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ORIGINAL ARTICLE

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The hidden emotions of therapists: An autoethnographic exploration of working with clients who self-injure

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Abstract

Introduction: This paper explores how working with clients who self-injure generates significant emotional reactions in therapists, often difficult to manage. Drawing on my clinical experience as a researcher and counsellor, I provide an evocative autoethnographic account, highlighting hidden, forbidden or taboo feelings. The aim was to deepen understanding of therapists' emotional realities and contribute to the limited literature on this subject.

Method: Through journaling, sketching, metaphor and field notes, I detail personal experiences with clients who self-injure. This autoethnography explores my emotions and reactions. A case vignette illustrates my experiences, promoting critical and empathic consideration of how therapist emotions are experienced.

Data Analysis: I use autoethnographic methods to analyse the emotional impact and existential reflections of working with clients who self-injure, employing layers of qualitative interpretation from various personal data sources.

Results: Findings reveal that working with clients who self-injure forces me to confront my mortality, evoking deep existential reflections and intense emotions like vulnerability and fear. This disrupts my sense of immortality, highlighting my role's limitations and evoking shame and self-doubt about my ability to alleviate suffering.

Implications for Practice: This paper advances research on self-injury and emphasises autoethnography as a valuable avenue for counsellors engaging in research. Grounded in PhD study, this paper makes an original contribution to knowledge. Integrating discussions on mortality and emotional vulnerability into supervision and training is crucial, alongside comprehensive training that addresses emotional and unconscious issues. Accessible supervision fosters growth, reduces stigma and supports therapists working with clients who self-injure.

KEYWORDS
autoethnography, existential anxiety, self-injury, supervision in therapy, vicarious trauma

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1 | INTRODUCING THE CASE OF KIT

As usual, the 'thimbled' therapy room feels as stuffy as a blanket at the back of an airing cupboard. I open a window, momentarily irritated that the school provides the most basic rooms for the most precious of counselling interventions.

Kit loves working in the sand. Sandplay therapy, based on the work of Carl Jung and Dora Kalff, is already proving beneficial for him, though self-injury continues to assuage his distress during fits of anger. In Kit's case, this involves skin cutting. Sitting across from him, I recall the International Society for the Study of Self-Injury's definition of self-injury: 'The deliberate, direct, and self-inflicted destruction of body tissue resulting in immediate tissue damage, for purposes not socially sanctioned and without suicidal intent' (ISSS, 2018; Nock et al., 2006). There is always something uncomfortable about the language surrounding self-injury. The terms deliberate self-harm and self-mutilation carry weighty implications of control, or worse, lack of willpower. Mangnall and Yurkovich (2008) urge us to reconsider these labels as these terms do not capture the inner turmoil; the knot of shame, anger and relief that Kit seems to be trying to unravel.

He doesn't use words to articulate his feelings well. It's in the cutting that his emotional experiences find clarity, even if for a fleeting moment. Labelled as 'problematic and disruptive' by his teachers, Kit's shame significantly fuels his self-injury, escalating when he faces criticism during difficult tasks. Shame disrupts his sense of self and his ability to organise emotional responses effectively, contributing to his volatility.

Tooher (2022) highlights that many young people like Kit struggle with expressing their emotions. Anxiety and depression tangle together, and in his case, bouts of self-injury surface as a way to manage when emotions crest too high. Spandler (1996) suggests that these acts can serve as a form of self-punishment, but there's more to it—low self-esteem and intense self-hatred. These attributes suggest therapists face complex, challenging presentations, even for seasoned professionals as Whisenhunt et al. (2014) remind us.

As a therapist working with individuals who engage in self-injury, I often navigate complex emotions and insecurities. In this paper, the term 'therapist/s' refer to professional helpers—psychotherapists, counsellors and psychologists—like me, who support these clients. For Kit, and others like him, self-injury serves to manage overwhelming emotions, and this process can evoke powerful reactions in those of us tasked with providing support.

Engaging with clients such as Kit triggers strong emotional responses within me, often stirring insecurities reminiscent of my early training days. Back then, I viewed these feelings as indicators of my lack of competence. However, conversations with peers revealed that such emotional reactions were not uncommon. This discovery led me to delve into the literature on self-injury to better understand its emotional impact on therapists—an exploration that has now become essential for my own growth and effectiveness in this field.

Implications for practice and policy

- Heightened self-awareness is critical for therapists working with clients who self-injure, helping distinguish personal emotions from those within the therapeutic relationship and enhancing authentic connections. Embracing emotions in this setting encourages genuine self-disclosure and meaningful exchanges, maintaining self-awareness while reducing desensitisation or compassion fatigue.
- Encouraging conversations about mortality and emotional vulnerability in supervision and training can help therapists confront fears and desires for connection. Given the adverse experiences interventions can evoke in individuals who self-injure, it is imperative for counsellors to reflect on their own existential fears, shame, anger, and associated emotions. Engaging with these complex feelings helps therapists understand their reactions and their potential impact on practice, ultimately benefiting clients.
- Training should address emotional issues and unconscious influences in therapy, including existential perspectives on death.
- Supervision should deepen our understanding of self-injury (Tooher, 2022), its psychological underpinnings, links to suicide, and provide emotional support strategies. Supervisors must possess diverse knowledge and skills to meet supervisees' needs effectively.

2 | AUTOETHNOGRAPHY AS METHOD

As I sit with my journal in hand, reflecting on the words of Ellis and Bochner (2000), their ideas about autoethnography as both a research and writing process shape my thoughts. It is strange how personal experience becomes the bridge between theory and practice. Autoethnography captures not just my own experiences but the broader cultural context in which they unfold. Throughout this paper, I interweave examples from my autoethnographic reflections, drawn from my journals and subtly integrated into the narrative.

Autoethnography blurs the lines between autobiography and ethnography, with the researcher's personal narrative serving as a focal point for understanding wider social and cultural phenomena. Sparkes (2024) expands on this, noting that autoethnography connects personal narratives with broader social dimensions, providing a lens through which personal experience gains social relevance. This method emphasises subjective experience and the researcher's influence on research outcomes, enhancing authenticity and fostering empathy.

Writing serves as a primary method of inquiry in autoethnography, blending communication and storytelling to explore sensitive topics like trauma. Various forms exist, including dyadic,

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duo, analytical and performative autoethnographies, each emphasising the researcher's self and contextual power dynamics (Adams et al., 2013).

Evocative autoethnography, as exemplified by Ellis and Bochner (2000), immerses individuals in their personal experiences and transports them through transformative storytelling. It acknowledges bias as integral to the narrative, aiming to propose new ideas and influence thinking.

In this research, I used evocative autoethnography to create a 'layered account' (Ronai, 1995) of my experiences as a therapist working with clients who self-injure. This method integrates personal narratives, introspections, dialogues, visual elements and literary responses to emotionally engage readers and foster a deeper connection with the subject.

Autoethnography is particularly relevant in psychotherapy, highlighting the connections between personal narratives, cultural contexts and therapeutic issues. It mirrors the interpersonal nature of therapy, where the therapist's 'self' is a crucial tool, influencing both personal and professional identities. Overall, evocative autoethnography provides a methodological framework that aligns with therapeutic practices, emphasising empathy, understanding and the transformative power of personal narrative within cultural contexts.

Over nearly 6 years, I have maintained a journal documenting my emotional responses while working with clients who self-injured, also capturing reactions to the literature on emotion, self-injury and counselling. My entries included audio recordings, sketches, poems, photographs and reflections, providing materials for self-exploration and evocative narratives beyond textual data (Chang, 2008).

Data analysis involved qualitative coding to categorise emotions into themes related to my role as a therapist. This process required iterative reflection due to the interconnected and subjective nature of emotions. Reflective processes evolved from structured approaches to more fluid methods, capturing my evolving emotional experiences during my work.

Arts-based techniques enriched data analysis, using poetry, photography and artwork to summarise emotional intensity. These creative outputs illustrated the emotional journey, offering insights beyond conventional textual analysis. By using symbolic representations, including vivid imagery and emotional sensations, I explore my experiences with clients, as illustrated here through the fictional case of Kit.

The study culminated in emotional thematic stories that combine personal narratives with theoretical insights, aiming to evoke visceral reactions in readers. This iterative process of writing and reflection seeks to bridge academic rigour with emotional authenticity, contributing to the fields of psychotherapy and counselling research.

3 | ETHICAL CONSIDERATIONS

Ethical guidelines from the British Association for Counselling and Psychotherapy (BACP, 2018) supported the research process. Autoethnography, which incorporates the researcher's subjective experiences, presents unique ethical challenges, blurring the usual distinctions between researcher and subject (Morse, 2007). Ethics approval for my autoethnography was obtained from the University of Central Lancashire (UCLan) Ethics Review Panel as part of my PhD study.

In autoethnography, the researcher often serves as the primary subject, necessitating self-protection measures. My narrative inherently involves relationships with others, raising ethical concerns about representation and ownership. To protect identities, I utilised composite amalgamations of actual and fictional clients, significantly altering characteristics and life situations to create composite characters such as Kit. This approach ensured the focus remained on my personal feelings rather than on the factual attributes of individual clients.

The process was emotionally intense and challenging, reflecting the vulnerability inherent in autoethnography (Douglas & Carless, 2016). Following ethical guidelines (BACP, 2018), I prioritised beneficence, aiming to benefit others through increased understanding while being mindful of my impact on them.

I hope that my work inspires others to share their experiences and develop their practices. To manage impact and reveal professional subjectivity, I engaged in personal therapy and supervision throughout this research.

4 | THE LITERATURE REVIEW

Reflecting on the research process, I engaged with the existing literature on self-injury. The prevalence of self-injury is challenging to determine due to underreporting, the secretive nature of the behaviour and the fear of negative judgement (Klineberg et al., 2013). Despite this, it remains a growing global concern, with Kit being one of the estimated 17.2% of young people worldwide who engage in self-injury (Swannell, 2014). In England, 25.7% of women aged 16–24 have self-injured, more than twice the rate for men in this age group (McManus et al., 2014). As a result, therapists increasingly encounter clients who self-injure, making it essential to examine their emotional responses, especially since negative reactions can affect the therapeutic relationship.

Kit's self-injury is linked to various adverse outcomes, including infection, scarring, and psychological effects like shame and guilt (Baer et al., 2020). Like other clients, Kit experiences social alienation and stigma (O'Connor & Surgenor, 2023), as well as a higher risk of suicide (Andrewes et al., 2019). Understanding the purpose behind Kit's self-injury is vital for developing effective treatment strategies. Self-injury may serve multiple functions, including self-punishment (Ferenczi, 1956), affect regulation and interpersonal communication (Babiker & Arnold, 1997). It can provide relief from intolerable emotions like shame, guilt, anger and anxiety (Nafasi & Stanley, 2007). Other functions include anti-dissociation, peer-bonding, sensation seeking and boundary assertion.

Each client's circumstances and needs are unique, and so are therapists' emotional reactions. Clients like Kit are among the most

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challenging to treat, with many counsellors feeling uncertain about the best interventions. As an integrative therapist, I seek research that supports my interventions, believing that autoethnographic research can enhance understanding of therapists' emotional reactions and improve treatment.

The increasing rates of self-injury (Morgan et al., 2017) raise significant concerns about therapists' effectiveness with clients. Understanding their emotional responses to clients' self-disclosures could be crucial, as it complements existing research on clients' experiences of therapy (O'Connor & Surgenor, 2023).

Recognising the significance of therapists' emotional reactions seems imperative, as it influences the therapeutic process. McLeod (2013) asserts that a strong, trusting therapeutic alliance, fostered by a non-judgemental attitude, is paramount to successful therapy—a concept I strive to embody with every session. Kit's need for empathy and autonomy reminds me of Spandler's (1996) observation that clients who self-injure value these qualities in their therapists.

Yet, it's not always easy. The emotional intensity of hearing Kit describe his self-injury overwhelms me at times, threatening to disrupt the very connection we are trying to build (Bunclark & Crowe, 2000). According to Klonsky and Muehlenkamp (2007), authentic connections that offer empathy and unconditional positive regard may also be critical. I recall Fleet and Mintz (2013) warning that unresolved responses in the therapist can affect both the client and therapist. I feel this unease viscerally, aware that Kit can likely sense this too. Hoffman and Kress (2008), along with Walsh (2006), suggest that novice therapists are especially prone to feeling fear and panic. While I may no longer be new to the profession, these emotions are still familiar.

McClure and Hodge (1987) note that low-anxiety therapists can provide better support, while those with high anxiety may react defensively, potentially creating stigma. For clients like Kit, stigma can worsen mental health, reduce recovery chances and increase suicide risk, as negative attitudes can weaken treatment efficacy (Corrigan et al., 2014). Therefore, understanding therapists' emotional responses and providing adequate support is vital for effective therapy.

The existing literature outlines key expectations for therapists working with clients who self-injure. Understanding clients' behaviours can enhance therapist self-awareness (O'Connor & Surgenor, 2023). This understanding enables therapists to empathise with clients like Kit and view self-destructive acts as part of human cultural development (Milia, 1998). My own self-observation raises awareness of my personal emotions, allowing access to covert experiences and highlighting unconscious patterns (Cameron, 2002). Poulos (2021) suggests that autoethnography can reveal these unconscious elements, which I found particularly compelling.

Rayner (2010) emphasises that considering transferential and counter-transferential aspects of therapy is crucial when working with clients like Kit, as these dynamics deeply affect both parties. Strean (1999) highlights the importance of resolving impasses by disclosing countertransference, while Kahn (1996) advocates for therapists to remain vigilant about their internal states, turning countertransference into an effective tool. Therapists' bodily symptoms can also reveal their experiences during sessions, acting as an internalised body language for primitive communication (Van der Kolk, 2015). According to Hovarth et al. (2011), emotional management is essential for a productive therapeutic alliance, with varying approaches across modalities. Psychodynamic therapies and humanistic approaches emphasise the importance of emotional presence, where emotional expression and regulation can reduce burnout in healthcare professionals (Weng et al., 2011).

Therapists are often encouraged to maintain a neutral, factual response to safeguard the therapeutic relationship. However, inner turmoil and cultural expectations can be misinterpreted as anxieties, leading to therapists to hide their internal experiences (O'Connor & Surgenor, 2023), or resort to coping mechanisms such as dissociation (Cameron, 2007). Therapists report experiencing profound emotional responses when working with clients like Kit who self-injure, encompassing feelings ranging from distress to despair to rage, shock and guilt (Mackay & Barrowclough, 2005). Negative attitudes towards self-injury can lead to shame and irritability, impacting how therapists perceive clients. Clinical norms frequently prioritise a detached stance, leaving therapists feeling isolated in their emotional journey (Chandler, 2012). Personal narratives from authors like Milia (1998) and O'Connor and Surgenor (2023) offer a more humanistic perspective.

The emotional toll can extend to issues like vicarious trauma, burnout and compassion fatigue, highlighting the need for effective supervision and emotional support (Figley, 1995). As a therapist, I've found that navigating my emotional responses when working with clients who self-injure is essential for fostering an authentic therapeutic alliance and enhancing treatment effectiveness. These emotional responses, often intense, can sometimes be triggered by the client's experiences—reminding me that as counsellors, we are not immune to our own trauma responses. These triggers can emerge unexpectedly, evoking feelings tied to our past or unresolved emotional experiences. Recognising and working through these moments is critical for me to engage meaningfully with Kit, creating a safe space where his experiences can be explored without judgement. Yet, the reality of this is easier said than done.

5 | THE TERROR OF THE THREAT TO IMMORTALITY

I propose that working with clients who engage in self-injury compels therapists to confront their own anxieties about mortality. While various therapists and psychologists discuss the difficulties of working with clients who self-injure, the specific aspect of facing mortality remains largely unexplored. I suggest viewing self-injury as both a manifestation of and a response to Ernest Becker's concept

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of the Denial of Death (Becker, 2020). In this framework, individuals and societies deny existential anxiety by engaging in immortality projects—symbolic constructs and hero systems to escape the fear of death (Solomon et al., 2015).

Self-injury directly confronts mortality, bringing physical vulnerability and the fragility of life to the forefront (Joiner, 2005), thereby challenging the denial that typically characterises day-to-day existence. Within Becker's framework, the Denial of Death is an attempt to control anxiety induced by the awareness of mortality. However, I propose that self-injury may serve as a strategy to regain control (Adler & Adler, 2011), contrasting with immortality projects which aim to create lasting symbolic meaning. Instead of contributing to the immortality project, self-injury could be seen as an expression of despair or internal turmoil, ultimately forcing therapists to confront their own mortality.

As a therapist, witnessing Kit's self-injury reminds me of human fragility. Empathising with his emotional pain and distress evokes existential reflections on human suffering (Frankl, 2006). I feel a profound responsibility for Kit's well-being and struggle with the limitations of my role when faced with his actual and/or potential self-injury, raising existential questions about uncertainty and vulnerability in therapy.

In my work, I recognise my engagement with what Yalom (2008) terms 'rippling'—immortality projects aiming to make a lasting impact on my clients and the counselling field. Kit's self-injury challenges this effort, making me question my effectiveness in alleviating his suffering and promoting long-term well-being (BACP, 2018). Despite trying to maintain professional boundaries, the nature of self-injury evokes existential reflections, highlighting the shared humanity between us, both struggling with the complexities of existence. This can lead to feelings of shame as I question my effectiveness.

Throughout my research, I have found that metaphorical narratives and visual elements, such as sketches, are instrumental in conveying the complex emotions encountered in therapeutic settings. Metaphors allow me to represent concepts imaginatively, offering insights beyond verbal expression (Eldridge, 2012; Owenby, 2013).

Self-injury challenges my sense of permanence, confronting the illusions I use to avoid thoughts of death. It holds a metaphorical 'death card', prompting reflection on these illusions.

My mind turns back to Kit's session in the sand.

Kit eagerly transforms in the sand—his inhibition melting away—he manipulates it, losing himself entirely, and I follow…

As I sit with Kit, quietly observing the creation of his world in the 'free and protected space,' (Turner, 2005), our work feels incredibly productive, and I sense a deep connection forming. I feel buoyant, like a balloon filled with positive energy, warmth and joy. My focus, akin to the process of Mentalization (Fonagy et al., 2004), is to hold Kit's 'Mind in Mind', immersing myself in his experience to understand, empathise, and help articulate what he feels. I strive for sustained empathic inquiry, offering Kit a sense of being fully understood. However, as Teyber et al. (2014) caution, I recognise the need to maintain a strong inner connection to myself to prevent being overwhelmed by my own shame.

But then…

Kit melts into his sand mountains. In my mind, the room becomes darker, like soot, resembling a stormy scene from a film like *Harry Potter* or *Lord of the Rings*, or a dark landscape painting. His eyes glaze red at the edges.

'Kit?' I venture, my voice barely above a whisper. 'Are you, okay?' It feels almost as if I am asking myself this question. Without a response, his movements grow larger, looming now, busting out of himself, as if he is melting into the walls of the sand tray. His huge arms engulf the remaining space. From his lunch-stained trousers, he unearths symbolic weapons—a monstrous Wenger Swiss Army knife, a stapler, a hacksaw, a cleaver—thrashing these around in giant swoops.

He smiles, laughs, gurgles, and with the 'Shan Zu Cleaver' chops hard at his arm, hack-hack-hack. He pokes around the new harsh opening in his arm while blood is spurting out everywhere, soaking the air. I feel sick, Shit… Blood. I'm pulling blood in handfuls from my eyes, it's all over him, all over the walls—blood is everywhere. My eyes are bulging, I am vomiting. It's a blood show.

As Kit's world becomes intense, I am embroiled inside; we are merging, the gravitational pull of trauma.

I see death.

Fuck.

Stolorow's (2007) concept of trauma as a 'portkey' is relevant. It abruptly transports me from the present to a distant world, not just reminding me of my trauma, but engulfing me in this trauma response. This involuntary immersion instantly overwhelms me, echoing the original experience.

Kit invites me to join him; he offers the hacksaw. Only fleetingly can I think straight; he is inviting me to contain and support his world, a co-crusader in his battle to control his psychological torment, but I am struggling. I am fighting hard to provide a consistent milieu of personal safety that allows him to process his layers of emotion.

I am forced into the empathic resonance, and in the main, this is unendurable. I feel sorry.

Shame, like gasoline, is flooding, igniting.

Fuck, inside my stomach is vomiting, and the eerie world of my emotions grow fantastical—grotesque bodily substances drip from the walls, my existence is entwined with memories of the macabre of my own five pregnancies, haunted by the relentless horror of Hyperemesis Gravidarum, hospital drips and 'guardian midwives'. Deadly, cancerous, grapefruit-sized ovarian dermoid cyst babies surge through the keyhole into the therapy room like mammoth worms ready to consume my life—the saclike growths bulging with hair, fluid, teeth, eyes and skin glands. Pregnancy illnesses drained my vitality back then and now echo our suffering selves.

I recognise his suffering in the sand.

Sand carnage in the shape of upturned dinosaurs, poured water, skulls, skeletons, grim reapers, spiders, battling out in a war of his unconscious. I see it now in my mind, it's as if his bleeding arm is flailing about me, his arteries gushing claret into my throat - I am absorbing and consuming him.

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'Yes, I'll join you, Kit, I'll come with you, I am prepared, I can do it, but I won't cut. I am here with you though'. I add in vain. I know that making myself vulnerable signals trust and respect, as does receiving and honouring vulnerability from Kit. Sheathed with the personal moral quality of courage (BACP, 2018), I go forward…

'Do you understand?' he booms. He is bestial.

'Yes, I do'! Trumpet calls and sirens.

But the ship has fouled—carnage. Tears mingled with vomit, sweat, blood and the spit from his words. A thin line between fantasy and reality.

'I know how rubbish you feel'. I hoick a futile retort, my voice lost in the barbarity. Flames of pain furrow our bodies, cutting them to pieces; sliced as if by a billhook.

Kit plumbs the depths of me.

At that moment, the significance of my everyday therapist world collapses into meaningless. I feel 'uncanny'—a strange and alien being—not of this world.

There is solitude.

His trauma shatters my illusions of impermanence—Kit plunges me into '*his*' traumatised estrangement, revealing his 'authentic being toward death' (Stolorow, 2007: 27). This exposure mirrors my own: each bout of my Hyperemesis Gravidarum dragged me into a vortex of relentless sickness, fatigue and loneliness as if my body were conspiring against me, much like Kit's body is conspiring against him, employing every means to expel, weaken and transform the psychological turmoil mind.

Nausea now becomes the ominous signal of my body's rejection, as if Kit's self-injury is a manifestation of something difficult for me to absorb or a malevolent force that needs expulsion. Each wretch felt immediate, urgent and repulsively tangible, like Kit's cleaver, slicing his arm—hack, hack, hack.

An act that threatens my total existence.

In this ritual of purging, self-injury emerges as a grotesque symphony—an abhorrent force mobilising unspeakable horrors within. My illusion of life is threatened as Kit's self-injury devours his surroundings and dignity, drawing me into his world. The experience blurs the line between feeling sick and embodying sickness, transforming sickness into a malevolent force that consumes and distorts my very existence. Each moment with him becomes a nightmare of self-injury, blood, nausea and despair, lingering as a symbolic horror.

Illness (inside that hospital for weeks on end) left me with an excruciating sense of singularity and solitude—near death, and I feel it now.

As Kit's process unfolds, my mind races with intrusive thoughts, spiralling into worst-case scenarios—the imagined crisis, fuelled by the gravitational pull of trauma, storms into a pattern of catastrophic thinking, where shame and exposure strip away any sense of reality, safety or control. God, this work! Causing states of fear and disgust so brief that speech always comes too late.

In my mind, Kit has self-injured during the session—like really done it—something I've feared for years!

Dissociative states are inevitable. My imagination runs riot. Suddenly I am thrown into a crisis.

Fuck, Fuck, Oh GOD! This is like Fuck! I am angry. Shit. The therapy door flies wide.

Shit.

Safeguarding staff, the headteacher and support workers blunder into the already too-small room. Scared faces everywhere—this is mayhem! I feel exposed and caught off guard. The atmosphere thickens with anxiety as the school's intervention—marked by exposing, reprimanding and shaming Kit—turns our therapeutic space into chaos.

Humiliation

Me and my previously inflated balloon self now deflating, soft, wilted and feeling utterly pathetic—the epitome of shame and humiliation, (See Figure: Humiliation).

And the sand tells the story.

His back against the wall, head bowed, my head low, finding his eyes. Both of us spliced yet split when the school treated Kit's self-injury as separate from him, reprimanding him and enforcing school rules—as if he had forgotten. There is shame and humiliation in the room. I felt fundamentally flawed, exposed and gate-crashed.

Shame is multifaceted, a powerful and ubiquitous (moral) emotion (Stadter, 2014: 46–48)—with feelings of anxiety, anger, disgust, a 'heart sink' feeling and a sense of self as inadequate, bad or defective in some way (Gilbert, 2014: 325).

And God, I feel it.

Shame significantly hampers therapy with clients who self-injure.

In shame, I experience a loss of empathic attunement. The experience of feeling shamed leaves me feeling disconnected and disempowered (Brown, 2006). I feel shame for losing attunement and disconnecting.

Shame was a powerful obstacle to connection in the therapy, I was fed up really, just so fed up. A shame obstacle in the shape of school staff and red tape, boundaries were getting in the way, and I felt squashed, my arms dropped to the sides, and I breathed in, a slow breath of useless sad exasperation.

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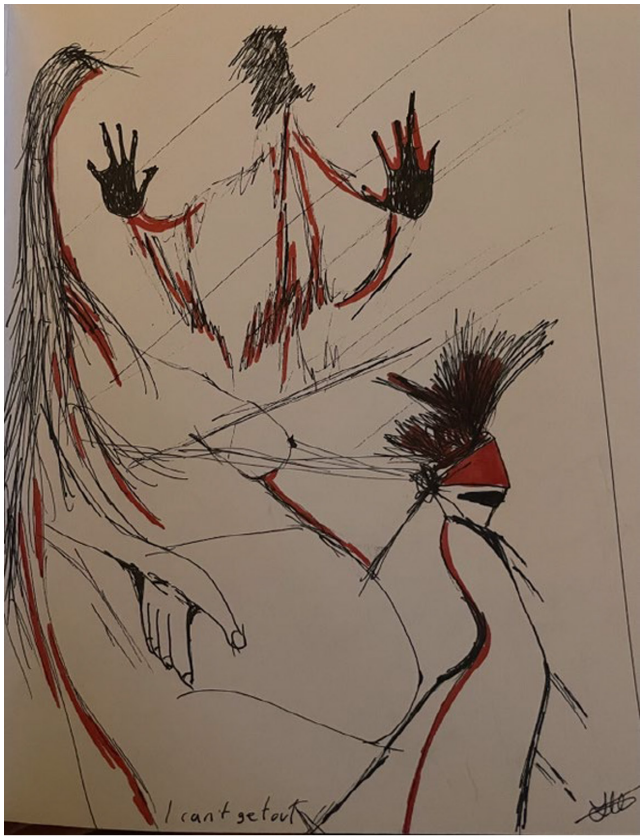
Both clients and therapists can experience shame. For therapists, shame is a deep, enduring reaction to perceived threats to their identity, exposing physical, emotional or intellectual vulnerabilities within the therapeutic context (Ladany et al., 2004). I felt shame while working with Kit, stemming from external cultural expectations, which eroded my self-worth. Brene Brown describes shame as the fear of disconnection and being seen as flawed (2006). This aligns with my reactions, such as feeling exposed, avoiding eye contact and wanting to hide.

As the session closes, Kit is escorted back to the classroom, and his parents are called. I am left alone, shocked and reeling.



I See Death

Later that night, as I reflected on my session with Kit, I felt compelled to sketch—driven to capture the swirling emotions and thoughts that lingered from it. Drawing has become a seismograph of my inner world, recording the intensity of feelings that arose during my work. The sketch I created encapsulated the narrative I have produced here, exemplifying the profound challenge of empathising deeply while striving to maintain my own boundaries and highlighting the core theme of existential anxiety (See figure: 'I See Death'). Confronting the stark face of mortality, the central figure is fragmented with exaggerated, angular lines and large hands cradling a pregnant belly, evoking a sense of despair in the face of past traumas.

The chaotic, contorted lower figure reflects the turmoil beneath the surface.

During that reflection, I realised that the pain in my shame felt tangible and excruciating. Like many therapists have experienced at some point in their careers, I felt like a useless therapist; fraudulent, nowhere near even 'good enough', and my perceived lack of competence in preventing self-injury was exposed—shame targeted the whole of us.

Walsh (2006) notes that less experienced therapists may feel increased fear, panic, upset and despair when dealing with self-injury. Therapists often fear clients will suffer permanent damage, worry about being blamed or feel guilt for missing signs of self-harm. For me, the most powerful and ubiquitous emotion was shame, leaving me feeling disconnected and disempowered. When the school shamed Kit, I realised how personal and ongoing the process of becoming a clinician is, often eliciting helplessness and vulnerability regardless of experience.

Effective therapy requires addressing one's own shame. My supervisor suggested I might have glossed over my shame, a comment that stayed with me and prompted deeper self-exploration while writing this paper. I hoped to provide Kit with an attuned presence and validation, helping him develop emotional resilience. But it was hard.

Despite my initial fears, I strive to be benevolent and more accepting of Kit's self-injury and my emotional responses, working to maintain our connection even amid the impasse and the threat of mortality. Over the following weeks, our strong relationship and mutual trust allowed us to openly discuss the event, highlighting the reparative power of our therapeutic alliance.

Stolorow (2007) aptly states that emotional trauma is always possible, but so is forming emotionally attuned bonds that can render pain tolerable and integrated. Accepting imperfection and embracing vulnerability has allowed Kit and me to deconstruct unrealistic images of who we 'should' be in therapy and other relationships. Working with clients who self-injure challenges my sense of immortality, inducing shame and highlighting a rarely explored aspect of therapeutic discourse.

Self-injury, as viewed through Ernest Becker's Denial of Death, both manifests and responds to existential anxiety about mortality. Therapists and clients use immortality projects and symbolic constructs to navigate the fear of impermanence. However, self-injury trauma disrupts this naïve realism, shattering the absolute that supports everyday functioning and resulting in a loss of innocence (Stolorow, 2007).

Witnessing or discussing self-inflicted wounds can act as an immediate portkey (Stolorow, 2007), transporting both therapists and clients to deep pain and challenging the therapist to manage their emotional responses while remaining supportive. This journey through trauma exposes the intricate relationship between shame and vulnerability, revealing the complexity in the therapeutic alliance. The trust between Kit and me enabled open dialogue after challenging events, fostering a transformative process. We moved beyond constructed ideals, deconstructing limiting images and fostering authenticity in therapy and other relationships.

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Meaningful connections, as this paper highlights, are fraught with emotional challenges.

6 | DISCUSSION

Working with clients who self-injure confronts therapists with intense emotions (Morrissey, 2015: 40). My journey, marked by intrusive thoughts and images, has elicited emotions such as fear, self-doubt, inadequacy, blurred boundaries and helplessness, indicating vicarious trauma.

Imagery, a hallmark of post-traumatic stress disorder (PTSD; American Psychiatric Association, 2023), evokes powerful emotional reactions, mirroring therapists' experiences with self-injury (O'Connor & Surgenor, 2023: 7) Despite the literature documenting the emotional impact on therapists (Alderman, 1997), the specific connection between self-injury and therapists confronting their mortality remains underexplored, even when mental imagery's capacity to provoke authentic emotional responses due to its vivid nature is well-documented (Mendley & Mathews, 2010).

This autoethnographic paper expands the discourse to an existential plane, suggesting that self-injury, framed by Ernest Becker's Denial of Death, acts as a catalyst for existential anxieties disrupting naïve realism, optimism and qualities typically considered crucial for everyday functioning and effective therapy. Self-injury thrusts therapists [me] vicariously into a terrifying awareness of a capricious and unpredictable world where safety and continuity are not guaranteed (Stolorow, 2007).

This exposure to trauma challenges both individual and societal immortality projects aimed at transcending existential anxieties (Solomon et al., 1991). Engaging with emotional trauma, particularly through the lens of self-injury, shatters my sense of absolutism and innocence (Stolorow, 2007: 16), profoundly altering how I perceive and interact with the world.

Witnessing self-injury involves confronting not just the physical harm (O'Connor & Surgenor, 2023) and associated behaviours but also engaging with the emotional turmoil underlying these actions. This confrontation stresses the shared humanity between me and my clients, emphasising the importance of empathy, ethical practice and the pursuit of meaning and healing within the therapeutic relationship.

Given my limitations and the finite nature of my connections with clients and others, the spectre of emotional trauma looms large. The concept of 'being with one another' remains largely unexplored (Stolorow, 2007: 49), particularly in our interactions with clients who self-injure. Thus, the potential for emotional trauma, whether vicarious or direct, is ever-present, alongside the possibility of forging emotional bonds that render profound emotional pain more bearable.

The notion of 'kinship in finitude' (Stolorow, 2007) serves as a synthesis of fear and sadness, highlighting how the quest for emotional kinship emerges as a consequential response to emotional trauma. There is an absence of other therapists' narratives about their emotional experiences with clients that leaves me feeling a profound sense of sadness, loneliness, fragmentation and alienation, trapped in a state of trauma that has led to authentic paralysis and an urgent longing for connection with someone who 'knows the same darkness' (Stolorow, 2007: 49).

Supervision is critical, providing a secure space to navigate therapists' adverse emotional responses (Schiavone & Links, 2013). Through parallel processes, therapists in supervision may unwittingly replicate dynamics seen in their clients, seeking reassurance or quick solutions from supervisors. Thus, supervision serves as a secure space to unpack these interactions (Watkins, 2015) and restore equilibrium, reminding therapists that they are 'not alone and unprotected' (Fickle, 2007: 101). Supervision should aim to provide the emotional kinship necessary to assist supervisees in reorganising and reintegrating feelings of stability.

Taboo emotions and the fear of judgement often hinder effective therapy (McClure & Hodge, 1987). I've struggled to disclose 'taboo' emotions like existential anxiety and visions of death due to fear of negative reactions and the lack of discussion in the literature. This mirrors the experiences of individuals who self-injure, as fewer than half disclose their behaviours due to fears of judgement (Park et al., 2021).

7 | LIMITATIONS

Autoethnography integrates personal experience with cultural analysis, which critics argue compromises rigour, theoretical depth and objectivity. Critics caution that emphasis on subjective storytelling over empirical analysis may lead to biases and self-indulgence, challenging traditional social scientific standards and impeding disciplinary progress. This paper advocates for autoethnography in counselling and psychotherapy, highlighting its accessibility and role in exploring therapists' emotional realities and fostering self-awareness (Boylorn & Orbe, 2020). The study emphasises transparency and reflexivity in autoethnography to ensure reliability and validity, aiming to resonate with practitioners for critical reflection and discussion. Despite inherent limitations, such as reliance on personal memory and interpretation, it asserts the value of offering unique insights and narratives that contribute to ongoing dialogue and development within the field (Denzin & Lincoln, 2000).

8 | FURTHER RESEARCH

Expanding this study to include data from other therapists working with clients who self-injure could provide valuable insights into therapists' emotional experiences. Qualitative research, such as interviews, could enhance understanding and address gaps in the field. Future research should explore how individuals who self-injure perceive therapists' emotional disclosures and the role of self-injury in evoking taboo feelings.

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Incorporating reflexivity and more autoethnographies from therapists, supervisors and clients is essential. Practitioners should feel empowered to creatively write about their emotional experiences which could shift perspectives from shame and doubt to contentment. The goal is to foster curiosity and challenge the notion that such emotions are inappropriate.

I am interested in further research on therapists' emotional responses to self-injury, especially regarding 'death anxiety' and 'threat to immortality' in therapeutic contexts. Additionally, I propose a duo-ethnographic approach involving both individuals with lived experience and supervisors to explore parallel processes and therapeutic movement.

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CONFLICT OF INTEREST STATEMENT

The author declares that they have no conflicts of interest.

ETHICS STATEMENT

This study was approved by the Ethics, Integrity and Governance Unit Research and Enterprise Service, University of Central Lancashire (UCLan).

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