Family Art Therapy with Adolescents who Presents Self-Harming Behavior

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Family Art Therapy with Adolescents who Present Self-Harming Behavior

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Abstract

Self-harming among adolescents is a rapidly growing clinical issue. The behavior is also one of the most difficult clinical issues for many professionals (Brown and Kimball, 2013; Favazza, 1998; Muehlenkamp & Gutierrez, 2004; Selekman and King, 2001). Therefore, it is essential to integrate and evaluate past treatment approaches and underlying theories to determine goals that address all aspects of self-harming behavior among adolescents. An array of literature exists relating the inability to regulate emotions in a healthy manner with adolescents who present self-harming behavior. This thesis addresses a psychodynamic framework that identifies the importance of early parent-child relationships. Although past literature addressing effective treatment for self-harming individuals is limited, it was found that adolescents tend to respond effectively to creativity and art-making when used as tools to regulate emotions (Huss et al., 2010; Malchiodi; 2003; Riley, 1999). This thesis provides a review of literature that discusses the phenomenon of self-harming behavior, past treatment suggestions, and theoretical information that supports family art therapy as an effective approach for most adolescents who self-harm for emotional regulation. The literature also provides information suggesting that the family may be counterproductive or even dangerous for an adolescent who self-harms. Therefore it has been concluded that one treatment plan cannot be generalizable enough to fit all families. However, some treatment goals were suggested that integrated psychodynamic theory, family art therapy, and self-harming behavior.
Dedication

I dedicate this thesis to the people in my life that I love. I am grateful for the extensive support and understanding these last two years.

To my Mother and Father:

I would like to thank the two of you most of all. Thank you for the motivation and dedication to my education and growth as a compassionate being.

To my sister, Heather:

I would like to thank you for your support, motivation and assistance in the editing process. I look forward to spending more time with you.

To all my friends:

Thank you for the dedicated support, encouragement, and laughter I needed to get through the program. You have always motivated me to be my best.

To my classmates:

I thank you all for the help and warmth you provided me throughout the program. I am blessed to have all of you as a part of my life.
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Introduction

According to Brown and Kimball (2013), the prevalence of self-harm among adolescents has grown at least 150 percent within the last two decades. “Adolescent self-harming behavior is one of the leading and most challenging presenting problems therapists face today” (Selekman and King, 2001, p. 103). As a result, it is essential to provide therapy interventions that address all aspects of this behavior. This thesis will provide a review of literature that discusses the definitions of self-harming behavior, past treatment suggestions, and psychodynamic theories that evaluate family art therapy as a treatment approach for adolescents who self-harm as a way to regulate emotions. Goals for treatment provided in this thesis are geared toward trained and certified art therapists that could potentially interact with adolescent clients who self-harm and evaluate the safety of a family art therapy session with an adolescent who self-harms. Any clinician who might interact with self-harming adolescents and their families must have an understanding of possible etiologies and ways to safely approach those who self-harm.

Brown and Kimball (2013) suggested that there are no empirically supported treatments available to decrease or slow the nationwide growth of self-harming behavior. However, the author noted that using family therapy within the framework of attachment theory could be an effective way to approach an adolescent’s self-harming behavior. Because affect regulation and coping skills are learned during infancy (Kissil, 2011) and self-harming adolescents have reported having trouble expressing their emotions (Brown & Kimball, 2013), the use of nonverbal symbolic communication in family art therapy seems to have the potential to help self-harming adolescents. For adolescents, being creative while working with the family can promote needed re-established bonds with parents in order to learn and internalize healthy ways to express emotions.
Many researchers have discovered a positive correlation between dysfunctional attachment among families and adolescents who self-harm (Brown and Kimball, 2013, Sim, Adrian, Zeman, Cassano, and Friedrich, 2009, Kissil, 2011, and Bureau et al., 2010). These researchers propose that the adolescents were never properly equipped with healthy skills from their caregivers to appropriately regulate and express overwhelming feelings of distress or even happiness. Research regarding attachment among children and parents demonstrates that children who are raised in homes with dysfunctional parenting could be at risk of developing the appropriate skills needed to cope with biological changes and social stressors that can promote depressive thoughts and traits (Kissil, 2011). Sim et al. (2009) mentioned that a parent’s emotional reaction to his or her child’s emotional reaction has a major influence on that child’s ability to moderate emotions later in life. The authors suggest that children in families that are accepting of emotions are more likely to develop enhanced awareness of emotion as well as be able to recognize how different emotions can affect his or her environment. On the contrary, Sim et al. (2009) suggested that if a family were to reject the expression of emotions by punishing or dismissing the child’s expression of emotion, the child is more likely to implement poor coping strategies such as self-harming behavior. This invalidating environment might look, to a child, like an inappropriate, erratic, or complete nonrecognition or denial of the child’s emotional expression. As a result, these adolescents’ ability to express emotions appears to have been damaged (Sims et al., 2009). According to Sim et al, (2009) individuals raised in these environments are prone to having difficulty accurately identifying their emotions and expressing them. This struggle could potentially heighten their risk in engaging in self-harming behaviors (Sim et al., 2009).
When researchers aimed to study dimensions of self-harm, they discovered that many adolescents reported feelings of fear, alienation (Brown and Kimball, 2013), and isolation (Brown, 2013). In their qualitative study, Brown and Kimball (2013) discovered that many adolescents reported that their relationships with their families did not provide a healthy space for emotional expression. The researchers found that self-harm became the adolescent’s reliable coping strategy that veered attention away from overwhelming emotions by focusing on physical pain.

It is still uncertain what the most effective treatment is for those engaging in self-harming behavior (Brown, 2013). Several researchers have studied therapeutic approaches to this type of behavior that include dialectical behavior therapy (Feigenbaum, 2010), cognitive behavior therapy (Moorey, 2010; Slee, Spinhoven, Garnefski, and Arnsman, 2008), and emotion regulation group therapy (Graz and Tull, 2011). However, many available treatments do not directly address the systematic aspects of early family relationships with adolescents who self-harm (Kissil, 2011).

Because the capacity to regulate emotions begins to develop during the attachment relationship in infancy, investigating self-harm within the context of attachment theory seems appropriate (Kissil, 2011). Kissil proposed that family therapy appears to be an integral component when working with adolescents who self-harm and are still dependent on their families. Because appropriate attachments among family members tend to correlate with the capacities for adolescents to regulate emotions and self-harming behavior, family therapy with adolescents who self-harm can help repair attachments among family members. This reattachment during family therapy appears to be a major contributor to decreasing the tendency for an adolescent to self-harm in order to manage overwhelming emotions (Kissil, 2011).
Integrating art therapy and family therapy can provide a way for families to interact and express emotions to one another while using art and creativity to discover deeper levels of experiential understanding for an individual and her family during treatment (Kerr and Hoshino, 2008). It can promote the process of repairing attachments, identifying emotions, regulating emotions, and implementing effective communication among family members to ultimately help the adolescent decrease self-harming behavior. Riley (1999) offered art therapy as a way to dive into the internal world of a troubled adolescent. She encouraged art therapy as a “therapeutic tool to encourage the story the youth would like to tell” (Riley, 1999, p. 21). Through art, the adolescent has the chance to view the problem and use creativity to solve it (Riley, 1999).

Kerr and Hoshino (2008) discussed that in families with adolescents, family art therapy can simulate the emotional interactions that were important during early childhood experiences. This is beneficial for adolescents who self-harm because the adolescent may not have had the emotional experiences in early childhood needed to develop a way to regulate and cope with emotions in a healthy manner. Current research regarding attachment is “beginning to link the capacity to develop coherent narratives about attachment experience with the possibility of transforming attachment patterns” (Kerr and Hoshino, 2008, p. 76). In her mother-child group art sessions, Judy Rubin (1978) discovered that a shared creative experience between parent and child holds the potential to discover new forms of communication. Woodcock (2003) considered that positive coping skills may occur when an adolescent has the ability to direct his or her feelings of rage, pain, shame, and other strong feelings into art making. This can then be shared with the art therapist and the adolescent’s family.

Adolescents seem to respond to creativity as well as art-making and previous research has proposed a need to include the family in treatment for adolescents who self-harm. Could
family art therapy contribute to the treatment of this population by integrating these crucial components? It seems as though the self-harming adolescent needs an appropriate outlet for emotional expression as well as an opportunity to establish new connections with family members. It also appears essential to motivate and provide the opportunity for family members to accept and discuss emotions appropriately with one another to promote healthy expression of overwhelming emotions. It is hypothesized that family art therapy would be an appropriate therapeutic approach for families and their adolescents who self-harm. The purpose of this thesis is to provide an overview of the concepts and common diagnoses affiliated with self-harm, psychodynamic theories that support the integration of art and family in the therapeutic environment, and past treatments that have addressed these behaviors. Because self-harming adolescents can come from several different types of familial patterns, family art therapy goals will be suggested that could help practitioners create safety plans and interventions that address specific issues presented by each family.
Methodology

According to Whittemore and Knafl (2005) integrative review research is a systematic method that practices reflecting, questioning, and focusing. The authors state that this is an approach that allows for experimental and non-experimental research to be integrated in order to have a wide understanding of a phenomenon. This integrative understanding can help create a comprehensive intervention for adolescents who self-harm. By studying the literature that describes the experiences of self-harming adolescents as well as the previous treatment approaches, this study hopes to promote family art therapy as a comprehensive treatment approach that addresses several aspects of an adolescent's motivation to self-harm.

The search strategy for this systematic review of literature consisted of the use of multiple databases provided through Indiana University-Purdue University of Indianapolis University Library, and through sources provided by art therapy research advisors at Herron School of Art and Design. Databases used to review the literature included PsycINFO and WorldCat as well as several others presented in Table 1. References were also found using reference lists from enlightening articles.

Table 1

Databases from Which References were Retrieved

<table>
<thead>
<tr>
<th>Alphabetical Listing of Databases Utilized</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ArticleFirst</td>
<td>PsycARTICLES</td>
</tr>
<tr>
<td>CrossRef</td>
<td>PsycINFO</td>
</tr>
<tr>
<td>EBSCOHost</td>
<td>PubMed</td>
</tr>
<tr>
<td>ERIC</td>
<td>ScienceDirect</td>
</tr>
<tr>
<td>MEDLINE</td>
<td>Web of Science</td>
</tr>
<tr>
<td>ProQuest Central</td>
<td></td>
</tr>
</tbody>
</table>
Search

The search was conducted using current sources ranging from 2003 to 2013. However, sources ranging from 1953 to 1992 were also used for information regarding philosophies of significant theorists that are important to address in this review. Years of publication for articles, books, and other resources are presented in Table 2.

Table 2

Publication Dates of Resources

<table>
<thead>
<tr>
<th>Publication Date</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-2013</td>
<td>15</td>
<td>14%</td>
</tr>
<tr>
<td>2000-2009</td>
<td>54</td>
<td>49%</td>
</tr>
<tr>
<td>1990-1999</td>
<td>23</td>
<td>21%</td>
</tr>
<tr>
<td>1980-1989</td>
<td>9</td>
<td>8%</td>
</tr>
<tr>
<td>Pre-1980</td>
<td>9</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>100%</td>
</tr>
</tbody>
</table>

The primary key terms researched include several terms that are used among professionals to describe self-harming behavior. These terms include, “self-harm,” “self-mutilation,” “deliberate self-harm (DSH),” “self-injury,” and “non-suicidal self-injury (NSSI).” These terms were then paired with other search terms applicable to self-harming behaviors,
treatments, and aspects that describe the phenomena. All articles referenced are written in English. Table 3 outlines the terms used in the databases during the research process.

Research was not limited to the field of art therapy and family therapy because it is important to gain a wide perspective of all health professions that contribute to interventions and theories regarding adolescent who self-harm. Research literature addressing interventions other than family art therapy included individual therapy, dialectical behavior therapy, cognitive behavior therapy, group therapy, and Emotion Regulation Group Therapy. In addition, literature describing theories that address parent-child relationship were addressed. These theories include Bowlby’s (1977) Attachment Theory, and Winnicott’s (1953) Object Relations theory.

Table 3

*Search Terms and Phrases*

<table>
<thead>
<tr>
<th>Self-Harm</th>
<th>Art Therapy</th>
<th>Family Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliberate Self-Harm</td>
<td>and Alexithymia</td>
<td>Family art therapy</td>
</tr>
<tr>
<td>Self-mutilation</td>
<td>and adolescents</td>
<td>and Attachment Theory</td>
</tr>
<tr>
<td>Self-injury</td>
<td>and self-harm</td>
<td>and Object Relations</td>
</tr>
<tr>
<td>Cutting</td>
<td>and Attachment Theory</td>
<td>and Transitional Object</td>
</tr>
<tr>
<td>Emotion Regulation</td>
<td>and Object Relations</td>
<td>and Separation Individuation</td>
</tr>
<tr>
<td>and Dialectical Behavior Therapy</td>
<td>and Transitional Objects</td>
<td>and self-harm</td>
</tr>
<tr>
<td>and Cognitive Behavior Therapy</td>
<td>and adolescents</td>
<td>and group therapy</td>
</tr>
<tr>
<td>and Alexithymia</td>
<td></td>
<td>and Alexithymia</td>
</tr>
</tbody>
</table>
and Attachment Theory
and Object Relations Theory
and Transitional Objects

The method of data management used in this study was the matrix method. In this method each data source was organized by title, author, and year, methods, participants, variables and constructs, data collections, results, implications, and key terms. This data was then compared and analyzed to find patterns and trends among the literature. Discovering trends, implications, and previous findings in the literature about helping those who self-harm can help propose family art therapy as a comprehensive intervention. This data can be found in Appendix A.

Table 4

*Types of Resources*

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Articles-including peer reviewed journals</td>
<td>79</td>
<td>72%</td>
</tr>
<tr>
<td>Books/Chapters</td>
<td>27</td>
<td>24%</td>
</tr>
<tr>
<td>Doctoral Dissertations</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>100%</td>
</tr>
</tbody>
</table>
Review of the Literature

The following review of literature discusses self-harming behavior, treatments currently used to address the behavior, and an overview of theories to support the efficacy of family art therapy with this population. The review begins with a background on self-harming behavior among adolescents with a focus on the definition of self-harm, biological implications of self-harming behavior, and a description of the onset and prevalence of the behavior. Then, a description of the conscious motivations as reported by adolescents who self-harm will follow.

The theoretical frameworks include theories of the collective unconscious and personal unconscious that include topics of ritualism, Object Relations, the transitional object, and attachment theory as they all relate to self-harming behavior. Diagnoses affiliated with self-harming behavior and individual and group therapies that a typical treatment facility would consider will follow. Family therapy is introduced as a means to approach self-harming adolescents. Finally, a focus on the theories and information regarding art therapy will be explored to support family art therapy as an effective approach for adolescents who self-harm as a way to regulate emotions.

Self-Harming Behaviors

Favazza (1998) defined self-harming behavior as a deliberate and direct destruction of body tissue without suicidal intent. While those who self-harm do so to cope with stress, those who attempt suicide do so to remove themselves from the stressful situation (McFadden, 2005). Favazza (1998) described self-harming patients as some of the most difficult to interact with. The author noted that a clinician who works with these patients often feel helpless, guilty, disgusted, betrayed, and sad. He stated that self-harm has been widely misunderstood as a suicide attempt. However, self-harm tends to be presented as an act toward goals of self-soothing
(Favazza, 1989; Rissanen, Kylma, Laukkanen, 2011; Milia, 2000; McFadden, 2005; Hicks and Hinck, 2008).

The different terms used to describe self-harm can create difficulty in understanding the phenomenon. The three most common terms used include, self-harm, self-injury, and self-mutilation (Rissanen et al., 2011; McFadden, 2005; Selekman & King, 2001; Sim et al., 2009; Hilt et al., 2008) other terms include autoaggression, self-cutting, delicate self-cutting, and deliberate self-harm (McFadden, 2005). For the purpose of this essay, self-harm will be the term used to describe this behavior.

According to Favazza (1998) self-harm has been regarded by many clinicians solely as a symptom or criterion of a separate mental diagnosis such as borderline personality disorder. However, other clinicians and researchers argue that because this behavior exists among individuals without mental diagnoses, self-harming behavior could be considered a separate clinical syndrome (Favazza, 1998; Muehlenkamp, 2005). In 1938, Karl Menninger attempted to classify self-harming behavior into four categories: neurotic, psychotic, organic, and religious. However, since Menninger’s proposed classification, there were very few empirical studies regarding self-harm, and many clinicians and researchers were unable to agree on a common definition or term to describe self-harm. As a result, Menninger's classification was not widely accepted (Favazza, 1998; Muehlenkamp, 2005). In 1983, Pattison and Kahan developed the term “Deliberate Self-Harm Syndrome” (McFadden, 2005, p. 21) to describe self-harming behavior. Pattison and Kahan’s attempt to compartmentalize different components of self-harm helped clarify some confusion about self-harming behavior among mental health professionals (Favazza, 1998; Muehlenkamp, 2005). In 1996, the diagnosis was relabeled by Favazza and Rosenthal as “Repetitive Self-Harm Syndrome” (Favazza, 1998, p. 262). They refined the
diagnosis by subdividing the syndrome into three specific categories: Major, Stereotypical, and Superficial/Moderate Self-Harm. Major self-harming might include eye extracting, scalping, or amputation of genitals, arms, legs, breasts, or any self-harming act with a great deal of tissue damage. This type of behavior is typically associated with states of intoxication, major depression, mania, or schizophrenia (McFadden, 2005; Favazza 1998).

Stereotypical self-harming includes episodes of head banging, self hitting and biting, throat and eye gouging, dislocating joints, or tooth extractions. These behaviors are typically prevalent in individuals with disabilities associated with acute psychosis, schizophrenia, autism, Lesch-Nyhan syndrome, de Lange syndrome, Retts’ disorder, neuroacanthosis, and Tourette syndrome (Favazza, 1998). This thesis will primarily focus on the superficial/moderate category of self-harming behavior, which is the most common form of self-harm among adolescents. This category includes hair pulling, nail biting, skin picking and scratching, skin cutting, carving, and burning, bone breaking, and interfering with healing wounds (Favazza 1998).

Common self-harming behaviors among adolescents can include the intentional act of cutting, scratching, or burning skin on parts of the body, punching oneself, banging head repeatedly, pulling hair, scratching scabs or previous wounds, and breaking bones (Favazza, 1998; Brown and Kimball, 2013). These behaviors are characterized as repetitive and low-lethal acts that damage the body tissue without the intent of suicide (McFadden, 2005). The act of cutting to self-harm generally refers to using razor blades, scissors, knives, needles, tacks, pins, fingernails, and broken glass to injure their skin. Many adolescents who burn their skin might use lighters, cigarette butts, matches, or any heat source that has the ability to burn skin. Scratching refers to scratching the skin until it is raw or until blood is drawn (McFadden, 2005; Favazza, 1989) Common locations on the body that adolescents harm their body include the
forearms, wrists, thighs, abdomen, ankles, feet, armpits, and under the breast. Many adolescents who self-harm use multiple methods to harm these areas of the body (McFadden, 2005; Favazza, 1989)

**Onset and Prevalence of Self-Harm**

Research supported that self-harming behavior can begin between the estimated age range of 5 and 17 years old. This research also found that self-harming behaviors will often persist for approximately 10 to 15 years (Muehlenkamp, 2005; Muehlenkamp & Gutierrez, 2004; McFadden, 2005). Muehlenkamp (2005) cited that adolescents who self-harm reported harming themselves between approximately 50 and 400 times. Self-harming this frequently can lead to accidental critical wounds or death (Muehlenkamp, 2005).

It is difficult to report an accurate prevalence of self-harming behavior since it occurs in several facilities, is frequently unnoticed by clinicians, and is often hidden or unreported by patients due to embarrassment or shame (Muehlenkamp & Gutierrez, 2004; Muehlenkamp, 2005). However, in 1998 Briere and Gil conducted a study surveying the general population in order to uncover the prevalence of self-harm among adults. The authors found that 4% of the general population reported at least one occurrence of self-harm without intentions of suicide within the previous six months. The researchers also found that approximately 21% of adults in inpatient and outpatient mental health facilities reported self-harming behaviors. Other researchers estimated that 13 to 46 percent of adolescents and college students self-harm (Ross & Heath, 2002; Muehlenkamp & Gutierrez, 2004; Muehlenkamp, 2005; Hilt et al., 2008; Brown & Kimball, 2013). Of the individuals who reported self-harming behaviors, Favazza (1998) estimated that 40 to 65 percent had been sexually abused in the past.
Ambivalence exists among studies that address gender differences of individuals that self-harm. Muehlenkamp and Gutierrez (2007) indicated that females were more likely to self-harm while others found no difference between genders (Briere & Gil, 1998; Muehlenkamp & Gutierrez, 2007). The ambiguity in research might suggest researcher bias, differing sampling techniques, or expectations and trends influencing disclosure of behavior (Brown & Kimball, 2013).

Muehlenkamp (2005) warned that reported prevalence rates of self-harming must be understood with skepticism. The estimates are likely to be low because self-harming behavior “produces wounds that most individuals can care for by themselves” (p. 327). Even though researchers have discovered the troubling popularity of self-harm among adolescents, in order to decrease these rates, more research is needed to assist professionals in understanding the concepts and factors that lead individuals to self-harm (McFadden, 2005).

Motivations of Self-Harming Behavior

After reviewing health, psychology, and education literature up to 2007, Hicks and Hinck (2008) defined self-harm as the deliberate act of tissue destruction, without the aid of another person, in order to alter overpowering emotional feelings with a more recognizable physical pain. In this study, Hicks and Hinck (2008) found that the lack of coping skills and unhealthy responses to stressful situations can result in the unbearable amount of emotion that can push an adolescent to find physical pain for relief.

Self-harm tends to be an impulsive act rather than the result of a long process of planning and decision-making. Immediate internal and external experiences tend to influence the behavior (Nock, 2005; McFadden, 2005). In 2005, Nock organized several motivations for self-harming into four categories: automatic negative reinforcement, automatic positive reinforcement, social
negative reinforcement, and social positive reinforcement (Nock, 2005; McFadden, 2005, Hilt et al., 2008).

Automatic negative reinforcement, according to Nock (2005), is a process in which individuals attempt to avoid or decrease emotional pain. Researchers claim that adolescents self-harm as an effort to replace or avoid emotional pain with physical pain in order to self soothe (Favazza, 1998; Selekmam & King, 2001; Nock, 2005; Hilt et al., 2008; Rissanen et al., 2011; Scoliers et al, 2009; Brown & Kimball, 2013). Favazza (1998) mentioned that many of his patients reported racing or chaotic thoughts before self-harming. Many self-harming adolescents will harm themselves as an attempt to cope with overwhelming emotions, (Brown & Kimball, 2013; Scoliers et al., 2009) emotional abuse, or family violence (Selekmam & King, 2001). Selekmam and King (2001) described that the self-harming adolescent “[feels] tired of dealing with so much emotional pain that the focus on the physical pain of the cutting behavior is almost a relief in that it seems easier to deal with and accept” (p. 89).

Many researchers agree that one of the main components of self-harm is the regulation of overwhelming emotions (Brown & Kimball, 2013; Cooper & Milton, 2003; Cross, 1993; Crouch & Wright, 2004; Farber, 2000; Favazza, 1987; Harris, 2000; Herman, 1992; Hewitt, 1997; Hirsch 1994; Scoliers et al., 2009; Selekmam & King, 2001; Suyemoto, 1998; Suyemoto & Macdonald, 1995; Walsh & Rosen, 1988; van der Kolk, 1987). Self-harm is used to express, externalize, control, and avoid distressful emotions that are thought to be too difficult to change or contain. Favazza (1987) described self-harm as a remarkably effective technique in reducing tension and releasing anger, but the effects are so temporary that the actual conflict is never addressed. Although a sense of relief from self-harming might only last a few hours, the
instantaneous gratification may actually reinforce the behavior to continue (Suyemoto, 1998; Shalmon, 2007).

Nock's (2005) next category of the motivations behind self-harming behavior is automatic positive reinforcement which refers to the adolescent's attempt to "feel something" (McFadden, 2005, p. 29; Hilt et al., 2008; Rissanen et al., 2011). Favazza (1998) noted that while many of his patients claimed to experience an overwhelming amount of emotion before they decide to self-harm, many other patients claim to self-harm to find temporary relief from feelings of depersonalization, numbness, unreality, or emptiness (Favazza, 1998). Selekm and King (2001) described this sensation as an inability to connect the physical and emotional self. The authors stated that adolescents that experience these feelings may self-harm as "a way to return to reality or to jar themselves back to touch with themselves and their bodies" (p. 89).

Self-harm is extremely effective in ending dissociative experience due to the sight of blood (Farber, 2000; Favazza, 1987; Herman, 1992; Hewitt, 1997; Milia, 2000; Shalmon, 2007; Suyemoto, 1998; Suyemoto & Macdonald, 1995). Many of these individuals claim to not feel any pain when they self-harm. This claim is indicative of their state of dissociation, or mental separation, from the body (Favazza, 1987; Suyemoto, 1998). Many researchers agree that for these adolescents, the sight of blood brings them back to reality by evidencing that they are alive (Cooper & Milton, 2003; Hewitt, 1997; Favazza, 1987; Milia, 2000; Suyemoto, 1998).

The last two categories that Nock (2005) proposed as the major reasons for self-harming include social negative reinforcement and social positive reinforcement. Social negative reinforcement describes the concept of individuals harming themselves to veer their attention away from hurting someone else (Selekm & King, 2001; McFadden, 2005; Nock, 2005).

Finally, some adolescents have found that self-harming is a way for them to seek the attention
that they desire (Favazza, 1998; Scoliers et al., 2009; Rissanen et al., 2011). Rissanen et al., (2011) described that some self-harming adolescents will seek attention to get help or to be noticed by family members or peers.

In addition to Nock’s (2005) four categories, researchers have found additional motivations to self-harm among adolescents. According to Rissanen et al. (2011) and Selekman and King (2001) some adolescents self-harm in order to gain control over their bodies. Especially if the adolescent’s body has been damaged as a result of abusive situations, an adolescent may self-harm as a way to self-preserve or take back the control over their bodies and skin (Rissanen et al., 2011; Selekman and King, 2001).

Researchers have also found that self-punishment is another reason some adolescents self-harm (Favazza, 1998; Rissanen et al, 2011; Scoliers et al., 2009; Brown and Kimball, 2013; Selekman and King, 2001). Selekman and King (2001) explained that punishing the self helps to confirm an adolescent’s belief that they are guilty and deserve to be punished. This type of punishment is said to help the adolescent change the view of themselves from “bad” to “good” (McFadden, 2005; Milia, 2000)

Scoliers, et al. (2009) conducted a cross-sectional survey and self-report questionnaires to discover the reasons for deliberate self-harm. The results confirmed their hypothesis that there are two themes that underlie adolescent self-harm. The first theme presents a “cry for help” (Scoliers et al., 2009, p. 1) or attention, while the other presents a “cry of pain” (Scoliers et al., 2009, p. 1) or a desire to punish the self. However, this study suggested that the reason most frequently reported for self-harming behavior is the desire to gain relief from overwhelming emotions and a desire to die (Scoliers et al., 2009). However, other studies mention that self-harming can be a way for adolescents to prevent themselves from committing suicide.
Brown and Kimball (2013) conducted a phenomenological study where eleven participants described their experiences of self-harm. Participants reported that they felt as if others greatly misunderstand the reasons for self-harm. Although it is important to assess for suicidal ideation, participants reported that they do not self-harm as a means to attempt suicide, but it is a way for them to cope with overwhelming emotions. Participants revealed that they were able to regulate extremely stressful feelings by self-harming (Brown and Kimball, 2013). The participants who self-harm also reported feelings of isolation and traumatization during childhood. As a result, they tended to seek ways to manage stress by self-harming. Participants also reported the need for self-harm as a form of punishment regarding traumatic experiences (Brown and Kimball, 2013).

**Theoretical Frameworks of Self-Harm**

Although Nock (2005) and many other clinicians and patients have described self-harming as a way to avoid emotional pain, end a dissociative experience, veer attention away from hurting others, seek attention from others, or punish the self, it is imperative that clinicians and researchers explore underlying theories to explain the manifestation of self-harming behavior. In this paper, psychodynamic theory is explored to help better understand self-harming behavior. Psychodynamic theories are necessary to explore when investigating motivations for the behavior and implement appropriate treatment intervention for these patients. A psychodynamic approach to understanding and addressing those who self-harm can help the therapist and client understand the origins and development of the client’s self-harming behavior, and therefore become more mindful of emotional expression, coping with negative affect, handling feelings of depersonalization, and understanding the boundaries between client and others (Kumar, Pepe, Steer, 2004). Collective unconscious and unconscious phenomena will be
connected with the self-harming behavior of contemporary adolescent patients. A cultural and ritualistic framework is first introduced as containing archetypes of the collective unconscious to help clinicians understand possible motivations behind the behavior. Then, Object Relations and Attachment Theory are introduced in order to connect childhood upbringing and self-harming behavior later in adolescence.

**Cultural Rituals and Practices**

To help examine and understand the concept of self-mutilation among adolescents in inpatient and outpatient levels of care further, Favazza (1989) examined self-harm behavior as connected to the concept of cultural sacrifice:

The self-mutilative acts of some mentally ill persons may be understood in the light of this mythic process. Their bodies become a microcosm of the vaster cosmos, and the irresistible urge to self-mutilation becomes an unconscious reenactment of the cosmogonic myth in which chaos is averted and a new order established. Self-mutilation offers a temporary respite from illness rather than a permanent cure because the sacrificial death of the Primordial Being is not emulated; the mentally ill person sacrifices a body part or a portion of blood in order to achieve a modicum of well-being. A partial sacrifice achieves only partial peace (Favazza, 1989, p. 24).

Favazza (1989) examined self-harm in the context of cultural rituals and practices since many religions practice bodily mutilations in order to help individuals cope with suffering and establish order from chaos. He reported that many of his patients explained that self-harm temporarily reduces many pathological symptoms including anxiety, guilt, disassociation, and
hallucinations. He thought that an understanding of religion could help professionals understand the motivations behind adolescents’ self-harm. Because this behavior exists among different cultures and time frames, it seems as if ritualistic tendencies could be derived from the collective unconscious.

Jung (1969) introduced the concept of the collective unconscious to distinguish from the personal unconscious. While the contents of the personal unconscious are developed from forgotten or repressed experiences, the contents of the collective unconscious owe their existence to heredity. Additionally, while the personal unconscious consists of complexes, the collective unconscious consists of archetypes, or actions and situations that seem to represent universal patterns of human nature (Jung, 1969). The ritualistic aspect of self-harming behavior could be considered to have evolved from the collective unconscious that contains these archetypes.

Self-harm from the perspective of an adolescent in an inpatient or outpatient setting may be viewed as a pattern of instinctual behavior in the form of sacrifice or an attempt to transform into adulthood as a way to promote healing (Milia, 2000; Favazza, 1989). The idea of sacrifice and transformation could be affiliated with the sacrificial “scapegoat” that takes the blame for negative situations or the heroic journey to discover new land. According to Jung (1969) these mythological characters reside within people all over the world. However, self-harming behavior is not considered a healthy outlet for addressing these archetypal desires. Although this paper addresses the concepts of sacrifice and transition as related to archetypal characters, the complex topic of the collective unconscious is beyond the scope of this paper to discuss more possible connections between self-harming behavior and the collective unconscious.

An example of a ritual that incorporates self-harm as a form of transition and sacrifice exists among the Lakota Native American tribe of North America. The tribe uses ritualistic self-
harm as a major form of sacrifice in order to cope with suffering and promote well-being. During certain ceremonies, “dancers” of the tribe undergo high levels of pain and torture, including acts of peeling flesh, staring into the sun, and piercing the skin with sharpened objects. During the ceremony, the dancer’s family might pay a healthy amount of gifts to release a family member who is being tortured. This can help redistribute wealth among the Lakota community. In addition to redistributing wealth, the dancer who undergoes the most extreme level of torture has proven his eligibility for leadership, high reputation, and the role of a warrior. This sacrificial ritual is also considered to promote recovery of an ill relative or repay the gods for their own recovery from illness.

A more common example of ritualistic self-harming behavior is the act of circumcision among Jewish and Christian religions. The Bible stated that God expressed to a patriarch, “every male among [human kind] shall be circumcised. [The patriarch] shall circumcise the flesh of [his] foreskins, and it shall be a sign of the covenant between [God] and [the patriarch]” (Gen. 17:10-12, New Revised Standard Version). The scripture goes on to say that if a male is not circumcised, he will be cut off from his people because he has broken the agreement. The attempt to sacrifice the self as a way to connect to a higher power or to an authority figure among the Lakota tribe and Jewish religion seems to reflect an adolescent’s unconscious attempt of sacrificing the self. Sacrificing the self, or self-harming, can help the adolescent establish an unconscious boundary between the role of the child and the role of the parent in order to perceive the parent as a “good” object again.

**Culturally Sanctioned and Pathological Self-Harm**

Favazza (1989) divided self-harm into two major categories: culturally sanctioned and deviant-pathological. Culturally sanctioned self-harm is described as the rituals and practices that
infect self-harm in order to honor several generations of traditions, beliefs, and symbolism of a society such as the act of circumcision or torturous acts to prove strength. Self-harming in this manner affects the individual as well as the entire community. Self-harming rituals are practiced in order to prevent a dysfunctional society that might include disease epidemics, angry gods, failure to accept personal responsibilities, loss of group identity, unclear social roles, dissident behaviors, or environmental disasters. Self-harming rituals act as a way to correct these conditions if they occur. The rituals are believed to have the ability to promote healing, spirituality, and social order (Favazza, 1989).

In contrast, Favazza (1989) explained that self-harm is considered deviant-pathological when it becomes extremely individualized, personal, and does not have aesthetic value or ritual significance to society. This type of self-harm is typically performed in secrecy. After self-harming, individuals often feel guilty or shameful. These uncomfortable feelings may be a result of the individual’s cultural values that do not sanction acts of violence. The feelings may also not be understood by the individual because the behavior might be a result of collective unconscious or unconscious motivations. Therefore, the conscious meaning behind culturally sanctioned and pathological self-harm might differ. However, it is possible that the underlying and unconscious reasons for both types of self-harm could be understood as similar in a symbolic context.

**Contemporary Adolescent Self-Harming as Sacrifice**

Milia (2000) described the concept of sacrifice as necessary violence to prevent violence. She introduced several cultures that incorporate self-harm as a primary form of sacrificial rituals to promote purification, healing, and maturity. The author described how violence in the community, such as the Lakota tribe, can be channeled toward a scapegoat because the scapegoat acts as a boundary between “good” and “bad” violence. One way violence can be “pure” is the
dedication and blessing of a sacrificial victim. Violence in a “pure” form can also be seen in the biblical ritual of circumcision among male infants. The violence performed upon the infant is considered “pure” because it symbolizes the connection and obedience to God. This sacrifice serves as the “transformation of the victim into a venerated deity, or of bad into good” (Milia, 2000, p.185). Milia’s (2000) description of this transformation can relate to Favazza’s (as cited in Nicholson, 2004) approach that self-harming among the American adolescent culture is an urge to be initiated and transformed into adulthood.

Milia (2000) explained, more specifically, how the concept of self-sacrificing among the Lakota tribe, as well as other cultures, relate to contemporary adolescents who self-harm. Self-harming can be a way for adolescents to convert “bad” events or people into “good” by establishing a boundary between child and parent. Just as the Lakota dancers undergo severe pain as a sacrifice in order to allow for distribution of wealth among the community and to please the gods and icons, the sacrifice of a self-harming adolescent is meant to transform the other, such as a parent, from bad to good.

When considering the developmental stages of children, the knowledge that a parent is immoral can be too devastating to bear. The child protects his or her perception of the parent by assuming blame for the parents. This thought processes ensures the benevolence of the parent and the boundary between the role of the parent and the role of the child. During this time, the self-harmer chooses to be the “bad one” or a substitute sacrificial victim. Then, this “self-sacrificing” performance purifies the child, reversing him once again to a position of good (Milia, 2000). This transformation of the parent from “bad” to “good” via sacrifice of the self seems to parallel the cultural ideas of “good violence” via sacrifice of willing victims to the gods and icons (Favazza, 1989; Menninger, 1938; Milia, 2000). Therefore it seems as though the urge
to act as a scapegoat in order to change “bad” events into “good” can be understood as existing on the collective unconscious level of adolescents who self-harm (Jung, 1969).

**Contemporary Adolescent Self-Harming as an Attempt to Transition**

The ritual of self-harm may represent the adolescent’s attempt to gain power and control over the self, and a way for him or her to transition into adulthood. When the member of the tribe inflicts pain on himself, the pain can be seen to achieve a transformation from a helpless victim to a strong warrior (Milia, 2000).

Favazza (1989) theorized that there was a connection between ritualistic practices of initiation to the transition adolescents experience when moving from childhood to adulthood. At an innate level, the self-harming behavior of adolescents represent attempts to avoid the “childish” feelings of loneliness or abandonment, while hoping to gain the awareness and control that leads to maturity and acceptance in the adult world. This collective unconscious desire to transform can also relate to the situational archetype of “the journey,” or the universal desire to take on a heroic journey that searches for understanding of the nature of the world. Favazza (1989) stated that self-harming among today’s adolescents is a “desperate, primitive attempt to achieve social acceptance and integration into the adult world” (p. 281). When discussing the social significance of the rites of passage, Levine (1992) used the term “liminality” to describe the state of being in a transitional space. According to van Gennep (1966) human transitions is a cosmic idea that relates to the phases of human existence. Liminality is a space of inferiority and vulnerability without the ability to belong to a role or identity. A liminal position, however, can also give a person the opportunity to transform into a better being (Levine, 1992). On a collective unconscious level, it seems as if self-harming adolescents choose to heroically endure pain and suffering because they believe their behavior acts as a way to benefit them by transitioning them
into the adult community (Favazza, 1989). However, instead of transforming into a surviving warrior as the Lakota dancers do, the adolescent is identified as a deviant pathological patient who is unable to cope with overwhelming emotions in a healthy manner.

**Childhood Trauma**

Several studies found strong correlations between self-harming individuals and a history of physical and sexual abuse (Attias & Goodwin, 1999; Cross, 1993; Farber, 2000; Favazza, 1987; Harris, 2000; Herman, 1992; Hewitt, 1997; McFadden, 2005; Milia, 2000; Miller, 1994; Suyemoto, 1998; Suyemoto & Macdonald, 1995; Turell & Armsworth, 2003; van der Kolk, 1987; Zila & Kiselica, 2001). Many researchers and clinicians have found that many of those who have been abused in childhood tend to unconsciously recreate the trauma they experienced by damaging their bodies in various ways as an unconscious attempt to express and master the trauma (Shalmon, 2007; Milia, 2000; Herman, 1992; Farber, 2000; McFadden, 2005). McFadden (2005) proposed that some adolescents who experienced severe abuse and are unable to express anger can become trapped in a cycle where they repeat the actions that happened to them as children by self-harming. As many perpetrators tend to hinder the child from verbally expressing the traumatic events, the child may learn to communicate the events physically by self-harming (McFadden, 2005). An adolescent who has experienced trauma during childhood may have coped by experiencing their body as a separate self. To end overwhelming feelings or dissociative states, adolescents may use self-harming as a way to transition back to reality (Favazza, 1987; Herman, 1992; van der Kolk 1987; Shalmon, 2007; Milia, 2000; Suyemoto, 1998; Suyemoto & Macdonald, 1995; Farber, 2000). Abuse or trauma during childhood can lead to impaired Object Relations, attachment with a caregiver, which can then lead to symptoms of diagnoses such as alexithymia, anxiety, depression, or other personality disorders. Object
Relations, transitional objects, Attachment Theory, and diagnoses related to self-harm will be addressed in more detail later in this paper.

According to Shalmon (2007) and Herman (1992), physical reenactments of childhood trauma tend to prevent the individual from remembering or integrating the trauma and help him or her avoid the memories. Milia (2000) considered that physically abused children may mimic their parent’s abuse upon themselves because of their internalization of hostile and rejecting parents. As a result, the concepts of care and pain may become interrelated, from the self-harmer’s point of view, in order to maintain some sort of connection to the abusive parent (Milia, 2000). More information regarding physical reenactments of childhood trauma by self-harm can coexist in several patients diagnosed with posttraumatic stress disorder, dissociative disorder, and substance abuse disorders. Diagnoses related to physical reenactments of childhood trauma will be discussed further in “Comorbidity of Self-Harming Behavior.”

**Object Relations**

According to McWilliams (2011), the concept of Object Relations emphasizes the primary “love objects” in an adolescent’s world during his or her early childhood. Object Relations theorists, including Melanie Klein, D. W. Winnicott, W. R. D. Fairbairn, and Otto Kernberg share the belief that early childhood experiences are internalized and are re-experienced in significant relationships later in an individual’s life (Bliss, 2010). How do the relationships with early objects live on in the adolescent’s life? Utilizing the concept of Object Relations to understand self-harm can help therapists understand how their clients experience interpersonal connections (McWilliams, 2011).

Fairbairn (1963) theorized that, as long as early childhood relationships are suitable, an individual’s ego will remain intact and the individual will have the ability to integrate internal
and external experiences in a healthy manner. However, when an individual faces unsuitable childhood relationships, he or she may experience a great amount of aggression or hatred toward the caregivers that the individual needed as a child. Because these figures were required for survival, the individual is likely to repress these feelings as an attempt to not lose the parent on whom the person was dependent. As a result, the individual’s opinions of the parental object “are split in the individual’s mind, so that they can hold onto a loving version of the other without undue anxiety or conflict” (Bliss, 2010, p. 229). The individual’s ego then strives to please the ‘good’ side of the caregiver. However, when the adolescent is influenced under the harsh caregiver, the individual might feel a great amount of pressure to satisfy this love object. As a result the individual could fall apart once he or she fails to satisfy the high expectations (Fairburn, 1963)

Fairbairn (1963) defined the libidinal ego as the “object seeking, or needy part of the self” (p. 230) that is longing for a relationship. Fairburn’s concept of the “internal saboteur,” describes the part of the self that seeks to destroy any effort to connect with others while still expecting relational needs to be met. Bliss (2010) conceptualized self-harming behavior as an internal conflict between the concepts of the libidinal ego and the internal saboteur.

**Object Relations as Related to Self-Harm**

Milia (2000) utilized the concept of Object Relations to understand adolescent self-harming behavior. The author stated that “the skin is the primary container of the body, and the degree to which the body and its contents feel good may depend upon the earliest experiences of touching and holding” (Milia, 2000, p. 61). Milia added that when a primary caretaker is not accepting or restricts the infant’s expression of aggression, the child might experience an
accumulation of hostility turned in toward the self. Common forms of self-directed aggression in early childhood can include head banging, hair pulling, and self-biting.

During early stages of development, a child may begin to associate love with pain if the child experiences harm from the primary caregiver in the form of an aggressive holding style, rejection, or harsh punishment. As a result, the child might relate physical affection with pain. At this point, the child might plea that the caregiver is a consistent “good object.” The child may be determined to protect the vulnerable self regardless of his or her poor expression of affection. In order to keep the caregiver in a positive role, a child takes it upon himself to identify as a “bad object,” occasionally described as identification with the aggressor. When directing pain upon the self, the child aims to protect and purify the primary caregiver as a “good” parental figure. The more the child internalizes the aggression from the caregivers, according to Milia (2000), the more likely the child will engage in extreme forms of self-harm. Again, this concept may be unconsciously linked to rituals like those of the Lakota tribe and Jewish practices of circumcision where “good violence,” or a willing sacrificial victim offered to the gods, is utilized in order to establish symbolic boundaries and obedience between beings (Favazza, 1989; Milia, 2000).

Because sensations of the skin allow communication with the external environment, the feelings an infant receives through touch influences the way the child perceives a relationship. If an infant experiences feelings of love and acceptance through touching and holding from the caregiver, the infant tends to internalize positive interactions with the world such as trust, unity, and wholeness. However, feelings of distrust and fragmentation may result from a negative experience with touch from the caregiver. In order to cope with negative experiences, an adolescent might resort back to these negative sensations (Milia, 2000).
Levenkron (2006) conceptualized that all humans seek what is familiar. A child can be raised in a supportive and caring home resulting in a healthy ability to express emotions, while another child can be raised in a neglectful and insensitive home that can bring about feelings of fear and abandonment. The author claimed that fear of abandonment can be one of the greatest fears a child could experience. The child accepting his or her parent as incompetent can be equivalent to having no caregivers at all. To a child, having no parents means a lack of protection and lost sense of security. Later, because interaction with others is internalized during infancy, it is the role of the adolescent to “recreate the pain that guided her through her early life, the pain that means home, safety, comfort” (Levenkron, 2006, p. 33).

Berliner (1958) suggested that aggression directed toward the self could act as a substitution for aggression toward the primary caregiver for poor treatment during the adolescent’s early childhood. In order to maintain the relationship with the caregiver, the child may accept self-harming because it prevents them from acting out aggressively against their primary caregiver, whom they still solely depend on. Milia (2000) stated that self-harming tends to occur when an adolescent expects to be abandoned by a loved one. Patterns of the adolescent’s unhealthy relationship with the primary caregiver can be replicated and mirrored in the adolescent’s future with later relationships throughout his or her lifetime (Berlinger, 1958; Milia, 2000).

**The Transitional Object**

Winnicott (1953) introduced the term transitional object to identify the first “not-me possession” (p. 89). Henley (2005) drew upon the concept of the transitional object to help describe the infant’s initial separation from the mother also called the separation-individuation phase of infant development. Henley (2005) defined the transitional object as a “symbolic
substitute for the nurturance provided by the caregiver” (p. 32). The transitional object can take
the form of the transitional space between the mother’s breast and the child’s teddy bear.
Winnicott (as cited in Henley, 2005) explained that the transitional object has the ability to exist
as the child’s inner imagination and as an object in the real world. This ambiguity between
imaginal and real is considered a transitional space according to Winnicott (as cited in Henely,
2005). Winnicott (1953) considered the transitional object as having the ability to give room for
the child to travel from a world of pure subjectivity to objectivity.

Using the transitional object is a major component of the separation-individuation phase
in infancy. It is a separate object such as a teddy bear or blanket that the infant is invested in
because of the comforting properties that remind the infant of the mother. The transitional object
has the power to comfort the infant when the mother is absent (Winnicott, 1971). Therefore, the
crisis of the separation-individuation phases is solved for the infant because he or she is able to
develop self-soothing capabilities and affect regulation techniques to use during future instances
of transition (Winnicott, 1971).

**Transitional Object as Related to Self-Harm**

Several clinicians and researchers have observed that the blood, scars, and materials used
to self-harm may operate as transitional objects. These concepts provide a soothing role when the
adolescent experiences intense negative emotions and lacks healthy self-regulatory skills
(Cooper & Milton, 2003; Cross, 1993; Farber, 2000; Favazza, 1987; Harris, 2000; Herman,
Macdonald, 1995). Clinicians have also reported that self-harming patients have referred to their
self-harming as a “special friend in time of need” (Shalmon, 2007, p. 16). Clinicians have found
that some patients reported using a blood stained cloth or a jar filled with their own blood as
transitional object (Favazza, 1987; Shalmon, 2007, p. 16). Winnicott (1971) stated that the body cannot be used as a transitional object. The transitional object must be a “not-me” possession that provides warmth. However, when the individual self-harms, feelings of a split between body and the self occurs. When a sense of body alienation is felt by the self-harming adolescent, the body is perceived as a “not-me” object to be taken possession of, and therefore serving the functions of a transitional object (Walsh & Rosen, 1988; Hirsch, 1994; Shalmon, 2007). However, using the body as a transitional object does not allow for the development of a healthy sense of self. Additionally, using the body as a transitional object does not allow the individual to develop the capacity to symbolize and are, therefore, unable to resolve the crisis of the separation-individuation phase. It leaves the self-harming adolescent in a compulsive cycle of attempting to cope with the stress by using their own body as a “not-me” object while never learning to use actual “not-me” objects to resolve the separation-individuation conflict (Farber, 2000; Milia, 2000; Shalmon, 2007).

Milia (2000) related the wounds and scars resulting from self-harming to transitional objects. If pain and neglect are internalized during infancy, the pain resulting from cutting or head banging could help an adolescent cope during the separation from a caregiver. Blood, scars, and wounds can act as a visual transitional object for these adolescents. These visual representations of pain can act as a clarification of boundaries between the inside and outside of the body. These scars can also give an adolescent a sense of pride for overcoming pain (Milia, 2000).

**Attachment Theory**

According to Bretherton (1992), Mary Ainsworth and John Bowlby helped formulate and expand Winnicott’s theory of Object Relations by establishing the theory of attachment. Bowlby
(as cited in Bretherton, 1992) formulated the idea that a child’s connection to his mother is related to the child’s disruption through separation, deprivation, and bereavement. According to Bowlby (1977) “in all things biological, it is necessary to consider both the subject and his environment and the man and his circumstances” (p. 201). Bowlby (1977) defined attachment theory as a way of understanding how humans tend to make strong emotional bonds to specific people and how these bonds can explain forms of emotional satisfaction or emotional distress including anxiety, anger, depression, and emotional detachment.

Bowlby (1977) strongly believed that a therapist must allow a client to consider how his or her current patterns and interactions with significant people in their life may have been influenced or disturbed by early childhood experiences with their parents. The author describes how the causal relationship between a person’s experiences with their parents and their capacity to make emotional bonds later in life can be revealed in marital problems, trouble with children, neurotic symptoms, and personality disorders.

Bowlby (1977) also stated that children of parents who provide an environment with a balanced experience of protection and exploration will grow to have the ability to help themselves and help others during difficult conditions. However, many children are raised with “pathogenic parents” (Bowlby, 1977, p. 206) who do not provide appropriate environments. Inappropriate parenting patterns can consist of unresponsiveness, disparagement, hospitalization or leave of absence, threats of abandonment, threats of killing another parent, and claiming that a child is responsible for a parent’s illness or death. These types of parenting not only influence a child’s anger toward a parent, but can constrain expression of their emotion. As a result, a child or adolescent is likely to have a conscious or unconscious longing for love and care. They may
search for care via superficial suicide attempts, conversion symptoms, anorexia, or hypochondria (Bowlby, 1977).

Ainsworth (as cited in Bretherton, 1992) added that the attachment figure is a secure unit once the child begins to explore the world other than the world of “mom.” Ainsworth (as cited in Bretherton, 1992) also added the concept that sensitivity to an infant’s primary needs plays a major role in the development of the attachment patterns between the infant and the mother as well as the infant and others later in life (Bretherton, 1992).

Attachment Theory as Related to Self-Harm

The literature emphasizes that the combination between traumatic experiences, insecure attachments, and disturbed Object Relations can result in the inability to self-soothe. This inability to appropriately self-soothe can lead to self-harming behavior (Favazza, 1989; Milia, 2000; Bureau et al., 2010; Sim et al., 2009; Shalmon, 2007). For individuals who self-harm, it is usually difficult to verbally express emotions. Among these individuals, emotions are typically felt as extremely powerful and threatening (Favazza, 1998; Milia, 2000; Scott, 1999; Suyemoto, 1998, Suyemoto & Macdonald, 1995; Zila & Kiselica, 2001).

The literature stressed that a disturbed Object Relations or unhealthy attachment style can result in an impaired ability to symbolize or communicate emotions (Farber, 2000; Milia, 2000; Suyemoto, 1998; Suyemoto & Macdonald, 1995) and can therefore also lead to certain diagnoses such as anxiety, alexithymia, and personality disorders. Diagnoses as related to self-harming behavior will be addressed in “Comorbidity of Self-Harming Behavior” later in this paper.

Because self-harm is often carried out by adolescents, it is possible that the developmental tasks of this age, such as separating from parents and developing a sense of autonomous identity can reactivate early traumas and unresolved issues from the separation-
individuation phase of infancy. As a result, the self-harming adolescent suffers from the inability
to appropriately regulate emotions which are perceived as intolerable and threatening to his or
her fragile sense of self. An adolescent may also experience dissociation, especially if he or she
experience abuse during early childhood. If the adolescent experienced abuse as a child, the body
may be perceived as separate from the self. There may be a deep sense of shame, self-hatred, or
unworthiness that may be confined on a part of the body that is then attacked. Self-harm acts to
reduce overwhelming tension, ends dissociative states, redirects anger onto the self, and may be
used as a transitional object in overcoming the conflicts and challenges of adolescence (Herman,
1992; van der Kolk, 1987; Shalmon, 2007; Milia, 2000; Suyemoto, 1998; Suyemoto &
Macdonald, 1995; Favazza, 1987; Farber, 2000).

In their study, Walsh and Rosen (1988) found that self-harming adolescents were
significantly more likely to have experienced a loss of their primary attachment figure during
childhood due to foster placement, neglect, or divorce. Any trauma or emotional uncertainties
experienced as an adolescent can result in hyperarousal and difficulty regulating overwhelming
emotions such as aggression or anxiety. However, if the adolescent experienced insecure
attachment styles during early childhood, these symptoms are more evident (Herman, 1992;
Klorer, 2005; van der Kolk, 1987; Shalmon, 2007). From the perspective of the Object Relations
theory, a lack of secure attachments in early childhood due to separation, abuse, or neglect can
result in a failure to develop a cohesive sense of self and the inability to cope with intense
affective experiences. A lack of secure attachments may also contribute to the child’s failure to
internalize a “good mother” that contributes to the child’s ability to self-soothe and regulate
emotions in a healthy manner (Shalmon, 2007; Farber, 2000; Favazza, 1987; Herman, 1992;
Milia, 2000; Suyemoto, 1998; Suyemoto & Macdonald, 1995). Instead, the child internalizes a
“negative ego ideal” (Noshpitz, 1994; Suyemoto, 1998) that encourages a sense of “badness” or unworthiness. These internalized negative feelings can be experienced as monstrous “and may be localized, in the act of self-[harm], onto the part of the body subject to self-inflicted damage” (Shalmon, 2007, p. 15; Herman 1992).

Additionally, Bureau et al. (2010) hypothesized that early parent-child relationship dimensions are related to self-harming behavior. The authors performed a qualitative study comparing 810 students who had never self-harmed and 105 students who claimed to have self-harming behavior. All participants were between 17 and 26 years old. After analyzing results from extensive questionnaires about relationship dimensions with parents in early childhood, the authors discovered that the participants who self-harm reported childhood relationships were characterized by feelings of failed protection from parents and fear related to abandonment. Also reported was a fear of more control exercised by parents, and increased feelings of alienation during early childhood (Bureau et al., 2010). The authors stated that the dimension of fear and alienation as significant predictors of self-harm is indicative of dysregulation within the parent-child relationship. Bureau et al. (2010) concluded that attachment theory research demonstrated that children’s disorganized attachment styles with parents tend to be marked by signals of anxiety and fear toward their parents. The participants reported early attachment experiences of fear and alienation with their parent. The authors concluded that these relationships could be associated with the unhealthy coping strategy of self-harming (Bureau et al., 2010).

Sim et al. (2009) were also interested in the associations between self-harming individuals, emotion regulation, and dysfunction in family environments. The authors performed a qualitative study with 131 adolescents between 13 and 18 years old who claim to self-harm because “this behavior reduced their negative emotional states” (Sim et al., 2009, p. 75). When
proposing cognitive behavior therapy for patients with borderline personality disorder, Linehan (as cited in Sim et al., 2009) proposed a framework which suggested that emotional dysregulation can likely be a result of an invalidating environment. According to the framework, invalidating environments prevent a child from learning how to regulate extreme emotions in a healthy way. As a result, Linehan (as cited in Sim et al., 2009) proposed that the individuals rely on self-harm as an impulsive and instantly gratifying technique to bring overwhelming emotions to a more tolerable level. In Sim et al.'s (2009) study, data was collected from interviews, an emotion expression scale for children, and a childhood trauma questionnaire. Results suggested that parental invalidation is associated with a difficulty in regulating emotional arousal. Participants who had difficulty identifying and expressing their feelings did not seem to be able to manage strong negative emotions in healthy ways (Sim et al., 2009). Childhood trauma, Object Relations theory, the transitional object, and attachment theory are not only affiliated with self-harming behavior, but other comorbid clinical diagnoses such as anxiety, depression, alexithymia, obsessive compulsive disorders, dissociative disorders, posttraumatic stress disorder, and borderline personality disorder.

**Comorbidity of Self-Harming Behavior**

According to Nichols (2000) self-harming behavior can be recognized as a symptom of a broader problem that can range from a normal phase of adolescence to a serious stage of emotional instability to a severe psychiatric disorder. Self-harming behavior has been affiliated with several mental disorders including: anxiety, depression, alexithymia, eating disorders, obsessive compulsive disorders, dissociative disorders, posttraumatic stress disorder, substance abuse, impulsivity characteristics, and borderline personality disorder (McFadden, 2005;
Muehlenkamp, 2005; Derouin & Bravender, 2004; Kumar, Pepe, & Steer, 2004; Lambert & de Man, 2007; Croyle & Waltz, 2007; Zlotnick et al., 1997; Klonsky et al., 2003).

Research indicated that anxiety plays a major role in self-harm. Evidence has supported that there are tension reducing qualities associated with self-harming behavior (Andover et al., 2005, Darche, 1990, Herpertz, 1995, Brain, Haines, and Williams, 1998). In their study Brain, Haines, and Williams (1998) discovered that individuals who self-harm showed a decrease in respiration, skin conductance level, and heart rate as a response to self-harming images which indicated a reduction in anxiety. Researchers additionally found that individuals who self-harm are more likely to have experienced increased levels of anxiety in the past (Klonsky, Oltmanns & Turkheimer, 2003; Penn, Esposito, Schaeffer, Fritz, & Spirtito, 2003, Ross & Heath, 2002). In their study, Klonsky, Oltmanns, and Turkheimer (2003) also found a high prevalence of symptoms of anxiety among participants who self-harmed compared to those that do not. Finally, one study found that several individuals who self-harm reported feelings of anxiety during childhood (Fulwiler, Forbes, Sanrangelo, & Folstein, 1997; Andover et al., 2005). This anxiety during childhood may be connected to unhealthy attachments or separation from caregivers. Due to the possible unstable attachments, the child’s experienced anxiety with caregivers may have been generalized to others in life as they mature into adolescence.

According to Borrell, Fox, Flynn, and Roger (2009) alexithymia is a term used to describe difficulties in expressing and identifying emotions. Researchers have connected childhood trauma and symptoms of alexithymia to self-harming behaviors (Muehlenkamp, 2005; Shalmon, 2007). “Results of recent studies also supported the view that alexithymia is a transmission mechanism between negative attachment experiences and impaired interpersonal functioning which, in turn, has been linked to [self-harm]” (Paivio & McCulloch, p. 342). Lambert and de
Man (2007) conducted a correlational study comparing fifteen adolescent females with self-harming behavior and eighteen adolescent females who do not self-harm. Using the Toronto Alexithymia Scale, Bermond-Vorst Alexithymia Questionnaire, and the Beck Depression Inventory, the authors found that there is a positive correlation between self-harming individuals, a major factor of alexithymia, and depressive traits. Participants who self-harm tended to have depressive symptoms as well as a difficulty identifying feelings and differentiating them from physical sensations (Lambert and de Man, 2007).

Zlotnick, Shea, Recupero, Bidadi, Pearlstein, and Brown (1997) mentioned that a major characteristic among those who suffer from posttraumatic stress disorder present several maladaptive defenses including dissociation, self-harm, and substance abuse. Their study consisted of 85 patients attending an inpatient substance abuse treatment program. The authors assessed each participant for trauma, dissociative experiences, self-harm, and impulsivity such as binge eating, shoplifting, sexual disinhibition, and gambling. Results suggested that those with a history of traumatic events reported prevalent self-harming behavior, higher levels of dissociation, and impulsive behavior than those without traumatic histories (Zlotnick et al., 1997). These findings are indicative of a pattern of maladaptive coping skills, such as self-harm, among those who have experienced trauma. Aforementioned, self-harm among adolescents may act as physical reenactments of childhood trauma as an attempt to master the traumatic event (Shalmon, 2007; Herman, 1992; Milia, 2000; Farber, 2000; McFadden, 2005). If the caregiver was involved in the traumatic event, the child might begin to associate pain with care and nurturance (Milia, 2000). Self-harming can be a temporarily effective, however unhealthy, technique in quickly ending the dissociative event that may be experienced among those with

Borderline personality disorder is a common Axis II disorder affiliated with self-harming behavior (Zanarini, Laudate, Frankenburg, Reich and Fitzmaurice, 2010). According to the DSM-IV-TR (2000) “the essential feature of Borderline Personality Disorder is a pervasive pattern of instability of interpersonal relationships, self-image, affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts” (p. 710) Suicidal ideation and self-harming behavior are also major criteria for this diagnosis. Zanarini et al. (2010) conducted a study that assessed the relationship between self-harming behavior and participants diagnosed with Borderline Personality Disorder over a ten year period. Results suggested that among individuals who are diagnosed with Borderline Personality Disorder, a history of traumatic experiences significantly increased the risk for self-harming behaviors over time. In addition, the study found dissociation and depressive episodes among these patients heightened the risk of self-harming behavior over the ten year period (Zanarini et al., 2010).

As mentioned earlier, regarding the transitional object, many researchers have hypothesized that an adolescent who self-harms regress to, or is fixated in the separation-individuation phase of infancy. This is the transition in which infants separate from the mother and develop autonomy while still remaining connected to her. However, this stage of development cannot be resolved if the infant does not have a secure attachment to separate from. As a result, the stage is revisited during adolescence due to the developing needs for more independence and sense of identity. Emerging into adolescence may also reactivate any early trauma because of the similar needs during infancy and in adolescence (Farber, 2000; Favazza, 1987; Herman, 1992; Milia, 2000; Suyemoto, 1998; Suyemoto & Macdonald). Difficulties
originating in the separation-individuation stage such as perceived or actual abandonment can result in overwhelming emotional states, unstable sense of self, and an inability to relate to others in a soothing manner. These symptoms relate to characteristics of borderline personality disorder, those who self-harm that do not qualify for a diagnosable personality disorder, and other survivors of early childhood trauma (Farber, 2000; Favazza, 1987; Suyemoto, 1998; Herman, 1992).

**Treatment Approaches to Self-Harming Behavior**

Treating the self-harming population is difficult because these individuals may be unwilling to give up their behavior. To the patient, the behavior might be considered ego syntonic, or regarded as the only and obvious way the client can imagine reacting to current life circumstances (McWilliams, Patients tend to lack the appropriate techniques to manage their emotions, especially when they have difficulties regarding interpersonal conflict and perceived or actual abandonment (Shalom, 2007). The self-harming adolescents may become more comfortable and familiar with these techniques and may be hesitant toward changing these old habits. Effective intervention identifies and works with underlying issues, recognizes patterns that lead to self-harm, helps to delay gratification to tolerate undesirable emotions, and helps clients acquire healthy coping strategies to enhance daily functioning and interpersonal skills. (Stone & Sias, 2003; McFadden, 2005; Muehlenkamp & Gutierrez, 2004). According to Milia (2000) it is important for therapists to understand that self-harming is not purely destructive and that it tends to be a desperate attempt at coping with high levels of stress. The therapist must approach the client with understanding, active, and genuine listening along with providing a trustworthy, safe and consistent environment (Stone & Sias, 2003; McFadden).
Additionally, results from Brown and Kimball’s (2013) study suggested that in treatment, therapeutic relationships are most important for patients who self-harm. Several participants who self-harm reported a lack of trust and empathy from clinicians. This lack of trust may be connected to the forms of abandonment, abuse, or neglect from caregivers during early childhood. According to the participants’ responses, Brown and Kimball (2013) suggest that a person who self-harms may have experienced negative events when looking for help and might be fearful that treatment will also be negative. Therefore, it is important for therapists to provide a positive experience by listening to the stories from these clients and create a positive therapeutic relationship (Brown and Kimball, 2013).

According to Derouin and Bravender (2004) the primary goals for clients who self-harm are to encourage feelings of “connectedness” or repair attachments to parents and other significant people in the client’s life, develop effective and healthy techniques of self-soothing, and improve the client’s strategies of emotion regulation. Because self-harming individuals tend to have difficulty verbalizing emotions, therapy must focus on improving communication skills, and learning how to effectively assert needs and express emotions (Derouin & Bravender, 2004; McFadden, 2005).

In 1987 Marsha Linehan proposed DBT to help treat individuals with borderline personality disorder. However, this approach has evolved to treat individuals with borderline personality disorder coexisting with disorders such as emotion dysregulation, substance abuse, binge eating, depression, or suicidal ideation (Dimeff & Linehan, 2001). Linehan (1987) described this approach as having two characteristics: “a behavioral, problem-solving focus, and an emphasis on dialectical process” (p. 272). The term dialectical, in this approach, refers to the multiple conflicts experienced by many patients with borderline personality disorder. In addition
to skills training, problem solving, and observing the present, Linehan (1987) named the three major conflicts that this approach addresses: “(1) emotional vulnerability versus invalidation, (2) active passivity versus the apparently competent person, and (3) unrelenting crises versus inhibited grieving” (p. 261). DBT tends to the five following functions: enhancing behavioral abilities, improving motivation to change, assuring new abilities are generalizable to the environment, structuring the therapeutic environment in ways that are essential to maintain patient and therapist proficiencies, and enhancing therapist capabilities and incentives to effectively treat a patient (Dimeff & Linehan, 2001).

Regarding the treatments utilized to address adolescents who self-harm, Feigenbaum (2010) proposed DBT to be a beneficial approach to people who self-harm. Feigenbaum (2010) suggested that since several studies supported that adolescents self-harm as an emotion regulation strategy, DBT can provide techniques that promote a healthier way of regulating emotions. The model aims to increase emotional regulation and problem-solving skills that may not have been internalized as a young child due to an unhealthy or insecure attachment to caregivers. Feigenbaum (2010) mentioned that DBT assumes that people who self-harm lack self-regulation skills, and that environmental factors might inhibit the use of behavioral skills or promote unproductive actions. This therapeutic approach can help facilitate learning of new skills, embed these skills into the person’s memory, and help them generalize these skills in other contexts (Feigenbaum, 2010).

James, Taylor, Winmill, and Alfoadari (2008) carried out pre and post assessment in an inpatient setting with 16 female self-harming adolescents between 15 and 18 years old before and after DBT. Authors noted that there was a significant reduction in self-reported depression, hopelessness, self-harm, and an increase in general functioning (James et al., 2008). However,
the authors also mentioned that only one other study of dialectical behavior therapy found similar results, but DBT was reported as being no more effective than other forms of treatment. In addition, there was a lack of persistent effects one year after treatment. James et al. (2008) also noted a positive correlation between the participants and dysfunctional family relationships.

Cognitive behavioral therapy is another common treatment used to decrease self-harming behavior. This approach emphasizes negative thought-stopping, interrupting catastrophizing situations, and utilizing visual resources such as psycho-education and worksheets. Therapists implement relaxation techniques, coping skills, assertiveness training, and changing negative self-evaluations. Cognitive behavioral strategies are used to block cognitive distortions, false inclinations about the self, and establishing appropriate and adaptive behaviors (Stone & Sias, 2003; Shalmon, 2007). Taylor et al. (2011) conducted an experimental study with 16 self-harming participants who completed cognitive-behavioral treatment. Authors gathered data from assessments before and after treatment from participants and their parents. The authors discovered a significant decrease in self-harm behavior and depressive symptoms among the participants. However there was no reported change in levels of anxiety or emotional expression from the parents of the participants. Authors claimed that further research would be useful to answer questions about parental involvement in the treatment of adolescents who self-harm (Taylor et al., 2011).

Gratz and Gundersons (2006) theorized that self-harming behaviors stem from the lack of the ability to regulate emotions (as cited in Gratz and Tull, 2011). They also found that teaching self-harming individuals about more adaptive ways of regulation and responding to their own emotions would reduce self-harming behavior (Gratz and Tull, 2011). Teaching appropriate ways of regulating emotions can help the self-harming adolescents who did not learn appropriate
regulation skills in infancy due to negative attachment experiences that may have resulted in impaired interpersonal functioning (Muehlenkamp, 2005; McFadden, 2005). Based on this theory, Gratz and Tull (2011) developed a study to further examine, through self-reports and interviews, the effectiveness of Emotion Regulation Group Therapy. Twenty-three women who self-harm took part in Emotion Regulation Group Therapy and reported their changes in destructive behaviors, psychiatric symptoms, and in social and vocational impairment. Results indicated that there were significant changes of “all outcome measures except quality of life and self-destructive behaviors” (Gratz and Tull, 2011, p. 316). This outcome points to the need of a different and more integrative treatment approach to assist in decreasing adolescent self-harming behavior.

Psychodynamic therapy can also be helpful for those who self-harm because a therapist will encourage the client to understand the origins and self-harming in the unconscious. Therapists stress psychodynamic models so that therapy is concentrated on expressing emotions, managing negative affect, managing episodes of depersonalization, and identifying boundaries between self and others (Kumar, Pepe & Steer, 2004). According to McFadden (2005) psychodynamic therapy accompanies explanations that include aggression turned inward and the need for control. Other interventions might include explanations of wounds and scars representing transitional objects to maintain a consistent connection with the mother, how a child might self-harm in order to identify as a “bad object” in order to keep the unattached caregiver in a positive role, or about the child possibly internalizing violence as a form of affection (McFadden, 2005; Milia, 2000).
Family Therapy and Self-Harm

Several studies have addressed the need to include family dynamics and attachment into the treatment approach for adolescents with poor coping strategies (Benson and Buehler, 2012; Sim et al., 2009; Kissil, 2011; Bureau et al., 2010). Benson and Buehler (2012) conducted a study relevant to self-harm and familial relationships. With a longitudinal quantitative study and a qualitative observational study, Benson and Buehler (2012) studied the correlation between family hostility, peer deviance, and adolescent aggression. Results suggested that peer deviance and family hostility and resentment tend to predict an increase of aggression among adolescents. Benson and Buehler (2012) noted that family warmth can play a role to lessen these outcomes of family hostility, but “remains overshadowed by the presence of family hostility” (Benson and Buehler, 2012, p, 1225). This study helps readers perceive the extreme effect family dysfunction can have on a child.

Because family relationships can have a significant impact on the psychological development of children and adolescents, Kerr and Hoshino (2008) would agree that the family structure is an important component of change in therapy because each family member can have a significant impact on the others. In family therapy, a change in one family member requires change in the other members of the family (Kerr and Hoshino, 2008).

Attachment-Based Family Therapy

Kerr and Hoshino (2008) mentioned that attachment theory can be a great component to family therapy because it offers the therapist knowledge of family systems and how behavior is influenced by the context and patterns of communication in the family (Kerr and Hoshino, 2008).

Kissil (2011) also believed it is important to integrate attachment theory and family therapy in order to effectively promote behavior change among adolescents who self-harm.
Kissil (2011) stated that since emotion regulation capabilities begin to develop during infancy and early childhood within the attachment relationship, it is realistic to address self-harming behavior within the context of the family and attachment theory. However, after reviewing the literature, Kissil (2011) claimed that most available treatments do not address the family, and focus only on the individual. Kissil (2011) discovered that children who are raised in a home with dysfunctional parenting could be at risk of developing unhealthy skills needed to cope with biological change and social stressors that can promote overwhelming thoughts and feelings. Kissil (2011) defined attachment-based family therapy as a developmentally based family therapy used specifically for treating depressed and suicidal adolescents. Attachment-based family therapy includes three phases during treatment. The first phase includes introducing the family into therapy and expressing that the focus of therapy is to improve interpersonal family relationships instead of the reduction of the adolescent’s symptoms. In this phase, the goal is to “build an alliance with each family member” (Kissil, 2011, p. 318) in order to promote more effective communication of emotions. The second phase primarily focuses on the reattachment of parents and child. Finally, the third phase focuses on reestablishing encouragement and positive communication between family members to promote adolescent autonomy and attachment (Kissil, 2011). These steps are meant to restore a secure base of attachment in order to promote therapeutic change (Kissil, 2011). Kissil (2011) provided a case study that gave a clear example of how reattachment among a family can help an adolescent with symptom reduction without addressing the adolescent’s symptoms directly.

**Family Systems Theory**

Family Systems Theory promotes the idea that a system can be viewed as a whole that is made up of individual parts. When an individual part of the system changes other parts are
affected. Pardeck and Yuen (1997), outlined six key components to the approach. First, systems theory concludes that the whole is greater than the sum of its parts. This means that systems theory primarily focuses on linkages, exchanges, and relationships that connect individuals together.

Second, systems theory also focuses on how the greater community impacts the family system. The therapist must consider how the family impacts the outer environment as well as how the greater community affects the family (Pardeck, 2004). Third, family systems theory believes that homeostasis is a critical component for clinicians to consider when working with families and understanding family functioning. Homeostasis among family members occurs when the family reacts to internal and environmental stressors. The family strives to achieve homeostasis, or balance and stability, when these stressors occur and influence change (Pardeck, 2004).

Fourth, circular causality is a concept that is important in understanding family functioning. The systems approach stress on the interactional, transactional, and shared patterns of behaviors that influence family dynamics. Fifth, the family life cycle can inform the clinician about the patterns that are affiliated with all family members. Whether these patterns go smoothly or not depends on the different strengths and weaknesses of the family system. Finally, systems theory suggests that each family member’s social functioning can highly influence the functioning of the family (Pardeck, 2004). For example, a father’s ability to maintain a high paying job can be just as influential as a child’s struggle with depression or self-harming behaviors.
Solution-Oriented Family Therapy

In comparison, the solution-oriented family therapy model combines various components of solution-focused therapy, problem-focused therapy, narrative therapy, collaborative language systems therapy, and several other approaches (Selekman & King, 2001). This approach can help the family identify the adolescent’s interpersonal, internal, and external dynamics that may have influenced the behavior (Stone & Sias, 2003). This model attempts to challenge unhelpful family beliefs or to help identify generational boundaries and roles within a family where the self-harming adolescent has become parentified (Selekman & King, 2001).

Solution-oriented family therapy focuses on client strengths and resources and respect for client goals (Bischoff et al., 2003; deShazer, 1988). This approach highly focuses on moving forward from the problem. Solution-oriented therapists assume that change is inevitable and constant, understanding the root of the problem is not necessary to help it, most complaints develop and are maintained in the context of human interaction, and rapid change or resolution of problems is possible (Bischoff et al., 2003; deShazer, 1988; O’Hanlon & Weiner-Davis, 1989).

Psychodynamic Family Therapy

Family therapists who incorporate a psychodynamic approach tend to stress the Freudian notion of psychic determinism and the unconscious. Contradictory to systems theory that addresses the immediate interaction among family members, family therapy with a psychodynamic emphasis focuses on the unconscious dynamics of family members and each of their libidinal attachments to their parental figures (Pardeck, 2004). Freud’s model of psychic functioning theorizes that all mental functioning is caused by identifiable factors already in existence such as unconscious drives or archetypes that exist in the collective unconscious. This
model is based on instinct theory that involves patterns of repression. A family member might repress instincts, feelings, or emotions in order to retain intimate relationships outside the self by making the relationships tolerable (Cooklin, 1979). When adolescents self-harm in order to change the perception of the parent from “bad” into “good” via sacrifice of the self, it seems as though the adolescent is repressing the wrong-doing of the parent and taking an overbearing responsibility to change the family system. The psychodynamic approach to family therapy has the ability to bring about insight and understanding, and to express emotions among family members in order to inform the rest of the family about the changes that need to be made.

As mentioned earlier, from an Object Relations perspective, family therapy has the ability to establish a new “not-me” object in replacement of the patient’s skin to help the patient promote a positive sense of self.

“Positive experiences build a positive sense of self. Occasional failures in the relationships may serve to strengthen the child’s ability to seek out and maintain connections. Failures serve the ego as long as they are infrequent, and not intense. Overwhelming the vulnerable young child may break the connection with the object”. (Kerr & Hoshino).

**Crisis Precautions**

Although family therapy can be an effective way for a family to become aware of familial patterns in order to improve family attachments and interactions, if a family is not willing to change and is continuing to abuse the child, it is important that the child ends contact with the abusers (Dale et. al., 1983). A therapist must be aware that a disturbed or threatened child may have to live in a therapeutic milieu for an extended period before they can be reunited with their families. After the separation, if the child continues to interact or live with the family,
the therapist must slowly engage the children in the family therapy process. It must also be
realized that, depending on the severity of the abuse and the family’s willingness to change, a
child may never return to see their initial family. As a result of the separation, a child may
develop further psychological issues (Dale et. al., 1983).

Art Therapy

Art therapy evolved from the foundational psychoanalytic theories of Sigmund Freud and
Carl Jung, who viewed symbolism as an important component of psychotherapy (Wadeson,
that Freud developed the theory of the unconscious appearing in dreamwork while Jung
proposed that there is a universal unconscious with common symbols among differing cultures
around the world (Wadeson, 2010). The author stated that imagery plays a significant role in
early childhood development. The images can influence and represent the several layers of
human development. She added that words can be said to explain artwork, but the actual
message is relayed in the image. Additionally, the art medium has the ability to stimulate the
production of different images because differing materials have the power to evoke primary
processes and secondary processes that enhance creativity (Wadeson, 2010).

Art therapy encourages clients to achieve self-expression and self-awareness by reflecting
on the process and product of art making. The founders of art therapy, Edith Kramer (as cited in
Rubin, 2001) and Margaret Naumburg (1966), had similar goals to combine art and psychology.
Although both Kramer and Naumburg strive for the same outcome, their approaches to art
therapy were slightly different. Kramer focused on art as therapy while Naumburg (1966)
focused on art psychotherapy.
Kramer's (as cited in Rubin, 2001) approach of art as therapy primarily focuses on the
sublimation achieved by the therapeutic act of creating art and expressing unconscious conflict.
Art as therapy does not analyze and interpret a client's image. However, the therapist encourages
the client to discuss his creations and be proud of the artwork. It focuses on the transfer of
negative energy to positive energy through art and the process of creativity to achieve
sublimation (Kramer, 2001).

According to Naumburg (1966) art psychotherapists analyze and discuss symbols of
emotions, latent wishes, desires and defenses in the product of the image. Naumburg described
her approach to art therapy as a release of unconscious thoughts through art making. She was
more interested in the client's relationship to symbolic forms and meaning in the artwork (Rubin,
2001). Art psychotherapy identifies defense mechanisms in the artwork and therefore identifies
possible inner drives of the client's id. From here the therapist can help the client find the
meaning of their behavior, how it relates to their unconscious, and how it is seen in their
behavior (Naumburg, 1966).

Art as therapy and art psychotherapy exist on a continuum because they have overlapping
concepts. An art therapist can encourage more psychoanalysis for one patient while helping
others achieve sublimation through art as therapy. This decision depends on how the client
responds to therapy, the client's presenting problems, and the client's goals. Along this
continuum, art therapy has the ability to utilize concepts of symbolism, creativity,
communication, sublimation, and expression of affect with an integration of therapeutic
philosophies to promote mental and emotional health. According to McFadden (2005) "imagery,
decreased defenses, objectifications, permanence, spatial matrix, and creative/physical energy
are all ways of explaining the advantages of art therapy" (p. 43).
Art Therapy and Self-Harm

Developing the ability to symbolize emotions is related to the degree of anxiety experienced during the earliest years of life. Too much or too little anxiety during this period can interfere with the process of symbol development (Milia, 2000). Those who are diagnosed with alexithymia, traumatized, or unable to identify or make sense of emotional responses tend to also have a diminished ability for symbolization, fantasy, or sublimation of emotions (Milia, 2000). Art therapy offers self-harming adolescents opportunities to externalize their emotions into artwork while redirecting expression away from their bodies onto the art materials and art product. The artwork can be utilized as an extension of their bodies; the surface of the artwork can substitute for the skin while the enactment of aggressive impulses and experimentation with boundaries may be safely performed (Milia, 2000; Shalmon, 2007; Cooper & Milton, 2003). The aggression and expression of undesirable affect can be a cathartic process while using symbols to process and identify emotions. According to Deri (1984) symbols possess the ability to connect and separate internal and external world. Symbols can organize complex emotions and situations while offering the client a reflective distance from subjective experiences. Symbolization among adolescents who self-harm is especially important because of their tendency to struggle with identifying and coping with strong emotions. Symbolic expression and communication through art may help introduce new coping strategies, strengthen ego, develop self-control, and reduce acting out aggression against the self. If these aggressive and depressive feelings can be identified and directed through the artwork and art materials, the adolescents might be less likely to continue expressing these feelings by damaging themselves.

used as an intervention to address the self-harming person’s desire for actions of ritualistic symbolism and the need to create transitional objects. According to Milia (2000) art making can be a symbolic form of self-transformation. Many authors mentioned that the access to art making is not as confrontational and direct as verbal communication (Winkler, 2000; Naumburg, 1966; Riley, 1999; Wadeson, 2010). Recalling that self-harming is an attempt to cope with stress (Hicks and Hinck, 2008; Scoliers et al., 2009; Brown and Kimball, 2013; Lambert and de Man, 2007; Milia, 2000; Nicholson, 2004; Feigenbaum, 2010; Gratz & Tull, 2011) it is essential to replace this coping mechanism with a healthier alternative. Art can offer a safe space to discover healthier expression. It can also provide a safe place for self-harming individuals to link subjective and objective experiences, develop symbolic abilities to express emotions, develop self-esteem, and to sublimate aggressive emotions (Milia, 2000). The author mentioned that all of these characteristics are essential to address in the treatment of individuals who self-harm.

**Art Therapy and Attachment**

According to Winnicott (1971), the art making process offers the opportunity to enter the transitional space; the space between internal and external reality in which the client can play in the presence of the therapist, just as the developing child plays in the presence of the mother, and from which the capacity for creative living can develop. In family therapy, the client has the opportunity to have their actual parental figures be present during this process and promote stronger attachments between family members. According to Farber (2000), self-harming adolescents have been compared to children that do not have the ability to play because of their weak ability to utilize a transitional object to self-soothe. As discussed earlier, self-harming adolescents use the acts of self-harm, blood, and scars as a transitional object. They may struggle to use other transitional phenomena to regulate emotions. Art therapy gives the client the ability
to repair attachments among family members because they are provided the opportunity to use art materials and images as transitional object. In return, the transitional object might help the client replace self-destructive actions with creative ones (Milia, 2000). While feeling safe and contained in the therapeutic environment, early Object Relations may be repaired along with the ability to self-soothe and regulate emotions (Farber, 2000; Cooper & Milton, 2003). If family members are present during the sessions, the client can express needs to his or her caregivers using artwork. Using artwork as a form of communication with family members can be more comfortable for the child while still direct toward the caregivers.

Malchiodi (2003) explained the developments of neuroscience in the context of early attachment and art making. Neuroscientists have found that the right orbitofrontal lobe, the area of the brain where early attachment is imprinted, is highly plastic, or malleable. Therefore unhealthy imprinting can be repaired with the help of secure attachments formed later in life (Farber, 2000; Malchiodi, 2003). The left hemisphere of the brain, affiliated with language development, is slower to develop than the right hemisphere, associated with creativity. Because art making is facilitated by the right cortex, it may be easier to access pre-verbal experiences of maladaptive attachments than by only utilizing verbal therapy. Art has the ability to activate the right part of the brain to help process concepts of trust and security in relationships so that new patterns of attachment and coping strategies can be encouraged to take place (Malchiodi, 2003). However, further exploration of art therapy, attachment, and self-harm as related to neuroscience is beyond the scope of this research.

Artwork and Emotional Expression

Adolescents who self-harm may resist dialogue in therapy because of difficulties regarding verbal communication. The fear of disclosing personal information may be a reason
for this resistance, especially with clients who experienced trauma. Introducing art materials to these clients allows expression through metaphor that requires physical involvement. As a result, art-making may be more appealing to clients who harm their bodies to express what is difficult for them to express verbally. The active-process of art-making can distance this expression from the body so that the expression that used to be attached to the flesh can be transferred to the artwork (Milia, 2000). Winkler (2004) mentioned that this artistic expression is effective because the artwork is being discussed, not the adolescent. The parallels between the artwork and the client can be discussed with less risk by the client, group members, family members, or the therapist. Riley (1999) stated, “Adolescents want to let others know how ‘screwed up’ they find the world, but they do not trust enough to use words” (p. 21). Art allows the adolescent to control their expression of feelings safely (Riley, 1999).

**Artwork and Self-Esteem**

One major component of art-making is the eventual mastery of the art materials and development of art-making skills (Milia, 2000). Substantial effort and time may be put into the awareness of an internal issue in an objective form. Adolescent clients who self-harm tend to have impulsive behaviors and may be impatient and give up easily. Giving up on artwork may reflect this tendency. However, with support of group members, family members, or the art therapist, self-harming clients can develop more effective self-control, concentration, and patience with the self (Milia, 2000).

Milia (2000) added that feelings of powerlessness are often a major component of adolescents who self-harm. The feelings of powerlessness or overwhelming emotions may motivate them to physically harm themselves. This act can be considered an attempt to take control over the body. Art therapy, according Landgarten (1991) can support an individual’s self-
esteem by allowing her to learn new skills, practice problem-solving approaches, and become more confident in her ability to make decisions. Many art therapy interventions and techniques can help a client confront problems and explore solutions with group members or an art therapist. In art therapy, the client is given new materials to be altered, mutilated, manipulated, and controlled. Mastery of art materials may provide an alternative satisfaction to control the body surface and a sense of autonomy in the external world (Milia, 2000).

**Sublimation and Art Therapy with Self-Harming Adolescents**

The destructive process of self-harm can be seen as a part of the creative process. Edith Kramer described sublimation as the process of the ego transforming primitive urges in order to indirectly serve instinctual gratification (Rubin, 2001). The individual achieves at least partial gratification and relief from the pressures of primitive drives. Kramer described that art can allow a person to travel between the conscious, preconscious, and unconscious safely and the art records this process and allows the artist to look back at their own intrapsychic process (Rubin, 2001). According to Milia (2000) the creative process can demonstrate and help a client work through emotions regarding aggression. When aggression is redirected toward the self, it can represent a restriction of the aggression from the actual target. This reversed thought process can easily remain in repetitive cycles of negative thoughts and self-destructive behavior intending to prevent greater destruction toward the real aim. Therefore, it can be understood that the constraint of aggression could ironically result in controlled aggressive behavior and inhibition of expression. The author added that art and creativity can allow the client's destructive energy to be cathected into constructive and expressive activities. While creating art, the client's sublimation can act as an elaboration of aggression as well as a transformational process (Milia, 2000).
Artwork as a Transitional Object

The process of art making can promote healing by containing and visualizing the artist’s conscious and unconscious thought processes. Using art materials, a client can express internal thoughts and feelings in a controlled and healthy manner. This, in turn, can promote self-awareness and mindfulness. Milia (2000) describes the art object as a “separate self-object,” outside the body, that the adolescent is able to form a relationship with. Winnicott (1971) noted that artwork can help an individual cope with pain and tension by providing a constructive way of expressing the emotions rather than keeping the emotions within the mind and body. Artwork has the ability to transform the tension and anxiety into a mechanism that helps regulate emotions, like the transitional object. Rubin (2001) breaks down the process of artwork regulating emotions into three steps: recollection of imagining an object when it is not there; the introjection of the object, where the individual takes it in but does not yet identify with the object; and finally identifying with the object to the point where it becomes a part of the person. By developing the ability to identify with the object, the individual can achieve a more independent way of relieving tension.

Further, Rubin (2001) stated that the persistent making of visual images in art therapy can encourage the development of the capacity to symbolize the mother that the adolescent has separated from. When scars and wounds function as a substitute for mother, they can be experienced as essential and cannot be given up or altered. When a client develops the capacity to symbolize in order to evoke the absent mother, the adolescent can begin to function more flexibly. The adolescent’s sense of security can consist now of a symbol of mother rather than concrete reminders of the absent object. Therefore, as art therapy promotes the ability to symbolize, the client can begin to function without the scars and wounds as a concrete reminder.
of the separated mother (Rubin, 2001). Additionally, during art therapy sessions, the client has the power to modify and adjust the artwork in any way she desires until she creates a representation of the self. Rather than harming parts of the body, an adolescent is able to use artwork and the creative process to use symbols that organize and connect inner and outer experiences (Milia, 2000). Because many adolescents utilize this poor coping skill, learned from early childhood experiences, as a transitional object it would seem beneficial to include the family in the adolescent’s treatment process. At the same time, since artwork and symbolization can also be considered a transitional object, it would seem likely that artwork would help satisfy the adolescent’s need for the transitional object in a healthier manner than physically harming the self.

**Common Graphic Indicators of Self-Harming Adolescents’ Artwork**

McFadden (2005) proposed that the motivations behind self-harming behavior can be identified as graphic indicators in adolescents’ artworks. The author conducted a study that examined the artwork of several adolescents who self-harm. As a result of McFadden’s research, she concluded that because self-harming behaviors and the process of creating art are both non-verbal ways of communication, several of their emotional states can be discovered in their artwork. The study found several artworks that portrayed victims and perpetrators. This is indicative of the client’s history of abuse (McFadden, 2005). She also found that the majority of facial expressions in the artwork created by self-harming adolescents do not portray physical sensations of pain. In contrast, faces seemed to be calm, neutral, or blank. Several images of a person or object in an isolated environment were also found in McFadden’s study. This is indicative of the social withdrawal or feelings of loneliness that connect with depressive symptoms or patterns of abandonment. Other images portrayed a lack of a face or a hidden face.
An unidentifiable face can connect to feelings of shame or an unwillingness to express feelings to the self or others. These hidden features could also indicate the low sense of self or lack of identity that many self-harming adolescents may experience as a result of being punished as a child for expressing emotions (McFadden, 2005).

**Family Art Therapy and Self-Harm**

Because self-harming clients tend to lack the language to communicate their emotions and pain, Winkler (2004) stated that emotional expression might not have been praised or available to express in a safe environment during early childhood. Because of this lack of room to express emotions during early childhood, the child might internalize these emotions as well as introject the harsh environment she calls home. When the ability to communicate feelings of anger or aggression is prohibited, feelings of frustration, anxiety, and self-destruction may increase (Winkler, 2004). Family art therapy can satisfy the adolescent’s need for a safe environment to express emotions creatively while addressing the possibility of reconnecting the adolescent to the caregivers.

From a review of literature, family therapy seems to hold the ability to address attachment issues and emotional dysregulation among adolescents who self-harm. Art therapy is said to provide a creative outlet for these adolescents to effectively communicate (Riley, 1999) as well as promote a symbolic form of self-transformation (Milia, 2000). As a result, utilizing family art therapy seems to be a beneficial interactive approach to address and repair attachments and affect regulation among family members in order to help the adolescent decrease the desire to self-harm and cope with emotions in a healthy manner (Kerr & Hoshino, 2008; Riley, 1999; Winkler, 2004; McFadden, 2005; Benson and Buehler, 2012; Sim et al., 2009; Kissil, 2011; Bureau et al., 2010).
Kerr and Hoshino (2008) addressed the benefits of art therapy, attachment theory, and family therapy. They claim that art can provide a foundation of communication and interaction to promote reattachment. Kerr and Hoshino (2008) described that a “shared creative experience for the mother and her child might help them find a new form of communication” (p. 79).
Results

The literature expressed the need to address reattachment, effective communication of feelings, emotion regulation, emotion expression, stress management, coping skills, and healthy interactions among parents with adolescents who self-harm (Gratz, 2006; Milia, 2000; Hicks and Hinck, 2008; Scoliers et al., 2009; Nickolson, 2004; Gratz and Tull, 2011). The literature also emphasized that while many adolescents who self-harm has been abused as a child or is currently abused by parents or by those trusted most, others are a part of families that are not abusive but need help establishing healthier relationships. Therefore, it seems impossible and counter-therapeutic to create one plan that is generalized to treat every family that faces this behavior. Therapists must continually evaluate individual safety needs and appropriateness of family interaction.

A family art therapy session may not be appropriate if a family member was or continues to be a dangerous. In situations like these, it may be essential to confirm the safety of the adolescent by separating him or her from the perpetrator instead of pushing reattachment between the family members. On the contrary, other families may benefit from family art therapy because of their need for better communication and reattachment. In order to begin moving forward with this wide array of client possibilities, goals must be established to address the needs of self-harming adolescents that experience several different types of attachment styles, introjections, and family dynamics.

Clarifying the family dynamics and the initial role of each family member can help a therapist understand how the family works together. Once the family is able to understand how they interact with one another, they may be able to identify problems and ways to improve them.
This can also help the therapist identify any perpetrators or crisis within the family that must be addressed immediately.

For families who are able to interact with one another and promote safety for the adolescent, families with adolescents who self-harm must also work to build trust and increase effectiveness of communication between family members. If assessed that the primary caregiver proves safe support, the adolescent may work to establish and re-establish a healthy attachment with him or her. It is important that with this new attachment, a healthy level of confidence for the adolescent is also developed so that family members can more readily communicate emotions and events and therefore, begin modeling healthy tactics for coping with overwhelming emotions. Therapists are also encouraged to motivate the family to help the adolescent create a new transitional object outside of the skin so that they are able to be reminded of the family in a more positive form than violence.

According to Mila (2000) utilizing art and symbol formation can promote more effective techniques of achieving these goals because of the difficulties of verbalization, fear of self-disclosure, and the act of using a language that requires active involvement with the body.

Art making can be appealing to adolescent clients that tend to use their body to act out what cannot be put into words (Milia, 2000). Symbol formation is extremely helpful for the adolescents who fear verbal expression of events because of severe trauma. This study revealed that it may be more appropriate to address traumatized clients individually, rather than family based, if their perpetrator is still interacting with the family.

During family art therapy sessions, it is important the art therapist is mindful that art therapy is based on the knowledge that every individual has a latent capacity to project his or her inner unconscious conflicts into a visual form. The rudimentary treatment methods of art therapy
utilize the psychoanalytic approach with the mechanisms of repression, projection, identification, sublimation, and condensation. In art therapy, a client's spontaneous visual creations and unconscious responses are more easily and more frequently expressed in pictures than in words. It is important for the art therapist to allow the client to explore his or her unconscious responses at a pace that is safe and not too overwhelming for the client, while encouraging the client to explore unconscious material at appropriate times. Therefore the art therapist does not interpret artwork for the client, but encourages the client to discover his or her own meaning of the artwork. It is the art therapist's role to help the client process the moods or circumstances under which the designs were made in order to help the client discover the meaning of the artwork. An art therapist must alter and develop art interventions that are appropriate for the level of progress of the client. As clients view such inner experience at their own pace, they begin to become more verbally articulate of inner experiences by explaining their artwork to the therapist or their family (Wadeson, 2010).
Discussion

Throughout this research, psychodynamic theory was used to understand conscious and unconscious motivations of adolescents who self-harm. Having a thorough understanding of the overt symptomology and origins self-harm is important for a therapist so he or she can develop appropriate interventions and goals to meet the needs of a specific family. An understanding of the potential underlying motivations of self-harm also informs clinicians of the possible dangers of family therapy and historical abuse within the family system. Therefore, it may be counterproductive to create an art therapy treatment plan to address all families with an adolescent who presents self-harming behavior.

Engaging in research about the collective unconscious and how it relates to self-harming behavior among adolescents in current society can help clinicians understand the innate desire to visually express self-sacrifice and rites of passage to adulthood. Tattooing or piercing can be considered a more acceptable version of ritualistic self-harming. Just as the Lakota tribe subdued high levels of pain to obtain scars that symbolized suffering, power, and strength, tattoos and piercings are desired in today’s society for similar reasons. Today, people crave tattoos to symbolize a major change, gain control over their body, express emotion, identify themselves as a part of a group, or to disguise a scar into something artistic. Researching the unconscious motivations of self-harming on a universal level seems to normalize the act of self-harming among adolescents and illuminates the instinctive human desire to gain mastery over feelings of victimization and can lead to more knowledge about both conscious and unconscious motivations.

Gratz (2006) stated that “among women with a history of self-harm, emotional inexpressivity was associated with more frequent self-harm, as was the combination of greater
maltreatment, greater inexpressivity, and lower levels of positive affect intensity/reactivity” (Gratz, 2006, p, 240). As a result, it is essential to develop art therapy interventions in order to address these concepts along with art to support adolescent’s preference for symbolism, active engagement, and their need for the transitional object (Milia, 2000). Family art therapy interventions have the ability to integrate an adolescent’s need for active engagement with family interaction in order to address attachment, family discord, and emotion regulation by revealing unconscious material and promoting effective communication. However, the research concluded that family art therapy interventions must not be created as a generalizable treatment plan for all families because of the risk of compromising the adolescent’s safety.

Researching the psychodynamic contexts of self-harming behavior enlightened the high possibility that adolescents who self-harm have experienced violence as a child from a trusted caregiver. It was noted earlier, from an Object Relations perspective, the act of self-harm may be an unconscious form of a transitional object. The violence of self-harming behavior may be an unconscious reminder of the violence experienced from a primary caregiver during childhood. It was found that self-harming may also be used by the adolescent to take on the “bad” role in order to place the caregiver into the “good” role again. If the perpetrator is still a part of the family, art therapy with the family may be more counterproductive because of the adolescent’s innate need to keep the abuser in the “good” parent role. It is often difficult to establish additional goals until the adolescent’s safety is created in the family unit. The initial projects must be created to help the therapist evaluate the safety of the adolescent when interacting with his or her family, particularly for clients with traumatic histories, which is so often the case with self-harming patients. A therapist must look intensely into the family system in order to identify maladaptive patterns that might hinder or worsen the adolescents ability to change.
As a clinician moves forward with family art therapy for adolescents who self-harm, it is essential to note the importance of establishing trust and a positive therapeutic relationship before expecting a client and their family to address feelings that may be difficult for them to express. In the participants' responses, Brown and Kimball's (2013) study revealed that adolescents who self-harm reported a lack of trust toward clinicians. Researchers considered that this lack of trust could be a result of the clients' previous negative experiences when looking for help. These adolescents might also be fearful that treatment will also result in a negative experience (Brown and Kimball 2013). Therefore, it is important for therapists to begin treatment with this population with an expression of interest in their stories and empathy for their feelings to create a positive therapeutic relationship and environment.

Family relationships can have a significant impact on the psychological development of children and adolescents. The research indicated that adolescents who self-harm tend to be involved in dysfunctional family systems, have insecure attachment styles with caregivers, and have difficulty verbally expressing emotions. Adolescents might self-harm as a way to distract themselves from emotional pain, punish the self, prevent themselves from hurting another, end dissociative experiences, seek attention, or gain control over their bodies, especially if they have been physically abused in the past. Family art therapy has the ability to re-establish attachments between adolescent and caregiver, promote change in more than one family member, and increase healthy patterns of communication that will, in turn, promote healthier self-soothing tactics. Establishing a more secure attachment can allow the adolescent to develop healthier ways of regulating emotions, coping with overwhelming emotions, and strategically solving problems rather than avoiding them. Art therapy has the power to provide visualizations of unconscious
experiences of all family members. This might bring about tendencies or patterns of family interactions that may be contributing to the adolescent’s self-harming behavior.

From an Object Relations perspective, using art therapy within the family can promote safe self-expression away from the body while helping the adolescent, and other family members create a healthier and more effective transitional object by encouraging symbol development. Art can be used as an intervention to address the self-harming person’s desire for actions of ritualistic symbolism and the need to create transitional objects that carry them from childhood to adulthood.

Other art therapy interventions can be served to develop creativity, motivate pride in accomplishment, promote a sense of control and empowerment, increase self-esteem, increase the ability to communicate among family members, help family members understand the reasons their adolescent self-harms, help family members effectively and appropriately express their needs, and allow the adolescent to understand the viewpoints of self-harm from others in the family. The desired goals of these interventions are these results, not the completion of the art project. According to Wadeson (2000), “In art therapy, a simple drawing often facilitates therapeutic goals as readily as an elaborate art production” (Wadeson, 2000, p. 240).

Wadeson (2000) mentioned the importance of the way an art therapist thinks about the work with the clients. The therapist must first address the goals that the therapist and client or family has set, and then think of ways to achieve these goals. She warns her readers to not blindly choose a project and figure how it might be used during the session. Wadeson (2000) advises to identify the value of a specific intervention and art materials that could address the specific goals set by the client and therapist in this specific population. An art therapist might be inspired by these ideas and modify them to satisfy the needs of the client and their family.
Conclusion

It was hypothesized that family art therapy would be an appropriate treatment approach for families with adolescents who self-harm. However, after exploring psychodynamic theories as they relate to unconscious motivations of self-harming behavior, it is understood that addressing the family may not be appropriate for all adolescents who self-harm. It was discovered that many individuals who self-harm have experienced severe abuse from primary caregivers. Although looking back on childhood relationships among family members as it relates to current behaviors may be therapeutic, reconnecting a child with an abuser can certainly be counterproductive. It is important for a therapist to continually evaluate the safety of each family member in regards to abuse among the family unit. Because of the risks that follow family therapy among this population, a treatment plan cannot be created to address the needs of every family with an adolescent who self-harms. However, many goals were established to help art therapists begin creating their own treatment plans devised to address the specific needs of the adolescent and their family.

Researching psychodynamic approaches can help professionals understand the importance of addressing early childhood relationships. The exploration of unconscious motivations of self-harm also enhances the importance of art therapy as an approach to self-harming individuals and their family. Because the nature of art therapy primarily focuses on bringing unconscious material to conscious awareness, art therapy can address unconscious material of the family while helping the family members establish healthier communication and attachment styles. By projecting pictures of the unconscious, art therapy encourages symbolic communication between patient, family, and therapist (Naumburg, 1966) that can encourage healthier coping mechanisms and emotion regulation strategies.
Examining environmental, biological, and emotional aspects of self-harming allows researchers to discover the characteristics, motivations, and unconscious functions associated with this behavior in order to implement appropriate treatment interventions. The literatures revealed that while self-harming has been misunderstood as an attempt to commit suicide, the primary goal of self-harming behavior is to self-sooth and relieve stress. Additionally, self-harming adolescents tend to lack secure early childhood attachments with caregivers. These adolescents typically present with a history of childhood trauma, such as abuse and neglect, and experiences of dissociation. If the caregiver, who is supposed to provide love and safety for the child, acts as an aggressor or neglecter, the child may begin to associate love with pain. Because of the tendency to internalize experiences from early childhood, if feelings of disorganization or distrust result from the physical sensations of an adolescent’s infancy, the adolescent might resort back to the familiar painful sensations to relieve symptoms. Because of the tendency for infants develop dissociation as a coping strategy during traumatic events, the later adolescent might self-harm to relieve symptoms of dissociation by attempting to “feel something.” The adolescent might also self-harm as an attempt to relieve symptoms of stress by distracting him or herself from overwhelming emotions that include anger, shame, anxiety, and depression. The literature also stated that some individuals who self-harm tend to have a history of aggression with others as a learned behavior from childhood. Individuals may self-harm as a way to avoid harming others. As self-harming is typically a result of an attempt to self-sooth, self-harming behavior are often unconsciously used as transitional objects and have ritualistic and universal frameworks.

While art therapists have the advantage of identifying the feelings and experiences of an adolescent who self-harms by means of symbolism and graphic indicators, art therapy can also
help the adolescent and family give light to the unconscious and preverbal impulses and conflicts motivating the self-harming behavior. In addition, art therapy can help family members discover unconscious tendencies that influence a dysfunctional family. Through externalization of unconscious patterns onto artwork and the help of the art therapist, the unconscious material is able to enter consciousness and be verbally expressed and understood more clearly by each member of the family. Through family art therapy, the impulses and conflicts driving family discord and acts of self-harm can be made conscious and incorporated into the client’s personality and the reattachment of clients and caregivers. This process of identification and realization offers the potential for lasting renovation.
Recommendations

This research possesses limitations and recommendations for future research. The relationship between self-harming and the collective unconscious was addressed briefly, but beyond the scope of this research, in hopes that the interested reader will be inspired to extensively research this connection further. It may be helpful to continue exploring the connections and differences between cultural and pathological self-harm.

Second, the topic of neuroscience was also briefly addressed in this research. Many researchers have linked biological components to the reasons individuals self-harm (Favazza 1989; Hicks and Hinck, 2008; Crowell, Bearuchaine, McCauley, & Smith, 2008). Cloninger (2008) stated that dopamine is a neurotransmitter involved with brain functions of rewarding experiences and feelings of euphoria. Favazza (1989) described dopamine's role in increasing self-harming behavior. He discussed several studies in 1967 and 1981 in which drugs such as caffeine, pemoline, and low doses of amphetamine were injected into rats to increase levels of dopamine. As a result, the rats exhibited self-harming behaviors. In 1987, Sokol et al. (as cited in Favazza, 1989) reported fingertip biting while taking high doses of methylphenidate, a drug that may mimic dopamine activity.

According to Hicks and Hinck (2008) a release of endorphins after the physical damage of self-harm contributes to feelings of relief. The feelings of relaxation as a result of this behavior can support self-harm as an addictive coping mechanism. The author concluded that these findings suggest a "biological reinforcement theory, which suggests that the pain from self-mutilation may cause the production of endorphins that reduce dysphoria" (Favazza, 1989, p. 140).
Crowell, Bearuchaine, McCauley, and Smith (2008) explored peripheral serotonin levels relating to mother-child interaction patterns with self-harming adolescents. Serotonin, according to Parsey et al. (2006) is a neurotransmitter that has been affiliated with major depressive disorder and is one of the major components that current antidepressants imitate. Crowell et al., (2008) claimed that “disruptions of the serotonin system are consistently associated with nonsuicidal self-injury, suicide attempts, and suicide” (p. 15). In their study, Crowell et al., (2008) compared the peripheral serotonin levels of 21 typical adolescents with 20 self-harming adolescents. Results showed a significant relationship between adolescent’s peripheral serotonin levels and their expressions of positive emotions either within family dyads or by themselves. Results also revealed higher levels of negative emotions among families with adolescents who self-harm (Crowell et al., 2008). Because serotonin levels seemed to have increased while expressing positive emotions with their family, the researchers made an implication that self-injuring adolescents would benefit more from addressing the whole family. Decreasing negativity and conflict seems to be essential in reducing self-harm. Addressing the family can be an effective way to address these issues in order to implement reduction of emotion dysregulation, impulsivity, and interpersonal discrepancies (Crowell et al, 2008). A more in-depth approach to the neurological effects of early childhood attachment with later adolescent self-harming behavior can help enhance the argument that unhealthy attachment styles can motivate self-harming behaviors as the child ages into adolescence. A deeper exploration of neuroscience can also help promote the neurological apparatuses of art therapy.

Third, due to the literature review methodology chosen for this study, no actual case or experiment has been presented to illustrate or verify the effectiveness or outcome of family art therapy with adolescents who self-harm. Therefore, the integration of theories remains at the
theoretical or hypothetical level. It would be interesting and helpful for interested readers to create a family art therapy treatment plan that is specific to a certain family to determine the effectiveness of the outcome and provide a case study that evaluates efficacy. It may also be helpful in understanding the efficacy of this treatment approach by performing quantitative studies to measure the effectiveness of improvement among adolescents who self-harm. These studies can not only measure the frequency of self-harming behavior but also measure their ability to cope with overwhelming emotions, communicate with family, and identify feelings.

It may also be helpful for future research to evaluate the correlations between divorce rates, parents in the military, death of a parent, or foster care and self-harming behavior among adolescents. This can further explain the importance healthy childhood attachments with primary caregivers.

Because it was discovered in this research that a family art therapy treatment plan must be created specifically for a family’s needs, it would be helpful if future researchers studies the different needs of the adolescents with differing attachment styles. How are the needs in a neglectful family different than the needs of a family with overbearing parents? How can clinicians alter their family art therapy treatment plans to address the specific needs of these families? This research has provided information regarding the connection between early family relationships and self-harming behaviors during adolescents. While providing a plethora of information about the benefits and dangers of family art therapy with this population, this research provides a foundation for future work in the field of art therapy to treat complex and unique families of self-harming adolescents with the power of symbolization and creative processes.
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