
Developing and Maintaining the Therapeutic Alliance With Self-Injuring Patients



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In this article, the authors outline methods of strengthening the therapist-patient bond with individuals who self-injure. Self-injuring patients present with a host of challenges that differ from other patient populations and therefore certain approaches may be more effective than others. Among the strategies described are validation, checking in, working collaboratively toward goals, providing support, and repairing a ruptured alliance. Potential pitfalls (e.g., reinforcing maladaptive behavior, negative judging, and the fundamental attribution error) to which psychotherapists often fall prey are discussed as well. Self-injury is explained as functional rather than manipulative behavior and detailed clinical guidelines and examples are provided to better illustrate approaches that will improve the therapeutic alliance. © 2007 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 63: 1069-1079, 2007.

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An effective therapeutic alliance is one of the key factors that helps patients develop alternative modes of coping with intolerable affects when habitual self-injury has become common. Patients may choose to try alternative coping strategies only because they trust their therapist and believe that the therapist holds their best interests at the forefront. Furthermore, at the beginning of therapy, a patient may try to refrain from self-injuring

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because of a promise made to the therapist. A positive therapeutic relationship is not the solution to self-injury, but it provides a context in which problem solving and behavior change can take place. Because patients must be willing to endure urges to self-injure without engaging in the behavior itself, having a therapist who provides support, encouragement, and validation for how difficult this is, becomes vital.

Non-suicidal self-injury can elicit fear, blame, and disgust in some practitioners. Although these emotions are understandable, therapists must effectively manage these feelings or they may otherwise interfere with the creation of a productive therapeutic relationship and jeopardize the patient's well-being. In this article, we suggest methods of strengthening the therapist-patient bond in a population of self-injurers. We also discuss some potential pitfalls that psychotherapists should try to recognize and avoid.

Understanding Self-Injury as a Prerequisite to Developing a Therapeutic Alliance

Self-injury, the deliberate self-harm without the intent to die, is generally characterized by unbearable emotional pain coupled with periodic strong and persistent urges to physically hurt oneself. Thus, it is important in any therapeutic approach to acknowledge that self-injury is a way of coping with this pain. The urges may be resisted for a short time, but ultimately the individual becomes overwhelmed with negative emotion and engages in self-injury, often resulting in tissue damage (Simeon & Favazza, 2001; Stanley, Gameroff, Michalsen, & Mann, 2001). Those who self-injure offer a variety of reasons for their behavior: to experience relief from unbearable tension and upset, to distract themselves from intolerable feelings, to communicate distress, to improve their mood, to self-punish, to restore a sense of equilibrium, to provide proof to themselves that they are, in fact, suffering, and to achieve a sense of control (Brown, Comtois, & Linehan, 2002; Klonsky, 2007; Nixon, Cloutier, & Aggarwal, 2002). Following the act, individuals generally report feeling better, and thus the behavior continues as a viable solution to their problems.

In a sense, self-injury is a coping mechanism similar to overeating, purging, excessive drinking, and drug abuse. The danger of self-injury, of course, is in its threat to the individual's physical health. In its most extreme forms, self-injury may cause accidental death. Furthermore, non-suicidal self-injury is one of the strongest risk factors for suicidal behavior.

Self-injury is phenomenologically and empirically different from suicidal behavior. With regard to intent, the aim of non-suicidal self-injury is to obtain relief by removing one's intolerable emotions, whereas suicidal behavior aims to obtain relief by ending one's life. People who commit suicide and those who self-injure are often grouped together because individuals who self-injure are at a heightened risk for suicide (Fyer, Frances, Sullivan, Hurt, & Clarkin, 1988; Stanley et al., 2001). Therefore, it behooves therapists to ask in-depth questions about a patient's suicidal ideation following self-injury. They should not simply assume that every self-injuring individual is suicidal.

Validation: A Basic Ingredient for an Effective Therapeutic Relationship

Therapists typically possess compassion for their patients; nevertheless, it is a challenge to maintain this attitude in the face of feeling frightened, frustrated, or ineffective. These are all common experiences when treating individuals who self-injure. It is important for therapists to "validate the valid" in their patients' experiences. Not only does validation promote confidence and help patients learn to trust themselves, but it also strengthens the patient-therapist alliance and is associated with effective psychotherapy (Cooley & Lajoy, 1980; Keijsers, Schaap, & Hoogduin, 2000; Norcross, 2002).

The following conversation with one of our patients illustrates validation:

- PATIENT (P): I hate that I have never spoken up for myself. All those years of teasing, of being pushed down the stairs for being fat, of verbal abuse by my parents . . . I just let everyone treat me like garbage and make decisions for me. Now I have so much pent up anger—I hate the world, I hate my parents, but most of all I hate myself.
- THERAPIST (T): You have a long history of being taken advantage of and a lot of feelings about how your life would be better now if you had asserted more power back then. (*listening and reflecting back what was heard*)
- P: Exactly. The only thing that makes me feel better now is hitting myself with a metal pipe, as punishment for never speaking up and as a relief when my guilt or anger becomes overwhelming.
- T: The way that you learned to deal with your intense feelings of guilt and anger was to take it out on yourself—maybe because you didn't feel strong enough to confront the abusive people in your life. You were very angry, but couldn't show it for fear of what would happen so you kept quiet. I think you've said that you did this with your father. How did staying quiet help you during your father's angry tirades? (*refraining from showing judgment or disgust, promoting insight*)
- P: Well, I knew that if I disagreed with him, he would only lash out at me more, say more hurtful things, and sometimes he would hit me.
- T: So, being passive was adaptive for you. It helped you avoid further abuse. (*validating reason for patient's past behaviors*)
- P: Yeah, I guess that's true. But I didn't feel good just being quiet, so I started to hit myself. The more I did it, the better I felt. Also, the physical pain feels good—a lot better than the emotional pain.
- T: I understand why you were passive back then. Even though it left you feeling weak, it served you well in preventing further abuse. In a way, you were protecting yourself. I also understand why you continue to hurt yourself. It soothes your emotional pain and makes you feel good. You never learned a healthy way of being assertive without being completely aggressive, and so I don't blame you for reacting the only way you know how. Now our challenge will be to help you learn more assertive responses so that you can feel more in control and at peace without damaging your body. (*reframing self-judgment into more accepting terms*)
- P: But I don't want to stop—nothing else makes me feel good right now except the pipe.
- T: I know that the physical pain is your only effective solution right now. Let's work on some alternative solutions that will make you feel just as good, if not better. To begin with, we're going to start having you practice compassion for yourself—on a daily basis. One way of doing this is to start noticing when you are being judgmental towards yourself and then very consciously restating what you're thinking and feeling in nonjudgmental terms. The kinder you are to yourself for the decisions you made, the less you will hate yourself. The less you hate yourself and the more effective your assertiveness skills become, the less you will want to harm yourself. (*taking her word, encouraging self-validation, instilling hope*)

This conversation reflects validation of the patient through listening, understanding, and believing the patient's feelings to be real. This patient seems to have had few validating experiences in her life. The therapist's understanding of the patient's pain and impulsive behaviors gave the patient a feeling of empowerment; the patient successfully relayed her thoughts and feelings and her therapist valued them. This connection served to bolster the patient-therapist bond. The fact that the therapist refrained from judging the

patient allowed the therapist to understand the patient's core beliefs and automatic thoughts more deeply, which helped the therapist tailor the treatment to meet the patient's specific needs.

At the end of the dialogue, the therapist also highlighted the need for self-validation. It is not enough for practitioners to understand their patients' experiences; patients must also learn how to validate their own feelings and choices. With validation comes greater receptivity to change. This is just the beginning of helping the patient eliminate self-injury. Hard work fighting urges to self-injure, and developing new skills to fight those urges are what follow.

Check-In

A common goal of self-injury is to avoid some feared emotion or interaction. In fact, many individuals describe self-injury as a useful coping mechanism that helps them feel better without having to confront their painful feelings or thoughts. For these individuals, confrontation is fraught with the potential for rejection, disapproval, and criticism. It is, therefore, no surprise that these individuals are unlikely to articulate their feelings and concerns openly to their therapists. Not only do these individuals seek to avoid confrontation, but they may also be overly complimentary or apologetic towards the therapist, for fear that any expression of disagreement will be met with rejection of the patient's ideas or, at an extreme, discharge from the practice.

One of us recently had to reduce the number of times she saw a patient each month, and the therapist found herself rushing to convey her thoughts each time they met. The patient experienced the therapist's hurried manner as impatient and judgmental. Without telling the therapist how she was feeling, the patient came to the next session and proclaimed, "I think it's best that I look for another therapist. I don't think you can help me anymore." Upon inquiry and with much encouragement, the patient told the therapist that she interpreted her therapist's switch to giving a lot of hurried advice as judgmental and critical. Only then were the therapist and patient able to discuss the matter, clarify the therapist's positive intentions, and problem-solve on how to proceed. Had there been a routine check-in about how the patient was feeling about the therapy, the situation would have been caught earlier. This example is meant to highlight the effectiveness of regular check-ins with our patients, as the empirical research consistently documents (Lambert, 2005).

It is good practice to get into the habit of checking-in or asking for patient feedback, in the following different ways:

1. Subjective rating forms that clients complete during the week that are reviewed at the outset of every session. These can include ratings of the alliance, treatment progress, and ratings of various symptoms. Obtaining patient ratings of suicide and self-injury urges can reduce therapist anxiety and allow for more appropriate treatment.
2. Ask for feedback at the end of every session, including how the patient experienced the therapist's methods and assessments and if the patient would prefer any changes. The therapist does not have to dispose of the case conceptualization, but the opportunity to have a conversation about how and why the therapist intervened in the way that he or she did, will improve therapist-client communication.
3. At times, when a patient is reporting one thing, but his or her nonverbal expressions are telling the therapist something else, it is important to ask the patient what else he or she is thinking. This is conducive to a strong therapeutic alliance

in that it lets the patient know that the therapist is taking notice of all aspects of his or her presentation. This conveys to the patient that he or she is important.

Integrating Patient and Therapist Goals

Psychotherapists may be frightened to give direct advice to their patients. Many of us have been taught that patients must come to their own insights for meaningful change to occur. This may be true with certain patients; however, we argue that one of the most compassionate actions you can take is to tell your patient not to self-injure. By asserting the elimination of self-injury, you not only help to protect your patient from physical harm, but you also demonstrate a genuine caring. In a world where they may rarely feel cared for, this directive may be a welcome change. It is one clear way to stand on the side of self-preservation and self-care and not been seen as tacitly approving of the self-destructiveness by ignoring or not addressing the behavior.

Psychotherapists are often invested in stopping self-injury as a priority. You may be surprised to find that many patients are motivated to stop self-injuring. These patients are aware of the negative consequences of self-injury, but they have not been able to develop effective alternatives to the behavior. Other self-injuring individuals, however, have no motivation to stop their damaging behaviors. This is a thorny issue: On the one hand, therapists do not want to jeopardize their relationship with patients by promoting their own agenda. On the other hand, they do not want to provide poor patient care to maintain a good alliance. When therapists and their patients differ in their priorities, collaboration and goal consensus suffer—as will the probability of a successful course of psychotherapy (Tryon & Winograd, 2002). Sessions tend to become more tense than therapeutic.

The keys to collaboration and consensus are *not* to let the patient set the therapeutic agenda entirely. If a therapist feels very strongly that a behavior or plan is life threatening or extremely self-destructive, then that therapist is obligated to make it a treatment priority in the treatment. There are various ways of dealing with this difficult matter.

If therapists explain in a compassionate and nonjudgmental manner why they believe that it is vital to address self-injurious behavior, patients almost always respond with a desire to try to change even if they feel they do not want to relinquish the behavior because “it works.” Strategically, if patients can be convinced that there is something else that will work just as well without involving bodily damage, they are willing to listen and to try.

From the outset, practitioners should collaborate toward a goal that is, first and foremost, to preserve their physical health. At this point, it is useful to ask patients to generate a list of negative consequences of self-injury so that they do not view ceasing self-injury as solely the therapist’s goal, but rather as a joint objective. Negative consequences will be different for each patient, and taking time to understand what is aversive about self-injury for a particular patient will help personalize and focus treatment. An important strategy is to validate the effect, but not the means.

If the patient is unable to think of any negative consequences of self-injury, it is helpful to offer some suggestions. First, educate the patient about how impulsive self-injury can sometimes lead to accidental death, which, if the patient is not suicidal, can be frightening. Second, wonder aloud if the patient suffers embarrassment from self-injury scars, especially in the summertime when bruises and cuts are difficult to conceal. Third, it may be helpful to remind patients that when they mutilate their bodies, it causes concern for their family members, friends, and even their psychotherapist. Some patients may feel bad about upsetting others, which might serve as a motivation for change. Fourth, self-injury fails to solve the underlying problem and promotes a vicious cycle of

destruction. For example, if the patient uses self-injury to avoid expressing his or her feelings, he or she is missing an opportunity to learn how to communicate successfully. Communication is an important skill that a patient will need often in the course of his or her lifetime. Self-injuring individuals will also lose the opportunity to gain a feeling of mastery and control, as well as the ability to handle fear, guilt, and other aversive emotions. Finally, it might be useful to talk with the patient about what kinds of negative emotions he or she experiences after self-injuring. In addition to relief, self-injuring individuals often feel embarrassment and self-reproach. Clearly explaining the treatment rationale communicates the therapist's desire to have an open, honest, and collaborative relationship with the patient. Involving the patient in the goal-setting process promotes greater collaboration, which is essential to a successful therapeutic outcome.

Another useful strategy is to connect different objectives by reframing the patient's and therapist's goals as one and the same. A 32-year-old self-injuring man stated that he wanted help controlling his intense feelings of guilt. The therapist explained that her primary goal was for him to stop burning himself. She then discussed various situations in which the patient burned his arm following an intense bout of guilt. The therapist pointed out this pattern and agreed that helping him manage his strong guilt feelings would be a useful endeavor. The therapist explained that she could offer the patient a variety of skills that would help him manage his emotions so that he would not have such an immediate urge to remove guilt via self-injury. By clarifying that burning himself will never permanently remove the patient's guilt (hence his unsolved problem), the therapist persuaded the patient to try replacement coping strategies.

A final approach is one of compromise. A therapist's willingness to consider alternative objectives often promotes greater cooperation on the part of patients. Compromise also instills in patients a sense of control over their therapy. Negotiation can take the form of lessening the intensity of a request (e.g., rather than throwing the razor blade away, give it to someone to hold), the frequency of a request (e.g., write down your thoughts 3 days a week rather than 7 days a week), or the duration of a request (e.g., if you won't promise not to cut yourself for the next 3 months, then promise not to cut yourself for the next month).

A word of caution: Before psychotherapists compromise their treatment goals, they must decide what is nonnegotiable based on clinical judgment, the research evidence, and their own limits. Therapists should never act against their better judgment because of demands made by patients or patients' family members. Such concessions may result in lethal patient outcomes (Hendin, Haas, Maltsberger, Koestner, & Szanto, 2006) and will not help patients progress. Using a "give and take" technique, therapists must strike the right balance between acceding to the patients' wishes, safeguarding their well-being, and observing their own limits.

Supporting Self-Injuring Patients

How can we help our patients feel hopeful when we are discouraged by their self-destructive behaviors? It is not easy to feel optimistic when a patient returns week after week with cuts and lacerations on his or her arms. Many therapists who work with self-injurers experience hopelessness, anger, patient-blame, and self-blame. If we, as therapists, feel so disheartened, then imagine how the patient's family members, friends, and the patients themselves feel. Chances are that these patients are surrounded by a great deal of negativity as a result of their struggles and the demands that they make on others. Staying positive and encouraging our patients is a tall order, but strengthens the therapeutic alliance.

One of us supervises psychology doctoral students who treat self-injuring and suicidal clients at a New York City hospital. These novice therapists often feel frustrated when clients do not appear to be getting any better. At times, patients are not improving and might benefit from a change in medication, contingencies, or therapeutic approach; nevertheless, at other times patients are improving, but their discouraged therapists cannot see the progress. Noticing any small sign of progress would likely make therapists more hopeful.

It is useful to examine any changes in frequency, duration, or intensity of behavior. For example, ask yourself, "How many times a week did the patient cut in the past compared to the number of times a week that she cuts now?" or "Did the patient used to engage in a more severe form of self-injury than she does now?" Even though the patient is still self-injuring, the rate or method of self-injury may be less acute.

It is also helpful to consider times when the patient is *not* engaging in the harmful behavior. For example, are there times when the patient has a strong urge to bang his head, but stops himself? If so, then he has some skills or motivations that could work to his benefit in therapy. It is often recommended that you consult a colleague when you feel burnout. A fresh perspective can prevent a therapist from becoming completely demoralized and it is essential for those who treat self-injuring individuals (Linehan, 1993).

Once a therapist feels more optimistic, it is easier to encourage and praise a patient. Self-injuring patients, however, often do not experience compliments as supportive. Though counterintuitive, some patients will interpret praise as unsupportive or invalidating (Linehan, 1993). Self-injuring patients may withdraw when complimented.

This week, a supervisee was describing a series of sessions with his patient in which he felt proud that she had not self-injured. He saw her making progress in a number of different areas—improved interpersonal skills, decreased urges to injure, and greater productivity at work. When he expressed delight at her improvement, she responded, "You don't understand how much I'm suffering. I'm not doing as well as other people in my life. I felt so pathetic the other day when I was on a road trip with a bunch of friends, and I was the only one who couldn't drive. I'll never amount to anything." In response to his positive outlook, she highlighted the negatives.

Linehan (2003) explains that individuals who have borderline personality disorder and who self-injure may frequently interpret praise as unfounded. Some have extremely high standards for themselves and tend to view the world as black or white—I am a success or I am a failure—with no room for grey. They react negatively to a discussion of their progress because they are still struggling with so many problems. Some patients fear that praise signifies the beginning of a distancing process, in which the therapist gives the patient more independence than they feel ready to assume. Still others do not want to raise their therapist's expectations because setting high standards will only result in disappointment and even greater frustration. Conceptualizing their fears in this way allows therapists to be more sympathetic to their patients' responses to praise and helps the therapist reframe "praise rejecting" to "praise fearing."

Practitioners can carefully assess their patients' beliefs about praise so that they know how the patients are reacting to their therapist's optimistic comments. Once a patient's reactions are assessed, therapists can address any fears directly. For example, a therapist may reassure a patient that although she is making progress, the therapist is aware that there are other problems with which she continues to struggle. A therapist can also let the patient know that the therapist will not abandon her, even if she begins to improve. Through this process of supporting our patients and assuaging their fears, a greater connection will be established.

Repairing a Ruptured Alliance

Despite our efforts to maintain a positive working relationship with our self-injuring clients, there will inevitably be moments of tension. Ruptures in the alliance may occur when a patient experiences a decrease in self-respect after an interaction with a therapist, or when a therapist makes statements that lead a patient to feel that the patient's needs are not being met (Muran, 2002). Ruptures even occur without the therapist's knowledge when certain negative self-representations are activated for a patient during a session. If handled properly, these moments may be extremely useful in propelling therapy forward. In fact, alliance ruptures that are addressed therapeutically can lead to enhanced outcomes (Kivlighan & Shaughnessy, 2000).

To repair an alliance, psychotherapists must notice that it is damaged. Self-injuring patients may not openly announce feeling slighted or misunderstood. Rather, therapists may need to recognize the signs on their own. Of course, an obvious change in behavior could signify conflict. If an otherwise well-engaged patient withdraws from or verbally attacks a therapist, it might indicate that the patient is offended. The moment at which the rupture occurs may be too subtle for a complete withdrawal or confrontation. It could be a slight stammer or pause at a therapist's request before the patient reluctantly agrees. It could be a grievance felt after a denial of a patient's appeal (Strauss et al., 2006).

According to brief relational therapy (Safran, Muran, Samstag, & Winston, 2005), ruptures in the alliance can be healed by:

1. Teaching mindfulness skills that help increase a patient's awareness of the internal processes contributing to negative therapist-patient patterns
2. Focusing on the process rather than the content of the argument
3. Working collaboratively with the patient to bring a greater awareness to the relationship
4. Treating ruptures as opportunities for understanding and change
5. Obtaining therapist supervision to promote greater self-awareness

A focus on the process rather than the content of a situation frequently brings the focus back to the pattern of dissatisfaction and response rather than to a single situation; therefore, it facilitates generalization to past and future scenarios that will trigger similar relational scenarios. Additionally, therapists should not only help patients identify poor communication patterns, but also help them look within themselves for reactions or judgments that might have contributed to a faulty alliance. In this way, there is a joint effort on the part of the therapist and patient.

As an indirect benefit of repairing a ruptured alliance, patients who often rely on self-injury during times of interpersonal conflict may learn alternative ways of experiencing relief and achieving their goals. Teaching interpersonal skills, apologizing when appropriate, and making an effort to reconnect show a patient, whose expressions of hurt have been often met with rejection or disregard, that there are many effective coping strategies. Though difficult to carry out, repairing a faulty alliance can have a ripple effect throughout treatment.

Pitfalls to Avoid

Several obstacles in treating patients who self-injure have already been referenced in this article. Other barriers to the therapeutic alliance, however, deserve special mention.

Reinforcing Maladaptive Behavior

Self-injurers have a variety of reasons, either conscious or subconscious, for injuring their bodies. If self-injury did not make them feel better in some way, they would not continue to hurt themselves. We must avoid inadvertent reinforcement of their actions when we react to or interact with them (Walsh, 2006). Many therapists have the natural urge to care for their self-injuring clients, especially if those clients receive little support from family members or friends. Whereas demonstrative compassion and kindness does wonders for solidifying a therapeutic alliance, one must be aware of the detrimental outcomes that over concern may have by way of promoting further self-injury. Patients may realize that if they self-injure, they will receive concern from others, which gives them positive reinforcement for their self-destructive behavior. Therapists who treat self-injuring individuals should try to maintain a neutral response style—very matter-of-fact and dispassionate (Walsh, 2006). In the same vein, an extreme negative reaction can jeopardize the relationship and the patient's care.

Intolerant and Judgmental Attitudes

Self-injury is a socially unacceptable behavior because it runs counter to the human instinct of self-preservation. Therapists without prior exposure to self-injury may experience a range of emotions, including fear, panic, upset, and despair. Even therapists who are experienced in treating this population may be taken by surprise or frightened by self-injuring behavior. They may fear that the patient will suffer permanent body damage, worry about being blamed by the patient or patient's family, or feel guilt for having missed a sign that ultimately led to the patient's self-harm. In response to these intense negative emotions, therapists can sometimes resort to scolding the patient, withdrawing, avoiding assessment, or minimizing the problem. Whereas those responses are understandable, they are far from helpful. As a consequence, patients may feel judged or embarrassed, may retreat, may avoid reporting any further self-injury, or, in contrast, may take some satisfaction in worrying their therapist. To avoid alienating a patient, one can respond with nonjudgmental compassion and calm curiosity that focuses on understanding the facts (Walsh, 2006).

Unrealistic Expectations

Psychotherapists hold certain expectations about the course of treatment, including the number of sessions, patient receptivity, and the goals that will be attained. When treating a self-injuring patient, realistic expectations are required to avoid intense frustration and countertherapeutic actions. Expect that self-injuring patients will take longer to progress than other patient populations. Expect to look hard just to detect small gains. Expect that a patient who refrains from self-injury for a period will suffer setbacks and relapses. Expect to witness and endure a patient's intense emotional pain, much like that of a grieving individual. Expect that suggestions for alternative coping responses will be met with outward hostility or passive noncompliance. Realistic expectations do not mean, however, that the therapist should give up—because progress will eventually take place.

Negative Judgments

Self-injuring patients present not only with bodily harm, but also with difficult personality characteristics, such as opposition, reluctance, close-mindedness, and hopelessness.

These patients are often unaware of why they behave the way that they do, and even when they develop more insight, they find it extremely frightening to change. Typically, family members and friends judge these patients negatively. They call them crazy or stupid for not understanding what their behavior is doing to themselves or others. They belittle the pain that these individuals are suffering and interpret their behavior as intentionally manipulative. Even therapists fall prey to these invalidating judgments.

Patients may also feel that they have no idea why they self-injure and that it is impossible to understand. They often report the sentiment, "It just happens. I don't have any thoughts." It is important that therapists not simply accept this response. Take an approach that conveys the feeling that patients may not be aware at the moment of what precedes the self-injury, but they will eventually become aware of the antecedents by placing the behavior under the "therapeutic microscope."

Therapists sometimes angrily discharge patients from their practice for self-injury because they view this behavior as purposefully manipulating and controlling. The multiple demands placed on a therapist by these patients can be overwhelming. Therapists may be asked to see such patients more often, to defend the therapeutic strategy to family members, to increase communication with other mental health professionals, or to be more available to the patient between sessions. Despite these inconveniences, one cannot and should not infer manipulative intent simply because a behavior has negative consequences.

To illustrate: Take a 2-year-old child who has been drinking from a cup (as opposed to a bottle) for close to a year. One afternoon, when his mother goes to answer the telephone, the child accidentally loses his grip and fruit punch spills all over the Persian rug in the living room. His mother is terribly upset because the stain cannot be removed. She blames her son for purposefully throwing the drink on the floor, just to get her attention. She yells at him because she "knows" that he is capable of drinking from a cup; therefore, his behavior must have been intentional. Because the consequences are so distressing, the mother infers that her son intended to cause her distress. This same error can be made with respect to patients' self-injury.

Negative intentions are frequently attributed to maladaptive behaviors in a variety of everyday interactions, but should be disregarded in treating a self-injurious patient. It is obviously an alliance-severing behavior, but it also perpetuates the negative judgment that others have of the patient and that the patient has of herself or himself.

Clinical Issues and Summary

It is a great challenge to maintain equilibrium and optimism when treating self-injuring patients. Therapist judgments, frustrations, and knee-jerk reactions are understandable and expected. The key to a successful outcome is learning how to adapt to the specific obstacles presented by those who self-injure. Validation, collaboration, and patience will enable practitioners to establish and maintain a strong therapeutic alliance. The subsequent opportunity to repair a faulty alliance comes with greater understanding and stronger communication. Conceptualizing self-injury as functional, rather than manipulative, and avoiding common pitfalls will help maintain that working alliance. Even more importantly, the alliance will assist your patient in moving forward toward eliminating the self-injurious behavior.

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