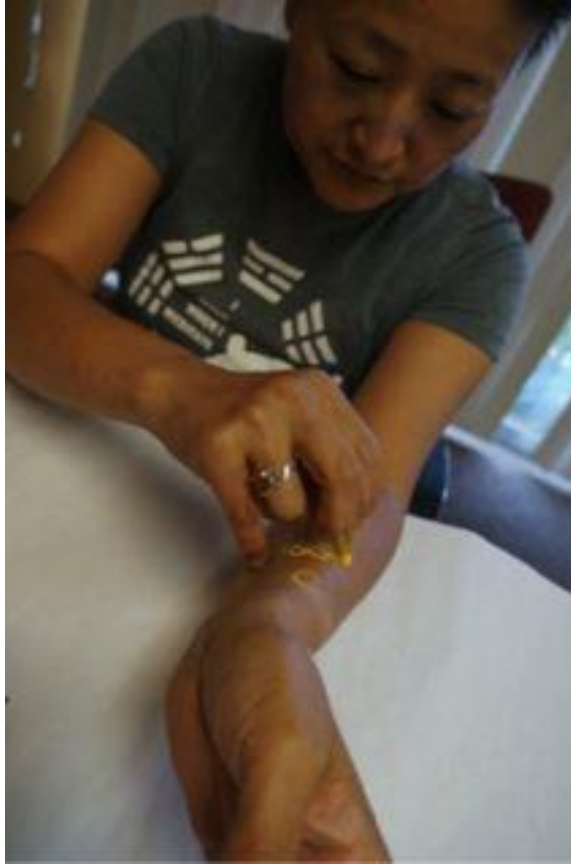
Hana discussed that through their therapy, her client has been able to move from the place of a warrior (Photograph 44) who wants to feel the pain to a wounded warrior who can exist without currently feeling pain. She talked about the importance of psychoeducation with other professionals to help them understand that cutting is a coping mechanism and does not mean a person is suicidal. Hana also addressed the importance of seeing the metaphor or message the person is trying to send. As a clinical supervisor, she encouraged her staff to explore the message with their clients (Photographs 44–47).



Photograph 44. Warrior. Hana



Photograph 45. Chain of Thoughts. Hana.



Photograph 46. Happy Thoughts. Hana.



Photograph 47. Mighty Hand. Hana.

Response to Question 2. “What do you wish you could tell your clients or yourself before, during, or after a self-injury incident?”

Hana wrote, “The blue is about nursing the wounds, peace, and calming everything down” (Photographs 48–54).



Photograph 48. Calming it Down. Hana.

In Photographs 49–54, Hana recreated a session wherein she felt there was a breakthrough with her client. She was able to collaborate with her client in a moment of acceptance of being a good person. They did this by discussing and exploring the idea of the heart chakra. The client was able to accept the heart and kindness that may exist within her. That she may not be “all bad.”



Photograph 49. Send Loving Energy. Hana.



Photograph 50. Noticing. Hana.



Photograph 51. What Do I Do? Hana.



Photograph 52. Magic. Hana.



Photograph 53. Bring it Closer. Hana.



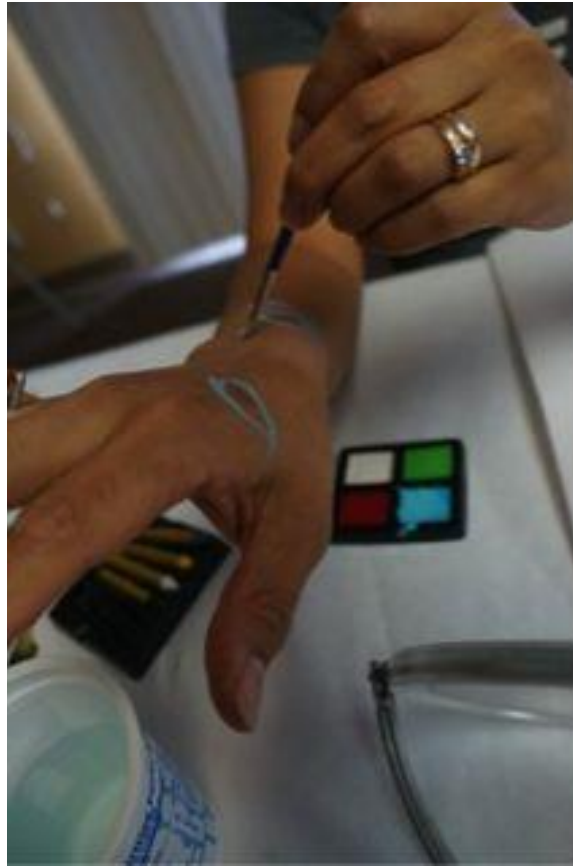
Photograph 54. Heart Chakra. Hana.

Hana wanted to have Photograph 55 in the study, even though the image is hard to see and appears almost blank. It represents that the resources and love needed to heal often feel far away, and you have to look closely to see that they are always with you.



Photograph 55. Presence. Hana.

Hana discussed the importance of scars in her own life and in the life of her clients. She believed scars tell stories, remind us of our mistakes, and remind us that we are alive. She spent the last portion of the meeting circling her own scars and telling the stories of their formation (Photographs 56–58).



Photograph 56. Being with my Scars. Hana.



Photograph 57. Scars Telling Stories I. Hana.



Photograph 58. Scars Telling Stories II. Hana.

Hana explored her own scars with art during the process and came to insights about how her scars told stories and were markers of important memories in her life. In particular, she told the story about a scar on her leg (Photograph 59) and how it represented a friend who had since passed away. This was a permanent badge of honor for her, of not only the experience that led to the scar, but also being able to survive the loss of a loved one. This seemed to lead her into an “ah ha” moment about the importance of the story itself.



Photograph 59. Scars Telling Stories III. Hana.

Hana discussed the importance of noticing, embracing, and honoring all her scars. She felt that represented the pain, joy, and experiences of truly living, whether self-created or created by life experiences (Photograph 60).



Photograph 60. Scars Telling Stories IV. Hana.



Photograph 61. Revisiting History Through my Scars. Hana.

Poetic Response to Hana

The Warrior

Initiated

scratched

cut

sitting with guilt

smearing the red and blue pain

Legs embraced nurturing the wounds

calm it down

send loving energy

notice

the change of thoughts

and the mighty fist of hope

Feel the presence of Magic
bring it closer with crossed hands
pressed into the heart chakra

The history revealed
through the scared flesh
stories
from the depths of the
warrior's soul

Unicorn

Unicorn was a 30-year-old White female psychologist from the Southern California area. She had been working at a psychiatric hospital and residential treatment program for the previous two years. Her passion was studying the impact of trauma on youth and helping the youth and their families break the cycle of abuse and healing. Although she had experience with several youth who self-injured, in the meetings she focused exclusively on one client with cutting, rug-burning, and head-banging behaviors. The client whom she represented in her work often banged her head on the wall and floor with great force, causing what looked like a unicorn horn on her forehead. In addition, Unicorn felt this client was unique and special; hence, she chose the name Unicorn to honor her own and her client's experiences.

Response to Question 1. “What do you think your clients or those who self-injure are communicating or expressing through this behavior?”

Holding the space became the most challenging during Unicorn’s meetings. There was significantly less dialogue between Unicorn and me throughout the art process. This could have related to our relationship, the relationship we both had to the client, or to her own process. It was hard to determine which factor contributed the most. Unicorn was the only participant who worked at the location where we conducted the study. Although I took vigorous measures to ensure clients could not see or hear us, and we could not see them, the client we were discussing was outside the door during two of the three meetings.

During the first two meetings, the client knocked, trying to see with whom I was working. Although I was able to hold confidentiality, the experience intensified as we heard her banging on the door, saying, “Dana, who’s in there with you? What are you doing? Are you talking about me? Let me in!” For the final meeting, another client was outside the door in a physical restraint (being held on the wall or ground by the staff for safety), screaming and yelling. As this was already an intense and overwhelming topic, the addition of her screams, cries, and head banging on the wall led to a rush of emotion for Unicorn and me. This moment exemplified the importance of this study and of creating holding spaces for the mental health providers who give care to clients that self-injure. Interestingly, although I completed all the meetings in the same room and at the same time of day, this experience with clients did not occur during any other meeting.

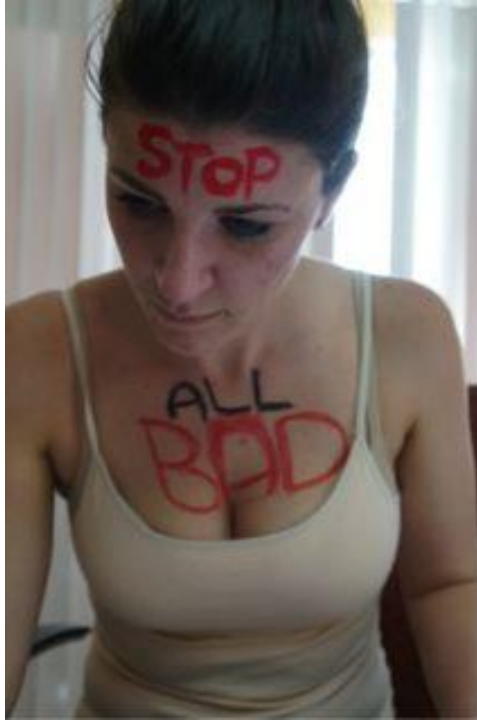
Unicorn believed that 90% of the time, her client had a script running through her mind about being all bad, unwanted, and left behind, which then led to her self-injury (Photograph 62).



Photograph 62. I'll Show You How Bad I Can Be. Unicorn.

Unicorn considered that her client's forehead literally stops on the wall (Photograph 63). This act of self-injury helped stop the thoughts of being all bad, even if only for a moment, that perpetually ran through her client's head.

Unicorn discussed that she and the client were able to communicate without words. They did not need to talk to each other to know what was happening in a moment or during a crisis. She addressed that this related to their strong bond. In addition, Unicorn said she had had to learn to listen to the whole person and not just the words—her actions or lack of action, the way she parted her hair, the music she listened to at a given time, and how she walked spoke louder than words (Photographs 64–66).



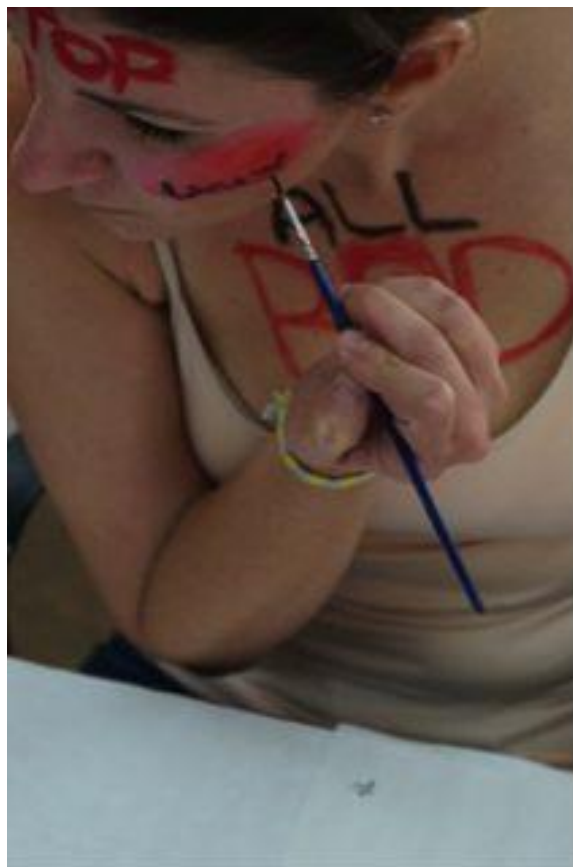
Photograph 63. Go Away. Unicorn.



Photograph 64. Carpet. Unicorn.

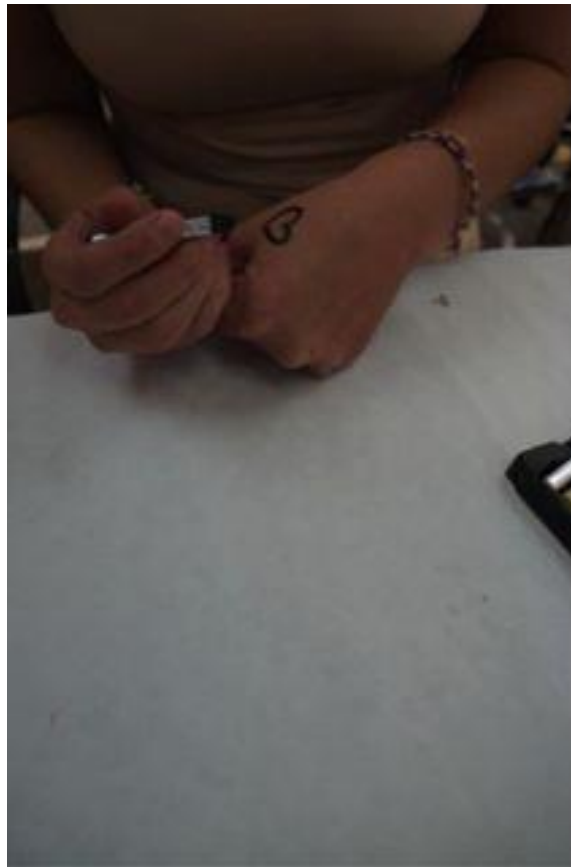


Photograph 65. Broken. Unicorn.



Photograph 66. Undeserving. Unicorn.

The heart tattoo Unicorn's client made became an important symbol that represented hope and a desire to try (Photograph 67).



Photograph 67. Tattoo. Unicorn.

Photograph 68 represents the act of cutting, but this client usually resorted to banging her head. Although cutting helped her in some moments, it did not stop the overwhelming and constant negative thoughts in her head.



Photograph 68. Cut. Unicorn.

Unicorn (Photographs 69–76) stated:

This one is darkness. This is the very deep dark recess of her psyche that she goes into and it is dark. It is really dark. I think it is much darker than people know or give credit for. I don't think she let anybody in that darkness. (August 18, 2015)



Photograph 69. I Felt Like No One Cares. Unicorn.



Photograph 70. Therapy. Unicorn.



Photograph 71. Darkness. Unicorn.



Photograph 72. Trauma. Unicorn.



Photograph 73. Shame. Unicorn.



Photograph 74. Mixed Messages. Unicorn.



Photograph 75. That's Who I Am. Unicorn.



Photograph 76. Negative Thoughts. Unicorn.

Response to Question 2. “What do you wish you could tell your clients or yourself before, during, or after a self-injury incident?”

Unicorn stated (Photographs 77–78):

So much of my work with this client is maintaining my own calm and cool and, you know, a little bit of neutrality and not feeding into her badness and feeding into her chaos and feeding into her desperation. But then, that doesn't leave a lot of space or room to have my own feelings. (August 18, 2015)



Photograph 77. Scars. Unicorn.



Photograph 78. Please Stop. Unicorn.

Unicorn discussed the importance of sending her client loving messages to counterbalance the thoughts that she is “all bad” (Photographs 79–84).



Photograph 79. What Else? Unicorn.



Photograph 80. No Such Thing. Unicorn.



Photograph 81. Truth. Unicorn.



Photograph 82. Heart. Unicorn.



Photograph 83. Progress. Unicorn.



Photograph 84. Empowered. Unicorn.

After the first session, Unicorn witnessed her client self-injure. Upon reflection of that moment, Unicorn stated:

Obviously, I do not know what it is like to drag my face across the carpet, but I can think about the sensation in each part of my head face and arm. It created a feeling when I watched her and it was a bit hard and jarring. It made it more difficult to be around her while she was injuring, because of the intensity of the feeling that came up, which I have not accessed before. (August 18, 2015)

Poetic Response to Unicorn

Hope of the Unicorn

Trauma and Shame

cut the Undeserving

broken, Damaged, Ugly

inside and out

alone in absolute darkness

STOP STOP STOP pounds into the head

Go away

no one cares anyway

negative thoughts burn the flesh

the carpet is my friend

STOP STOP STOP pounds into the head

Unwanted

all bad

I'll show you how bad I can be

lost in mixed messages of hope and pain

that's who I am

what else is there?

Please Stop Please Stop Please Stop the therapy says

For you for me for everyone

let the scars heal
 see the progress made
 because there is no such thing as perfect

Please Stop Please Stop Please Stop the therapy says

Keep trying
 you are wanted
 you are loved
 trust in the process
 empowered by the truth
 locked deep inside your heart

Blue

The researcher as final participant. I am an art therapist and marriage and family therapist in the process of completing my dissertation work through this study. Over the last 20 years, I have had the privilege to be a staff member, clinician, and supervisor in a setting where many clients have experienced complex developmental trauma and engaged in self-injury. In addition, I have supervised and supported several staff and therapists who experienced their own struggles with self-injury throughout their life.

Since I was a young girl, I have had a passion for photography, art, and poetry. Over the last 25 years, I have personally cultivated these passions and shared them with the clients and staff with whom I work. At the time of the study, I was clinically working

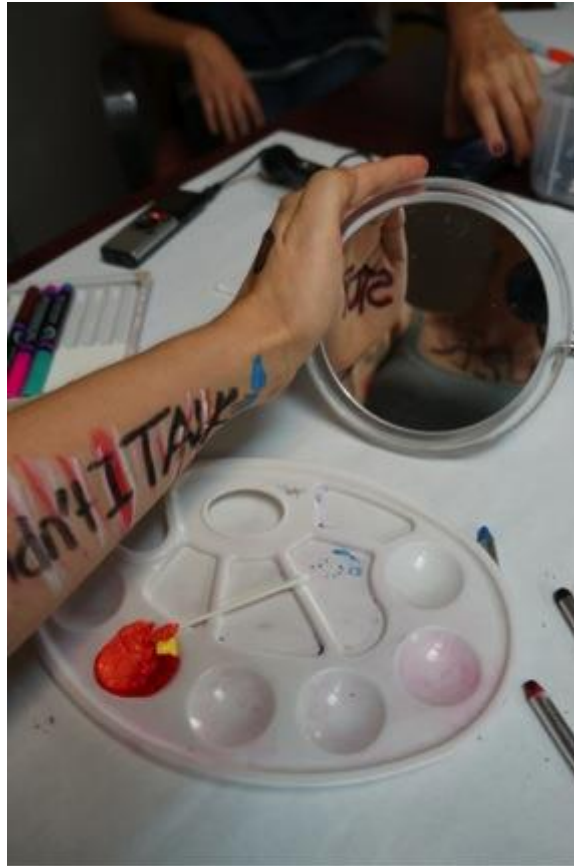
with a client who had both cutting and embedding (sticking foreign object such as metal, twigs, markers, crayons, and rust in open wounds on arms) behaviors. I was also providing clinical supervision to other therapists who served clients with cutting and other self-injury behaviors.

To immerse myself further in the creative process, I also chose a pseudonym to represent me as an artist, mental health professional, and participant. I chose Blue, which represents trust and loyalty—both important to this process as a researcher, witness, and participant. Blue also emerged as a color that represented endurance, hope, peace, and healing throughout the study,

Response to Question 1. “What do you think your clients or those who self-injure are communicating or expressing through this behavior?”

I remember being very concerned upon starting the process that my art would be too intense or that I would freak out the witness. It was hard to let go of these insecurities and just allow the process to happen. I imagine this is similar to what those who self-injure feel when they consider sharing their thoughts, experience, wounds, and scars with another person. Similarly, it was hard to give up the role of photographer. I took several of my own photographs (e.g., Photograph 85). I will note throughout which ones were self-created.

Photograph 86 represents a discussion in which one of my clients and I explored his ambivalence over continuing self-injury versus “staying safe.” I asked, “What would your scars say?” He pointed to one and referred to it as being the first—and the worst—he had ever made. He then stated, “It would say, why didn’t I talk?”



Photograph 85. Witness. Blue.



Photograph 86. Holding the Space. Blue.

I was trying to connect my experience not only to my own client's, but also to the participants. This heart (Photograph 87) is similar to the one Unicorn drew to represent the tattoo on her client. My witness commented that I took more time drawing the heart than I did other images, and that it appeared I nurtured this heart. She said I even cleaned up the edges, which I had not done with the other images or words. This photo is also self-created.



Photograph 87. Hope. Blue.

The quotation, “Take my arm,” represents my client’s own attempts to embed things in his arm, infect it, and then have someone take it from him. This could be about his feelings—that he does not deserve to be whole or his desire to look on the outside how he feels on the inside. There is significance in the passive attempts to lose his own body

part and his belief that he does not deserve to remove it himself. I remember a visceral fear after I put it on my arm—I wanted to wipe it off immediately (Photographs 88–89).



Photograph 88. Scarification. Blue.



Photograph 89. Guilt: The Aftermath. Blue.

Photograph 90 another example of a self-created photograph.



Photograph 90. Silenced: Won't Talk. Blue.

Photograph 91 represents what most people see when they see the scars or injuries or witness the cutting act. It is a mystery they are not sure they want to solve. It also represents what many clients with whom I work believe they are—a faceless monster to be feared.



Photograph 91. Faceless. Blue.

Even when you can see the face, and the person reaches out, fear can paralyze the individual and us. They are not always reaching out in a way that is easy to respond to or nurture. Photograph 92 captures the ambivalence of reaching out to draw someone in while holding them at arms distance or pushing away. To capture the feel of the push-pull, I also held the camera and took my own picture.

Both Faith and Hope drew flames on their neck and discussed significant changes in their energy and a feeling of tightness after painting it. I wanted to honor that experience, as well as the image of the throat burning and not being able to speak (Photograph 93).



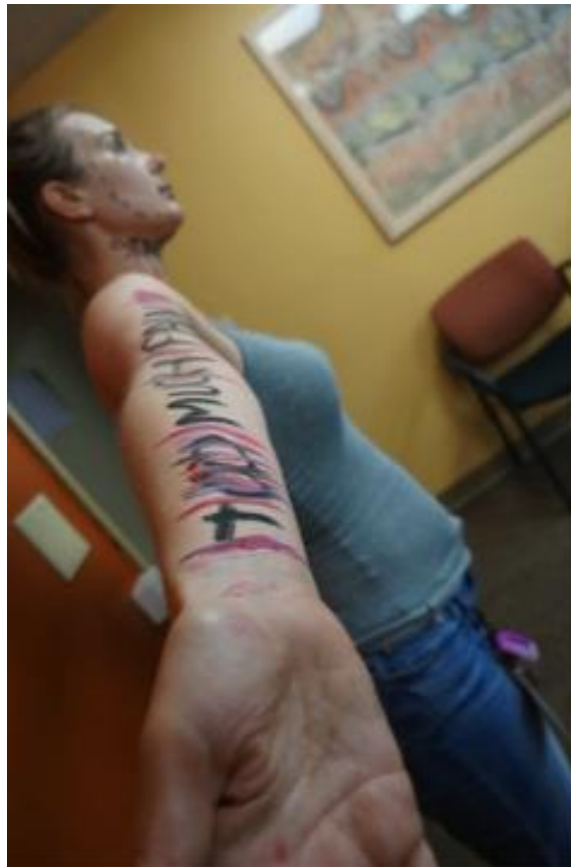
Photograph 92. Reaching Out. Blue.



Photograph 93. Seriously Disturbed. Blue.

Arthur discussed how being emotionally overwhelmed could lead to self-injury. I represented that through the writing on my arm, “Too much pain,” the image of the cut

and scar marks, and the lopsided and out-of-focus picture representing the inability to see all the resources or to ground myself (Photograph 94).



Photograph 94. Lopsided Twisted Guilt. Blue.

Photographs 95–96 represent the ambivalence and push–pull of the relationship with the individual. They represent the need for help, yet the constant rejection of the help provided, and therefore the reinforcement that “I am bad and not worthy of the help.” Oftentimes, the clients I work with use profanity, aggressive gestures, and assault in combination with the self-injury in an effort to protect self, avoid attachments, or express

fear. Many are scared they are not worthy of protection and safety, some feel they are truly “all bad” inside, while others do not know how to accept help. For some clients, being able to complete acts of self-injury is reinforcement that no one can keep them safe.



Photograph 95. I Don't Care Anymore. Blue.



Photograph 96. Don't Get Close. Blue.

Similar to Faith, I wanted to capture the reflection. I was struck by all of the participants' comments about seeing themselves in the mirror and reflecting on the aftermath of their art. I connect this to the guilt, excitement, or overwhelmed sense a person who self-injures may experience when "seeing the aftermath" (Photograph 97).



Photograph 97. Reflections. Blue.

Photographs 98–99 were self-created pictures to capture the angle of looking at the pain.



Photograph 98. Arthur Ashe. Blue.



Photograph 99. Run for Your Life. Blue.

Response to Question 2. “What do you wish you could tell your clients or yourself before, during, or after a self-injury incident?”

Photograph 100 represents the cooling of the brows that Hope created in response to Question 2.



Photograph 100. Resources. Blue.

The words “Beautiful” (Photograph 101) and “It’s okay” (Photograph 102) were responses from the clients who participated in the initial pilot study. As I began to explore those original questions, these words continued to surface—not only as important to tell oneself, but also in how difficult they are to hear and accept. The mental health professional and the client both struggle to believe these words about themselves in the face of overwhelming emotions and constant feelings of failure.



Photograph 101. Hard to Believe. Blue.



Photograph 102. Hiding. Blue.

I noticed not only that Question 2 took less time for the participants to answer, but also that most participants chose fewer pictures of their Question 2 responses for the study. This might speak to the intense nature of this work and the difficulty believing the

positive and healing words the clients and we desperately need to hear (Photographs 103–105).



Photograph 103. I'm Listening: Acceptance. Blue.



Photograph 104. Faith. Blue.



Photograph 105. Finding Peace. Blue.

Poetic Response to My Experience

Faceless Scarification

Stop

I don't care anymore

Run for your life

or get lost in my rage

You can't help me

I'm silenced, all bad, seriously disturbed

No

I won't talk

I can't talk

The reflections of my lopsided, twisted guilt
 flow out of my body
 an aftermath of overwhelming emotions

Reaching out
 I'm trying to stop
 It's hard to believe
 that any observer can hold this pain

Embarrassed and hiding
 { Why didn't I talk? }
 but the silence speaks
 Acceptance
 the witness hears the pain

The Alternate Witness

Dr. Nicole Klasey is a Caucasian female psychologist who worked with survivors of commercial and sexual trafficking. She had experience as a clinician managing self-injurious behaviors of clients and as a supervisor aiding supervisees and therapists in the exploration of countertransference issues that arise within this topic. As part of the process, Nicole was invited to choose two photographs from each question and reflect upon her experience as the witness.

Response to Question 1. “What do you think your clients or those who self-injure are communicating or expressing through this behavior?”

Nicole discussed a significant change in me, stating, “You look dead in the photo. It reminded me of your arm appearing dead during the first meeting after you drew on yourself, “Take my arm” (Photograph 106).



Photograph 106. The Live Corpse. Nicole.

Nicole discussed that, throughout the experience, my eyes showed feeling the intense heaviness of sadness related to the work and the art (Photograph 107). She also

reflected that after I drew the X on my mouth, I was silent and said little to nothing during the process, at times even pointing to things or gesturing instead of asking for help or for an object.



Photograph 107. Too Much. Nicole

Response to Question 2. “What do you wish you could tell your clients or yourself before, during, or after a self-injury incident?”

In describing her selection Photograph 108, Nicole said, “Seeing the smile and compassion and acceptance communicates more than words. It reminds me of you, and you have a little bit of a rebel side to you.”



Photograph 108. The Naked Rebel. Nicole.

Nicole stated, “This picture communicates a strong, powerful, confident, loved, and beautiful woman” (Photograph 109).



Photograph 109. I Am. Nicole.

Poetic Response to Nicole

Reviving the Live Corpse

Dead

empty

too much pain

heavy eyes

reveal the despair

Silenced

the arm won't move

unless to punish

the live corpse holding the pain

The naked rebel
reveals herself
with her mischievous plans
to inhabit the emptiness
acceptance and compassion
speak more than words

Strong
powerful
confident
loved
beautiful
she lends her faith
reviving the corpse

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