Countertransference and self-injury: a cognitive behavioural cycle

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Aim. This paper discusses the emotional, cognitive and behavioural effects of self-injury on nurses as helpers, and shows the usefulness of a cycle that can affect care provision for this group of people.

Background. People self-injure for many different reasons, such as feeling angry, sad, guilty or frightened and these emotions are often linked to feeling helpless, powerless or out of control. Self-injury has often been reported as a coping strategy to gain control. Psychoanalytic and cognitive behavioural concepts have been used to understand why people self-injure and also inform intervention strategies. Unfortunately, negative emotional responses in professionals may interfere with the effectiveness of any therapeutic relationship.

Discussion. Negative emotional responses from nurses can affect the way they think about and behave towards clients who self-injure. During clinical supervision or education, nurses' thoughts can be challenged to become less negative, so that their resulting behaviour can also become less punitive. Non-punitive or more positive behaviour can in turn challenge some of the negative self-beliefs of clients.

Conclusions. Knowledge about countertransference when working with people who self-injure may reduce nurses' negative thoughts and behaviours, which may result in improved client care.

Keywords: self-injury, self-harm, nurse countertransference, cognitive behavioural approach, interpersonal processes, personality disorder

Introduction

Self-harm, in which individuals deliberately cut or otherwise mutilate their bodies, has achieved considerable prominence in recent years, not only in clinical environments in which people receive care and treatment, but also in popular culture. Fletcher and Hogg (2001) argue that the disclosure of personal experiences of self-harm by celebrities, notably the late Diana, Princess of Wales, has been helpful in this respect.

Self-harm has consistently been a highly stigmatized behaviour. The labelling process has often included referring to the person in terms of the behaviour, such as 'cutter' or 'self-injurer'. Even those sympathetic to the individual's plight may feel strong emotions in dealing with this challenging behaviour. Allen and Beasley (2001, p. 73) stated that 'self-harm is undeniably an emotive issue, which evokes a response and opinion arguably in all of us'. It is likely that anyone who has close contact with a person who self-injures will

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experience an emotional response to this behaviour. In this paper we suggest that this response could, if properly directed, be therapeutic rather than debilitating. We use the term 'self-harm' for any method of harm to the self. 'Self-injury' describes a physical injury to the body, for example, cutting.

Background

The unhelpful reactions of helpers as a result of their lack of understanding of those who self-harm have been challenged and extensively documented, particularly by people who have used health care services following self-injury (Pembroke 1996). These often extreme reactions may limit helpers' ability to maintain a therapeutic relationship and prevent any further aid being given (Connors 2000). All too often rejection of the person occurs, which may reinforce their feelings of lack of self-worth and negative self-beliefs.

The expectation in many societies is that when people are ill they should seek professional help and adhere to the advice received. In health care the 'difficult' clients are often the ones who do not follow these rules. Self-injury challenges the established rules because the individual deliberately inflicts 'sickness' on the self. This contravention of the norms of health service culture can result in professionals feeling helpless, due to their inability to offer a remedy. This can also challenge their views of autonomy, competence and role (Fincham & Emery 1998). Indeed, 'good patients' confirm the role of the nurse, whilst 'bad patients' challenge it (Kelly & May 1982).

Although there are useful frameworks for working with people who self-harm, such as CARE (McAllister & Walsh 2003), we have developed a cycle to illustrate some of the interpersonal effects of self-injury on nurses. We envisage that this tool could be used in reflection or supervision to assist nurses in using the CARE framework with clients. The CARE framework has four broad principles of intervention: Containment, Awareness, Resilience and Engagement. Containment encourages health care seeking when the person has an urge to self-harm, promoting alternative self-soothing behaviours and providing risk assessment. Awareness means being available before during or after self-harm to discuss precipitants and processes and to encourage self-knowledge. Resilience is the reframing of distressing events to encourage survival, courage and the validation of clients' efforts at coping. Engagement is building a trusting partnership, learning new problem-solving skills and finding a sense of meaning and manageability in the recovery experience. In this paper we offer an additional cycle to help nurses to understand the interpersonal processes that may make these interventions in the CARE framework difficult to achieve.

Many people who injure themselves in psychiatric settings are labelled as 'manipulative' or 'attention-seeking' (Clarke & Whittaker 1998). As a defence mechanism, this serves to make the nurse feel better about themselves, locating the source of difficulty with the client rather than looking at the nurse's own knowledge, attitudes or beliefs. Indeed, the intense anxiety experienced by nurses in this case has been described as 'castration anxiety', and results in staff feeling 'impotent' and helpless following self-injury by a client (Pao 1969).

Whilst emotions may run high in nurses working with people who injure themselves, this may be further compounded by lack of knowledge. For example, in a paper by Jeffery and Warm (2002), medical workers (general practitioners and nurses in medical settings) were said to know less about self-harm than people who used this behaviour. A one-way ANOVA statistical test demonstrated a significant difference between medical workers' and psychiatrists' understanding of self-harm and the people who self-harmed. Whilst these authors did not state which type of nurses took part in the study, they found that professionals with psychosocial training had a better understanding of self-harm. Although mental health nurse education tends to be based on psychosocial theories and skills, all nurses need to be able to work professionally with an unbiased attitude towards people who self-injure. Increased knowledge and understanding can support helpers in remaining unbiased when working with this group (Rayner & Warner 2003). Connors (2000) discussed the often-negative effects of self-injury on a therapists' emotional equilibrium. These include fear, anger, helplessness and feeling a failure. It is for these reasons that responses, thoughts and feelings of those in contact with people whom self-injure need to be explored.

People who self-injure are often diagnosed by mental health care professionals as having a personality disorder, or more specifically a 'borderline personality disorder'. Although this is not always a helpful label for the person who self-injures, understanding some of the issues raised by this diagnosis may be of use to professionals. In analytic terms, people fitting the criteria of borderline personality disorder tend to use psychological defences such as splitting and projective identification (Gabbard & Wilkinson 2000), and these produce complex and chaotic reactions in the therapeutic setting, particularly from helpers.

Theoretical issues

Splitting

We refer to splitting as a defence characterized by polarization of good and bad feelings, of love and hate, of attachment

and rejection keeping contradictory intrapsychic aspects apart (Gabbard & Wilkinson 2000). This intrapersonal process clearly works to protect a client from anxiety, but often leads to turmoil and confused reactions from nurses. Often patients' who self-injure label nurses as 'good' or 'bad', and this may be mirrored when nurses label the patient in the same way. This is a normal reaction when people are angry, for example, but as they calm down the split between good and bad aspects of the other person begins to integrate. Splitting is the extreme version of this dichotomous thinking (in cognitive behavioural terms), and the person who has triggered an angry response remains 'all good' or 'all bad'.

An example of splitting is when a client who self-injures builds a positive relationship with a nurse on a ward. They may begin to idealize the nurse and invest them with strength, love and power. The nurse then finds it hard to resist these feelings. Indeed, most people like to believe that they are good carers and 'special'. Eventually, the staff member betrays the idealized image by behaving in a way that is 'merely human' and the client feels let down. The client may then turn on the nurse and 'attack' (usually emotionally). This can result in the nurse feeling demeaned, humiliated, attacked and a failure.

Projective identification

Klein (1946) first introduced the term projective identification to describe a defence mechanism that operates from early life. It was understood as an activity of pressing unwanted feelings, sensations and associated parts of the self on to an external object (Richards 2000). This idea has been developed further and is now thought to be an interpersonal communication strategy about inner world experiences, and has been noted in suicidal clients (Malin & Grotstein 1966).

Such a mechanism is very controversial, with many different definitions. We prefer that by Ogden (1982), who viewed projective identification as a process in which the therapist actually becomes involved in the client's 'inner world'. The client's projected material is internalized and fully experienced by the therapist, who may find it hard to differentiate between feelings that may be projected from the client and emotions linked to their own life experiences.

Ogden wrote about projective identification as having three steps. The first is the (usually unconscious) projection of a part of the self on to another person, with that part controlling the person from within. The second is an interpersonal interaction, where the projector actively pressures the recipient to think and feel in accordance with the projection. The third and final step is identification with the projection by the recipient.

An example of this process applied to Sandra (names are pseudonyms), a client who injured herself on an acute mental health ward and Kate, a nurse involved in her care. Sandra had built up a relationship with Kate and they had been getting on well. After a good session when Sandra began to feel really close to Kate (stage 1), she cuts herself and presented herself bleeding to Kate (stage 2). This resulted in Kate feeling rejected, a failure and 'not good enough' (stage 3). This then may have resulted in Kate thinking many negative thoughts about her ability as a nurse or her relationship with Sandra, for example, 'All our work has been wasted'.

This emotional reaction is mirrored by how Sandra feels about losing her home while in hospital, but is unable to communicate this verbally as the emotions are too intense (this was the trigger event). Often neither the client's nor nurse's feelings are recognized or discussed openly, and therefore neither person processes them effectively. The client who self-injures gets some short-term relief, but in the long term may feel worse. The nurse may question their ability to help and may withdraw from the client, thus reinforcing the latter's negative beliefs, such as: 'I am worthless and a failure' and 'Everyone leaves me in the end'. If these feelings had been verbalized, increased empathy and understanding of the process might have been possible. This might be discussed by staff in supervision and then with the client. The client would then be able to observe a role model coping with difficult emotions in alternative ways, and a person being able to survive experiencing these emotions. This might then prevent further re-enactments and negative influences on the client's beliefs. This perhaps conveniently simple example shows how self-injury and its presentation to nurses may be the interactive part of the projective identification process.

Racker (1957) described complementary and concordant projective identification. Complementary projective identification is where a nurse may feel emotions that complement a clients' self-belief and emotions. For example, a client may believe that they should be punished; they self-injure, then the nurse may feel angry and behave in a punishing way. Concordant projective identification is associated with empathy. The immediate emotional reactions of nurse and client are similar. For example, the client feels out of control and self-injures and the nurse does not know what to do and feels out of control.

When working with people who self-injure, the psychological defences used often produce negative reactions in helpers because the projections and activities bring up emotions in them that they find difficult to deal with. Gabbard and Wilkinson (2000) listed the common counter- transference reactions as guilt, rescue phantasies, transgression of

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professional boundaries, rage and hatred, helplessness and worthlessness and anxiety and terror.

Guilt

People who self-injure may experience angry reactions from nurses. This can then result in nurses feeling guilty because as professionals they feel that they are not supposed to have strong emotions about clients. This may then lead them to reject the client (withdrawal) or alternatively they may attempt to stick with the client by showing how devoted they are as a helper, possibly becoming over-involved. Both reactions are common nursing countertransference responses (O'Kelly 1998). Additionally, nurses may feel guilty about not 'helping enough' or not providing a 'cure'.

Rescue phantasies

Often people who self-injure feel helpless and nurses perceive them as such. Professionals often feel they must 'do' for a client and become a 'good parent' to make up for previous negative parental experiences. This then creates an overly dependent relationship and again reciprocates the splitting and projective identification. Staff may then rescue the client rather than empower them as adults (over-involvement).

Transgression of professional boundaries

People who self-injure can sometimes become an exception from usual procedures. Often staff feel intimidated and as if they are 'walking on egg shells' (Gabbard & Wilkinson 2000). Therefore, usual boundaries, such as time and contact may be changed. This may then result in extended sessions or time spent with the client, late night phone calls and meetings away from the clinical setting (becoming friends), or even sexual contact. The staff member finds it difficult to say no for fear of how the client will react. This is a real issue for nurses, as the idea of an 'individualized, flexible approach to nursing' may be emphasized by the nurse (Cleary 2003) and may also be the expectation of the user and their informal carers (Arnold 1994). Thus, a fine balancing act occurs between client-centred care and protection of nurses' boundaries.

Rage and hatred

Helpers may feel that they are being taken over by powerful feelings of hate or rage that do not belong to them (Gabbard & Wilkinson 2000). Alternatively, they may become increasingly angry at work. This may result in angry outbursts with clients, colleagues or in the nurses' personal lives. The issue of feeling rage and hatred, especially about a client, is still often taboo in nursing. Nurses need to discuss these emotions in clinical supervision.

Helplessness and worthlessness

As the client is feeling so helpless, nurses may also feel very helpless. No matter what they do, their help will not work or is not good enough. They can feel disliked, incompetent and ultimately worthless as professionals. They may also feel deskilled and incompetent. These are often the most difficult feelings for nurses to deal with, and could be classed as a concordant projective identification (Racker 1957), as described earlier.

Anxiety and terror

People who self-injure may elicit an anxious response in nurses as their coping strategies often create ethical and professional dilemmas (Fieldman 1988). Sometimes nurses may have a fear of complete fusion with the emotional state of the person they are trying to help. They need to be able to cope with their own anxiety in skilled and resourceful ways in order to continue to work with people who self-injure. The development of these skills is an essential aspect of clinical supervision when working with people who self-injure.

Countertransference

It is important to recognize that nurse countertransference can be valuable in understanding the emotional intensity of the person's internal world. Specific emotions may occur in different members of the team; for example, one may feel anger, another fear and another helplessness. Essentially, projective identification can be understood as a means of coping with negative emotions, as can increased empathy and communication about feelings and self-injury.

For example, Sandra had been working well with Kate on looking at alternative methods of coping with difficult feelings (rather than self-injury). Kate had been feeling useful and helpful, but Sandra heard that she has just lost her home and reverted to cutting. Kate felt rejected, a failure and worthless: 'All their work has been wasted'. This is actually very similar to how Sandra felt about losing her home, but was unable to communicate this verbally as her emotions were too intense. Therefore, neither person processed their emotions. The person who self-injures gets some short-term relief, but in the long term may feel worse. The nurse questions their ability to help and withdraws from the client. If these feelings had been verbalized, increased empathy and understanding of the process could have occurred.

Current working practices in mental health care often reflect cognitive behavioural theories (National Institute for Clinical Excellence 2004), and psychoanalytic theories may be overlooked. When working with people who self-injure,

we believe that it is essential to integrate theories. As a result of this philosophy, and based on a combination of our experience and the literature, we have produced the following model. The cycle illustrates the process of projective identification, by highlighting negative automatic thoughts and resulting behaviours (although the boxes are numbered in order, other sequences are also possible) (Figure 1).

The example of Sandra and Kate has been illustrated in Figure 2 in the form of a cognitive behavioural cycle of interpersonal processes.

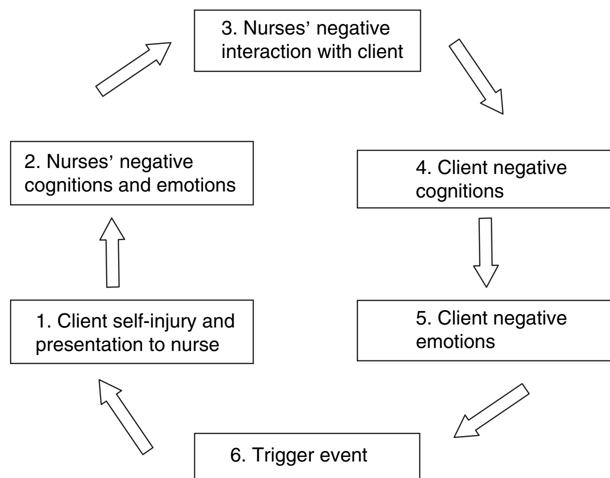

Figure 1 Interpersonal cycle of reinforcement of self-injury.

Nurses may shift into their own negative automatic thoughts and core beliefs, which may lead to behaviours or interactions that confirm the thoughts and beliefs of the person who has injured themselves. An interpersonal process may occur where both people are feeling and thinking similar things about themselves (in concordant projective identification), but this is not communicated. The nurse may feel and express anger towards the client, or turn the aggression inward to produce negative thoughts, such as 'I must have done something wrong'.

This cycle therefore illustrates the potential for nurses' reactions to people who self-injure to have a profound impact on these individuals. Pembroke (1996) discussed her own experiences of contact with health services, showing how the way that nurses responded to her influenced the way in which she perceived herself: sometimes the depth of feelings aroused provoked further self-harm.

We therefore argue that, with an appropriately challenging and supportive approach, both parties may benefit. Indeed, recognizing countertransference in nurses has led to a reported improvement in client care (Winship 1995), enrichment of nursing knowledge (Thompson 1990) and a sense of professional growth (Hallberg *et al.* 1994). Good clinical supervision, support and education are key in this respect. Supervisor or educators should discover and challenge nurses' thoughts and core beliefs and re-frame the incident in a more positive manner. This can help

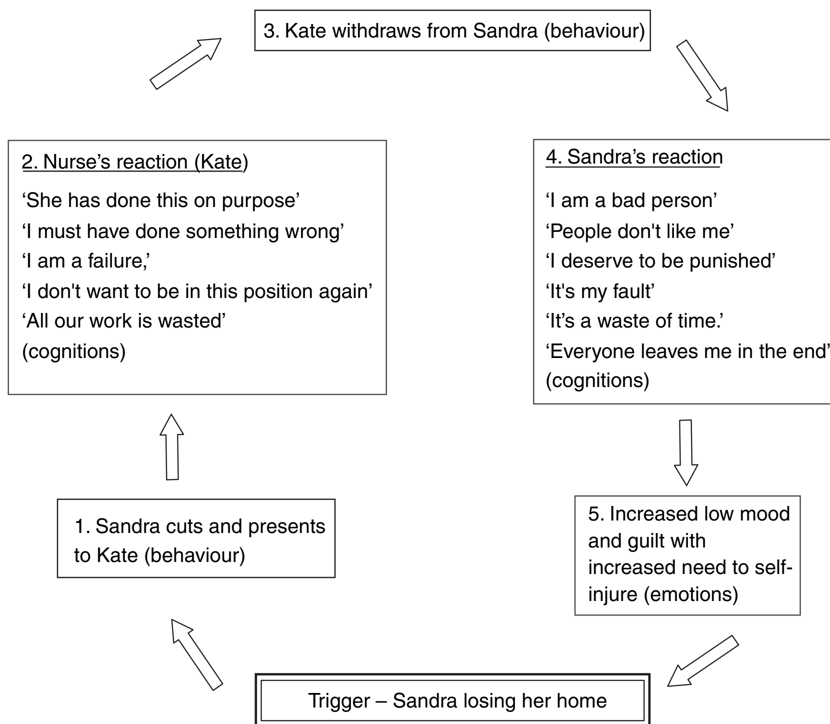

Figure 2 Negative cycle reinforcement of self-injury.

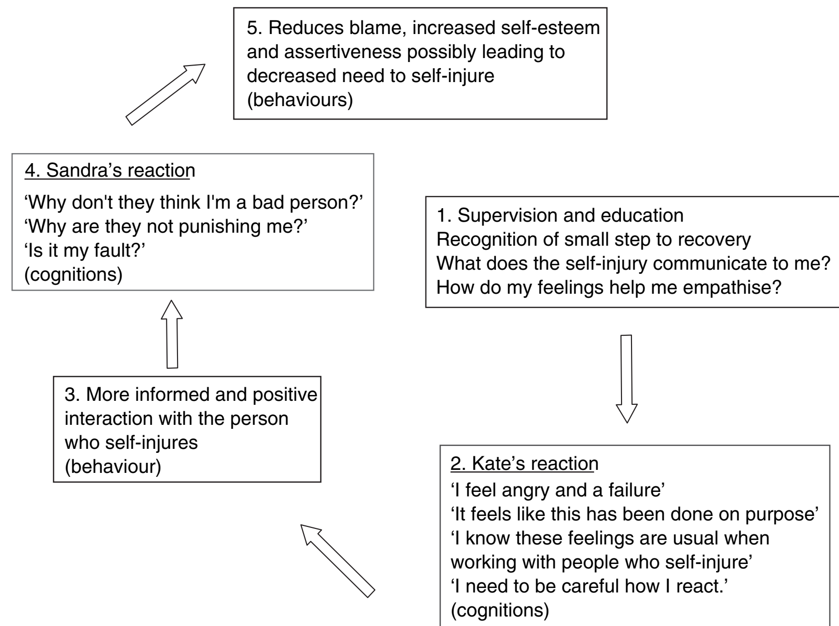

Figure 3 Positive (or less negative) cycle of self-injury.

nurses return to clients with greater awareness of their thoughts and self-beliefs. Hence, the cycle may become as illustrated in Figure 3.

Discussion

Through exploration and knowledge, nurses can begin to disentangle some of the issues associated with working with someone who injures themselves. They can begin to use their responses, thoughts, feelings and reactions to inform their work, thus challenging rejection and enhancing empathy. Of course, one intervention will not usually change a person's core beliefs. Given the stigmatized nature of self-harm, the therapeutic challenge is to reverse previously negative behaviour towards clients. People who self-harm have come to expect this negative response as they may have been treated in this way before. Thus, the recovery process may be a long one, with small steps to recovery.

Supervision can enhance nurses' 'comforting thoughts' and, in turn, the thoughts of people who have self-injured. Recent studies have found that people who repeatedly self-injure or have a borderline personality disorder are unable to soothe themselves or have 'comforting cognitions' (Linehan 1993, McAuliffe *et al.* 2002). This cycle is a 'schema focused' intervention, often used when providing cognitive behavioural therapies for people with personality disorders (Young 1999). The cycle of self-injury and punishment or rejection from others can be seen as 'schema maintenance' (reinforcement of early formulated core beliefs, such as 'I'm bad, I'm worthless'). As individuals, we are committed to our core beliefs, even if they are negative, and so information is distorted to support these beliefs and the consequent self-defeating behaviours reinforce the negative thoughts.

Young (1999), Beck and Freeman (1990) and Davidson (2000) recommend discussing the therapeutic relationship when events trigger a negative schema or core belief. The cycles described above can be discussed with other staff, a clinical supervisor and the person who self-injures in a collaborative manner. Indeed, ignoring the therapeutic relationship when working with people who self-injure may lead to people being deemed 'untreatable' by professionals. The cycle provides a vehicle for improving outcomes.

We have developed this cycle when working with professionals who work with people who self-injure, and we believe that it could be adapted for informal carers, who often report similar experiences.

Self-injury can be understood as a coping strategy for difficult emotions. These result from life events either in the present or in the past, and so self-injury may be viewed as a response to feeling helpless and unable to control life events. Helplessness may prevail as a result of feelings of anger, sadness, guilt and fear, and the person feels rejected or depressed (Babiker & Arnold 1997). The combination of feeling helpless, hopeless and trapped or neglected seems to underpin the complex reasons why people self-injure. In turn, self-injury may serve as an interpersonal strategy to force the health care workers to experience similar emotions. Professionals may assume that this is a conscious process, but this is often not the case.

What is already known about this topic

- People self-injure as a coping strategy to deal with difficult emotions and situations.
- Nurses' have found psychoanalytic and cognitive behavioural approaches useful when working with people who self-injure.
- Professionals often feel angry, sad, rejected or 'a failure' when working with people who self-injure.

What this paper adds

- Consideration of nurses' countertransference reactions to people who self-injure.
- An illustration of psychoanalytic concepts in cognitive behavioural terms.
- A cognitive behavioural cycle for understanding how clients' and nurses' emotions, cognitions and behaviours may influence each other.

Neither nurse nor client may have an opportunity to discuss these emotions in a constructive manner. If nurses use the cycle we have described, these issues may be discussed in supervision sessions or in reflective practice. In turn, they may also be discussed with clients when nurses and supervisors judge this to be appropriate. This is an essential part of any therapeutic approach when working with people who self-injure. Although many people outside of mental health systems who self-injure are not diagnosed with personality disorder, many within the system are. Instead of using this label to turn people away from services by deeming them 'untreatable', we could follow the recent report by National Institute for Mental Health in England (2003) and avoid their exclusion from care. In order to do this, however, nurses need to recognize some of the common defences used so that they increase their understanding and empathy and use these to help people who self-injure.

Limitations of the cycle

This cycle will only be as effective as the nurses and supervisors attempting to apply it in practice. In order to use it, nurses and supervisors must be able to identify thoughts and emotions that link to their own behaviour. Clients may also have difficulties identifying and communicating their thoughts and emotions. This may result in only part of the cycle being used. However, clients' behaviour may be observed and any changes recognized according to changes in nurses' interactions with them.

Additionally, the nurses' thoughts and emotions may be triggered by their previous life experiences, rather than interactions with clients. This should then lead them, via supervision, into counselling or therapy to discuss these issues, as it would clearly interfere with their ability to work with clients. As with other psychosocial interventions, the research base of the framework requires development.

Conclusion

In this paper we have illustrated a cycle for understanding nurses' countertransference reactions when working with people who self-injure. Although some nurses' emotional and cognitive reactions to these clients may be perceived as very negative and difficult, these reactions may be reflected upon and used to develop deeper empathic relationships with clients. By changing how nurses think about clients, their emotions and behaviours can become more positive (or less negative) and avoid exacerbation of the client cognitions and emotions that trigger self-injury. This, in turn, can promote a more positive therapeutic environment, rather than a punitive rejecting one.

Author contributions

Critical revisions of manuscript for important intellectual content – Gillian C. Rayner; drafting of manuscript – Gillian C. Rayner, Shelly L. Allen; editorial redrafting – Martin Johnson.

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