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A qualitative investigation of the counseling experiences of college-aged women with a history of self-injury

Laurie Marie Craigen
William & Mary - School of Education

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**A QUALITATIVE INVESTIGATION OF THE COUNSELING EXPERIENCES
OF COLLEGE-AGED WOMEN WITH A HISTORY OF SELF-INJURY**

A Dissertation Presented To
The Faculty of the School of Education
The College of William and Mary in Virginia

In Partial Fulfillment
Of the Requirements for the Degree
Doctor of Philosophy

By
Laurie Marie Craigen

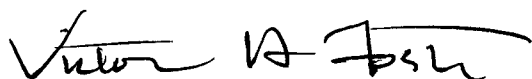
April 2006

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BEHAVIOR**

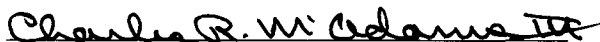
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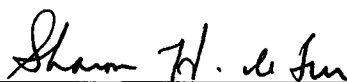
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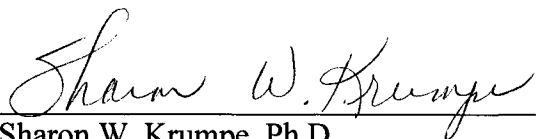
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DEDICATION

First, I would like to dedicate this dissertation to the ten women who devoted their valuable time and energy to be a part of this research. I admire your courage and it was an honor for me to bear witness to your stories and experiences as women who not only experienced—but also overcame their difficulties with self-injury. I would also like to dedicate this story to the first woman I worked with who self-injured. This young woman, at only fourteen years old, inspired me to learn more about self-injury and prompted me to investigate the counseling experiences of women who harm themselves. I would also like to dedicate this dissertation to Brianna, a phenomenal and insightful young woman, whom I worked with over the past year. I am continually impressed with your strength and perseverance in the face of adversity. Thank you for all of the lessons that you have taught me. Finally, I would like to dedicate this research study to all women who are self-injuring. Your wounds speak loudly to me. If you seek treatment, I hope that this study, as small as it is, will help you to receive more competent and effective care.

TABLE OF CONTENTS

DEDICATION	iii
ACKNOWLEDGEMENTS	vii
LIST OF TABLES AND CHARTS	x
ABSTRACT	xi
CHAPTER ONE: INTRODUCTION	
Understanding Self-Injury	2
Types of Self Injury	3
Classifying Self Injury	3
Characteristics of Individuals Who Self-Injure	5
Motivations for Self-Injury	6
Environmental Factors	6
Psychological Factors	6
Biological Motivations	7
Suicide and Self-Injury	8
Critiques of Self-Injury	9
Cultural Psychology Critique	9
Feminist Critique	10
Cognitive Developmental Critique	11
Cognitive Developmental Theory	11
Ego Development Theory	12
Stages	12
Applications of Ego Development and Adolescent Self-Injury	13
Treatment of Self-Injury	14
Treatment Modalities	14
Outcome Research	15
Current Trends in Treatment	15
Counselor Reactions To Self-Injury	17
Self Injury: Experiences in Therapy	17
Adolescents Experiences in Therapy	18
Purpose of Study	20
Rational for Study	21
Grand Tour Question and Sub-questions	21
Researcher As Instrument	22
Delimitations and Limitations	23
Definitions	24
CHAPTER TWO: REVIEW OF LITERATURE	26
Ego Development: Rationale	26
Introduction	26
Cognitive Developmental Theory	26
Ego Development	28
Stages of Ego Development	29

Applications of Ego Dev. and Adolescent Self-Injury	31
Characteristics and Prevention of Individuals who Self-Injure	34
Treatment	47
Treatment Models of Self-Injury	47
Inpatient Treatment of Self-Injury	49
Outpatient Treatment of Self-Injury	56
Counseling Experiences of Self-Injury	57
Summary	60
CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY	61
Purpose of Study	61
Characteristics of a Qualitative Research Approach	62
Rationale for a Qualitative Study	65
Research Paradigm	66
Research Strategy	67
Sample Selection	68
Participants and Sampling Procedure	68
Setting	69
Researcher's Role	69
Entry	69
Reciprocity	70
Data Collection Techniques	71
The Qualitative Interview	71
Reflexive Journal	72
Data Generation, Collection, and Analysis	73
Description	73
Plans for data generation/collection	73
Data Analysis	75
Ethical Considerations	77
Ego Development Data: Sentence Completion Test (SCT)	78
The Washington University Sentence Completion Test	78
Scoring the SCT	79
Demographics Questionnaire	80
CHAPTER FOUR: WITHIN-CASE ANALYSIS	81
Overview of Analytic Procedures	81
Analysis of Participant #1: Amy	83
Analysis of Participant #2: Claire	97
Analysis of Participant #3: Sam	106
Analysis of Participant #4: Ann	117
Analysis of Participant #5: Juliana	131
Analysis of Participant #6: Katie	146
Analysis of Participant #7: Calliope	162
Analysis of Participant #8: Jane	175
Analysis of Participant #9: Becky	189
Analysis of Participant #10: Kylie	203

Chapter Summary	220
CHAPTER FIVE: CROSS-CASE ANALYSIS	222
Overview of Analysis	223
Theme #1: Important Relationships	225
Theme #2: Self-Injury	233
Theme #3: College Experience	242
Theme #4: Counselor	250
Theme #5: The Counseling Process	258
Theme #6: Personal Reflections on Counseling	275
Chapter Summary	285
CHAPTER SIX: CONCLUSIONS AND IMPLICATIONS	286
Research Questions	286
Grand-Tour Question	286
Phenomenological Profile	287
Experiences in Counseling	288
Comparison to the Literature	292
Sub-Question #1	293
Comparison to the Literature	297
Sub-Question #2	300
Comparison to the Literature	302
Sub-Question #3	303
Comparison to the Literature	307
Study Implications	310
Treatment Implications	311
Implications for Future Research	316
Implications For Counselor Education And Training	319
Personal Statement	319
REFERENCES	322
APPENDICES	330
A. Informed Consent	330
B. Introductory Letter to Participants	331
C. Brief Demographic Questionnaire	332
D. Questions for First Interview	333
E. Questions for Second Interview	334
F. Sentence Completion Test For Women	335
G. Journal Reflection Prompts	337
H. Vita	338

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LIST OF TABLES AND CHARTS

Table 4.1	Ogive and Item Sum Table to 18-Item Forms	82
Table 4.2	Demographic Overview of Participants	83
Table 4.3	List of Themes and Sub-Themes: Amy	83
Table 4.4	List of Themes and Sub-Themes: Claire	97
Table 4.5	List of Themes and Sub-Themes: Sam	106
Table 4.6	List of Themes and Sub-Themes: Ann	117
Table 4.7	List of Themes and Sub-Themes: Juliana	131
Table 4.8	List of Themes and Sub-Themes: Katie	145
Table 4.9	List of Themes and Sub-Themes: Calliope	161
Table 4.10	List of Themes and Sub-Themes: Jane	174
Table 4.11	List of Themes and Sub-Themes: Becky	189
Table 4.12	List of Themes and Sub-Themes: Kylie	203
Table 5.1	Ego Development Grouping	222
Table 5.2	Cross-Case Themes	224

A QUALITATIVE INVESTIGATION OF THE COUNSELING EXPERIENCES OF COLLEGE-AGED WOMEN WITH A HISTORY OF SELF-INJURIOUS BEHAVIOR

ABSTRACT

The purpose of study was to investigate the counseling experiences of college-aged women with a history of self-injurious behavior. Although self-injury is an emerging phenomenon, the behavior continues to be stigmatized by the counseling profession. Further, research within the mental health community is conducted from the treatment providers' perspective or through quantitative experimental research designs; very few have investigated the counseling experiences of individuals who self-injure.

This study utilized an interpretive paradigm and a phenomenological strategy to investigate female adolescent self-injurers' experiences in counseling. The use of a cognitive developmental framework, specifically ego development, provided an appropriate lens in which to view the participants' responses. In past research studies, ego development has been used to conceptualize a variety of different clinical disorders.

Flyers and an online advertisement were used to recruit a total of 10 women from a small college in the Southeastern Region of the United States. Each woman was interviewed on two separate occasions. When the second interview was complete, Loevinger's Sentence Completion Test was administered.

The grand tour question for this study was: How do college-aged women with a history of self-injurious behavior experience counseling? The sub-questions were the following: (1) From the perspective of the college-aged females, what was the nature of the client-counselor relationship? (2) From the perspective of the college-aged females, how was their self-injury addressed in the context of the counseling relationship? (3)

Using Loevinger's framework for assessing ego development, how did college-aged women make sense of their counseling experience?

Data analysis revealed several indigenous themes, unique to each participant. A total of six interpretive cross-case themes emerged across the ten participants. They were: Important Relationships, Self-injury, College Experience, A Helpful Counselor, The Counseling Process, and Experiences in Counseling.

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**A QUALITATIVE INVESTIGATION OF THE COUNSELING EXPERIENCES
OF COLLEGE-AGED WOMEN WITH A HISTORY OF
SELF-INJURIOUS BEHAVIOR**

CHAPTER I

INTRODUCTION:

Understanding Self-Injury

Introduction to Self-Injury

Self-injurious behavior is an emerging phenomenon, affecting an increasing number of individuals in America (Favazza, 1996; Levenkron, 1998). Accurate statistics are not viable because of the privacy and secrecy associated with this phenomenon. Favazza and Conterio (1988) estimated the prevalence of self-injury in the general population to be 750 per 100,000 or 1800 per 10,000 in persons aged 15 to 35. On the other hand, the incidence of self-injury in the clinical population is much higher than the general population, ranging from 4.3% to 20% of all psychiatric inpatients (Suyemoto, 1998; Darce, 1990; Langbehn & Pfohl, 1993). Additionally, Gratz (2001) estimated that 35% of college students have reported a history of self-injurious behavior, with 15% reporting more than 10 past incidents of self-injury and 9% reporting more than 100 past incident of self-injury. In spite of this emerging phenomenon, self-injury continues to be misunderstood and stigmatized by the counseling profession (Favazza & Rosenthal, 1993). Consequently, many counselors lack a clear understanding of how to effectively intervene with this population.

Over the past several years, there has been a long-standing debate about naming this phenomenon. Psychologists have referred to self-injury as “deliberate self injury,” “parasuicide”, “self-mutilation,” “self-harm,” and “self-inflicted violence” (McAllister, p.178, 2003). For the purposes of this manuscript, the phenomenon will be referred to as self-injury. In addition to these multiple terminologies, no universal definition of self-injurious behavior currently exists. This paper will rely on the following two-part

definition. First, self-injury is the deliberate alteration or destruction of body tissue without conscious suicidal intent (Favazza and Rosenthal, 1993; Simeon, Stanley, Frances, Mann, Winchel, & Stanley, 1992). Second, the act of self-injury must be antithetical to culturally accepted forms of body modification or cultural practices (Favazza, 1998).

Types of self-injury

Cutting, burning, self-hitting, interference with wound healing, hair pulling, and bone breaking are all types of self-injurious behavior. The most common example of self-injury is cutting, which has also been popularized in contemporary literature and motion pictures (*e.g., Girl, Interrupted; Thirteen*).

Classifying Self-Injury

Individuals who self-injure can be divided into two dimensions; dissociative and non-dissociative (Favazza, 1993; 1996). Dissociative self-injurers are not aware that they have harmed themselves until the act is finalized or until they notice the blood running from the wound. These individuals may also experience dissociation in other areas of their life. In contrast, non-dissociative self-injurers aim to feel physical pain and are aware of themselves before, during, and after the act of self-injury (Favazza, 1998). Literature suggests that these individuals comprise the largest segment of this client population, and most treatment models are developed for this particular presentation.

In 1983, Mansell Pattison introduced a classification of self-injury based on three variables: the directness of bodily harm, the repetitiveness of the behaviors, and the potential for lethality (Favazza, Forward in: *A Bright Red Scream*). Favazza and Rosenthal (1993) expanded upon this classification and arrived at the following categorization of “deviant self-mutilation:” major, stereotypic, and superficial/moderate.

Both major and stereotypic self-mutilation may exist within certain medical or psychiatric diagnoses. Major self-mutilation refers to infrequent acts that result in the destruction of significant body tissue, such as limb amputation and eye enucleation (removal of the eye ball). This category is associated with psychosis and seen often in acute psychotic episodes, schizophrenia, mania, or depression. On the other hand, stereotypic self-mutilation refers to repetitive acts of harm, which includes head banging, self-hitting and self-biting. These behaviors occur most frequently in individuals with mental retardation, autism, or Tourette's syndrome (Favazza, 1998).

Superficial/moderate self-mutilation is reportedly the most common type of self-injury. It refers to behaviors such as skin cutting and burning, hair pulling, nail biting, and skin scratching. There are three types of superficial/moderate self-mutilation: compulsive, episodic, and repetitive. Compulsive self-mutilation is frequent and often ritualistic. Hair pulling, also known as trichotillomania, is one type of compulsive self-mutilation. Episodic self-mutilation occurs less frequently than compulsive self-mutilation and it is defined as individuals who "deliberately harm themselves to feel better, to get rapid respite from distressing thoughts and emotions, and to regain a sense of control" (Favazza, 1998, p.251). Finally, repetitive self-mutilation is a behavior that becomes addictive, as the person is unable to resist the impulse and feels compelled to harm herself repeatedly (Favazza, 1996). According to Favazza (1998), most repetitive self-mutilators have problems with other form of impulsivity in their lives. For example, there are high rates of co-morbidity with bulimia and kleptomania, two behaviors strongly linked with impulsivity. Considering these different classifications, this paper will focus primarily on superficial/moderate classification of self-injury.

Characteristics of Individuals Who Self-Harm

One's first experience with self-injury is estimated to occur within the age range of 13-23 (Favazza & Conterio, 1988). White et al. (2002) suggested that traditional college-aged students (18-23) are at the highest risk for self-injury. Recent research reports indicate that episodes of self-harm are three to four times more common in women than in men (McAllister, 2003). Others disagree, arguing that self-injury is grossly underreported by males (Favazza, 1998). Research has neglected the examination of other racial and ethnic groups. Thus, little is known about this activity in marginalized or non-dominant groups. Differing contextual elements and life experiences may contribute to the phenomenon of self-harm among individuals who cope with oppression and cultural invisibility.

Many individuals who self-injure are emotionally inarticulate, lacking an extensive vocabulary to express their emotions (Levenkron, 1998; Stone & Sias, 2003). On the other hand, these same individuals are often able to cognitively rationalize and intellectualize the reasons behind their self-injury at great length. In spite of these differences, the majority of those who self-injure share an enormous amount of pain and turmoil beneath their scars.

Individuals who self-injure commonly have co-morbid diagnoses with the following: depression, dissociative identity disorder, obsessive-compulsive disorder, schizophrenia, anxiety disorders, adjustment disorders, borderline personality disorder, and other personality disorders (Suyemoto, 1998). Additionally, it is increasingly common for women to have co-morbid diagnoses with an eating disorder. Individuals with eating disorders are suggested to be a high risk for self-injurious behavior. An investigation of a study that examined the prevalency rates of eating disorders in the self-

injuring population yielded eating disorder rates at 30% (Paul, Schroeter, Dahme & Nutzinger, 2002). These dual diagnoses may be valid. On the other hand, many individuals who self-harm may receive additional diagnoses because there is no official diagnosis for self-harm, and the clinician treating the individual may not properly understand the phenomenon of self-injury.

Motivations for self-injury

The reasons why an individual may choose to self-injure are likely numerous and complex. The literature revealed three primary motivating factors for self-harm: environment, biology and psychology.

Environmental Factors

Research indicates that the family of origin may influence later acts of self-injury. For example, strong correlations between childhood physical and/or sexual abuse and self-injury in later life have been discovered (Kiselica and Zila, 2001; Hodgson, 2004). Van der Kolk, Perry, and Jerman (1991) reported that 70% of adults who reported self-injury also reported a history of childhood physical abuse. Additionally, many who self-injure reside in a home with at least one alcoholic parent or within a home where drug abuse exists (Levenkron, 1998). Finally, individuals who self-injure commonly report tumultuous or distant relationships with family members. Evidence suggests that there is a strong association between poor parent-adolescent communication and self-injury (Tulloch & Blizzard, 1997).

Psychological Factors

Self-injury can also be viewed as an intra-psychic phenomenon. One frequently cited reason for self-injury is to end a period of depersonalization where individuals feel detached from their bodies (Favazza and Conterio, 1998). Some who self-injure explain

that harming themselves provides a grounding in reality and brings them back to the here and now. Self-injury may also provide individuals with a sense of control; for many, they can control different aspects of the behavior on their own terms. On the other hand, Bennum (1983) found that 70% of individuals who harm themselves reported that they felt no control over the act.

Many individuals who self-harm explain that the act of self-injury distracts from one's emotional pain. Additionally, those who self-injure oftentimes feel numb and void of any emotions. For example, clients may express that "feeling something is better than feeling nothing at all." Other clients may lack the ability to express their emotions verbally. Self-injury allows the person to consciously or unconsciously communicate a need for help. Additional reasons for self-injury found in the literature are tension release, self-punishment, punishment or revenge towards another person, risk taking, and frustration (Kiselica and Zila, 2001).

Aside from these numerous reasons, self-injury has also been categorized as a maladaptive coping strategy (Haines & Williams, 1997). For many, implementing self-injury across several problem situations indicates that individuals have few effective coping strategies (Haines & Williams, 1997). This stance is not without criticism; an alternate viewpoint suggests that it may be useful to understand self-injury as an adaptive act and as a means of a survival, rather than a deficient coping strategy (Solomon and Farrand, 1996). Many who harm themselves do so in order to stay alive, in order to prevent themselves from suicidal gesturing.

Biological Motivations

In addition to the environmental and psychological motivations for self-injury, research is now beginning to investigate biological explanations for self-injury. Recent

neurobiological research demonstrates that self-injury has physiological antecedents and consequences which may instigate the behavior, making it difficult for individuals who self-injure to stop (Winchel & Stanley, 1991; Naomi, 2002). Neurotransmitters have been investigated to determine their potential links to self-injury. For example, Simeon (1992) examined serotonin activity in a study of self-injurers and non-self-injurers with personality disorders. Research results illustrated that self-injurers had significantly lower levels of serotonin activity. These findings speak to the efficacy of using psychotropic medications to increase brain serotonin levels and consequently reduce incidence of self-injury (Favazza, 1998).

An additional group of neurotransmitters called enkephalins have also been shown to demonstrate a potential link to self-injury. The two major tasks of these neurotransmitters are to suppress pain and to regulate emotions. “One theory is that since enkaphalins have a generally pleasurable effect, individuals who self-injure may harm themselves to induce the production of them” (Favazza, 1998). If this is the case, individuals may link their harming behaviors with positive feelings and pleasure. This effect may then motivate individuals, when they are feeling depressed or unhappy, to harm themselves in order to feel better. Empirical studies examining the role of neurotransmitters in self-injury are limited, and future research, which may ultimately guide treatment, is needed.

Suicide and Self-Injury

Regardless of motivation, self-injury is distinct from a suicide attempt (Hodgson, 2004). For individuals who self-injure, the intent may be to release tension, and many individuals report a sense of relief after the act of self-harm. On the other hand, the goal for the suicide attempter is to end one’s life; feelings of hopelessness and despair

predominate (Fawcett, Scheftner, Clark, Hedeker, Gibbons, Coryell, 1987). In spite of the differences between suicide and self-injury, parallels exist between the two, and self-injury can coexist with suicidality (Vicekandanda, 2000). Research has demonstrated that approximately 55%-85% of individuals who self-injure have made at least one suicide attempt (Favazza & Conterio, 1989; Stanley, Gameroff, Michalsen, Mann, 2001). Additionally, the individual who self-injures is 18 times more likely than the rest of the population to eventually commit suicide (Ryan, Clemmets, & Snelson, 1997).

The foregoing sections of this chapter provide the reader with a comprehensive understanding of the self-injury. The following section will introduce three critiques of self-injury: a cultural psychology critique, a feminist critique, and a developmental critique. The developmental critique will serve as the theoretical framework for the ensuing research study.

Critiques of Self-Injury

Cultural psychology critique

Armando Favazza (1998), a cultural psychiatrist, is a contemporary investigator of self-injury. He disputes contemporary thought that self-injury is only atypical, pathological, and culturally unacceptable. Rather, he recognizes that cultural rituals often involve self-injury to promote physical healing, spirituality, and social order.

Within many tribes and religious groups, body modification rituals are thought to be pleasing to the gods, to serve the function of initiating adolescents into adulthood, and to allow individuals to achieve a state of insight or revelation.

Cultural rituals are distinguished from cultural practices. Although cultural practices involve self-injury, they usually lack significance and deep meaning and are viewed as normal and acceptable (Favazza, 1998). Some examples of culturally

approved practices include ear piercing, personal tattoos, and eyebrow plucking. For the majority of people, these cultural practices are viewed as “artistic” or a form of self-expression; many tolerate the pain for the finished product. However, some individuals with excessive tattoos or piercings may be satisfying the same intent as one who frequently cuts him/herself. In this case, the intent behind the self-injury is important to consider.

A cultural critique of self-injury encourages counselors to adopt a holistic understanding of body modification rituals. The milieu where the behavior took place dictates whether the act of self-injury is atypical or culturally appropriate. Moreover, a cultural critique of self-injury urges the mental health community to consider context when providing treatment to this population.

Feminist critique

A feminist framing of self-injury encourages therapists to look beyond the individual and to consider social factors that contribute to one’s self-harming behaviors. Naomi Shaw (2003) argued that the direct destruction of one’s body is symbolic of women’s experiences of injustice within our contemporary culture. The following quotation by a self-injurer helps to explain this argument:

Sometimes my wounds were light because I felt too undeserving to express anything. At other times, cutting was an act of defiance and anger. I was trying to reclaim my own territory, my body, my power, something which had been taken from me, rendered numb, silenced (Shaw, 1997, 438-9).

Self-injury in this case, and with many others, is an intentional act, one that seeks to be heard and understood by others. Many women who self-injure experience difficulty

verbally expressing their emotions. Thus, the act of self-injury may serve as a vehicle to communicate their feelings of discontent in their current society.

Self-injury, in the context of a feminist perspective, demonstrates that the behavior is a function of both the person and the environment; it fails to accept that self-harm is an intra-psychic or individual pathology. Further research on this perspective is warranted in the literature.

Cognitive Developmental Critique

Researchers argue that self-injury is a developmental phenomenon (Simpson, 1975; Doctors, 1981; Conterio and Lader, 1988). In spite of this, self-injury has never been examined through a developmental lens. Researchers have only drawn tentative parallels between self-injury and human development. In spite of this, examining self-injury through the lens of cognitive developmental theory could offer valuable information, providing wide-ranging implications for treatment and case conceptualization.

Cognitive Developmental Theory

Cognitive developmental theory is a comprehensive theory based on a set of assumptions about meaning making across different functional domains (Sprinthall, Peace, & Kennington, 1999). The basic premise of cognitive developmental theory is that reasoning and behavior are strongly associated with the level of complexity of psychological functioning. According to this theory, individuals at lower levels of cognitive complexity exhibit concrete and less adaptive behavior in solving problems. Conversely, persons at higher levels of development display more adaptive behaviors and are capable of more complex reasoning in problem-solving situations. By and large, the majority of research on self-injury has examined the behavior as a pathological

phenomenon. Many researchers argue that the behavior can be treated and extinguished with behavioral strategies. The inclusion of cognitive developmental theory moves away from this conceptualization altogether and argues that those with clinical disorders are not developmentally immature or deficient, but instead they have taken a different pathway. In fact, the developmental levels of adolescents with clinical issues are typically the same as those in normal development (Fischer, Ayoub, Singh, Noam, Maraganore, and Raya, 1997).

Ego Development Theory

Ego development is a specific model of cognitive development; this theory is one way of exploring the counseling experiences of college-aged women with a history of self-injury. Loevinger defines the ego as the master trait, the core component of one's personality, which organizes and integrates one's experiences so that meaning can be ascribed to them. Individuals at lower levels of ego development demonstrate simple, undifferentiated psychological perspectives, while individuals at higher levels of ego development demonstrate increasingly more complex, differentiated orientations of themselves and their environment (D'Andrea and Daniels, 1992).

Stages

Loevinger's theory of ego development consists of nine stages that move hierarchically, from the simple to the complex. The first stage is representative of the infant's world, in which the child constructs a stable world of objects. Due to the specific population of this study, the first stage is not applicable for this research study. Then, the Impulsive stage (E2) is the first stage, which is applicable to the examination of the counseling experiences of college-aged women. Dichotomous thinking and an inability to reflect inwardly characterize this stage. In the Self-Protective stage (E3), the main

characteristics are protection of self-interest and pre-occupation with “getting into trouble.” Within this stage, blame is understood but assigned to other or situations besides oneself. (Loevinger, 1976). The Conformist Stage (E4) is the first time that the individual begins to identify personal welfare with that of the group (Watt, et al, 2002). There is a right way and a wrong way, a delineation, which remains consistent in all circumstances and for all people. At the Self-Aware stage (E5), the individual has become aware that not everyone, including him/herself conforms to societal expectations (Loevinger, 1976). Growth to the Conscientious stage (E6) marks another shift in development where there is a heightened consciousness of the self and one’s inner feelings. Individuals at this stage recognize that there are multiple possibilities in situations, and they now understand that rules have exceptions. Individuals at the Individualistic Stage (E7) are more concerned with their own individuality and have a rising tolerance for individual differences. The Autonomous Stage (E8) features an increased expression of feelings and heightened tolerance for ambiguity. Within the Integrated Stage (E9) an individual is able to transcend conflict and differences and achieve an integrated sense of identity. This stage marks the highest developmental level and is more theoretical than empirical; very few individuals have ever achieved this level of functioning.

Applications of Ego Development and Adolescent Self-Injury

Ego development is one way of exploring the counseling experiences of college-aged women with a history of self-injury. In fact, Swenson (1980) stated that ego development, when compared to all of the developmental theories, seems best applicable to counseling. It is possible that college-aged females at various levels of ego development may reflect upon their experiences in counseling differently. This reality

may have direct implications for treatment conceptualization and planning; clinicians may need to alter therapy approaches based on a client's level of development.

In recent years, investigators have begun analyzing clinical problems in terms of ego development. This new direction is not surprising, since ego development refers to behaviors and attitudes involved in impulse control, anticipation, responsibility taking, social judgment, and cognitive complexity (Hauser, Powers, & Noam, 2001). For example, Evans, Brody, and Noam (2001) examined the relationship between ego development and psychological defenses related to aggressive behavior with a group of adolescent inpatients. Findings from this study found that those with externalizing disorders have lower levels of development than those with internalizing disorders.. Finally, Recklitis and Noam (1999) examined clinical and developmental perspectives on adolescent coping using a study of hospitalized adolescents. In this study, the authors found that coping is not only a response to stress, but is also linked to the ways in which individuals organize and make meaning of their environment.

The foregoing sections provide a rationale for the use of Loevinger's theory of ego development in this study. Ego development will provide an appropriate lens to conceptualize the counseling experiences of college-aged women with a history of self-injurious behavior.

Treatment of Self-Injury

Treatment modalities

Although self-harm is an increasingly serious phenomenon, past research indicates that there is insufficient evidence for the most effective forms of treatment for this population. Current literature presents a diversity of treatment options for self-injury. Individual counseling tends to dominate the treatment modalities, which include

psychoanalytic therapy, cognitive behavioral therapies, problem solving approaches, dialectical behavior therapy, hypnotherapy and relaxation training, and intensive in-patient treatment.

Outcome Research

Outcome research on individual treatment modalities remains limited. Many of the past studies have included far too few subjects to have the statistical power to detect clinically meaningful differences in rates of repetition of deliberate self-harm between experimental and control treatments. Additionally, the majority of studies employ heterogeneous samples, and the majority are convenience samples. Also, the majority of studies were conducted upon patients treated in emergency rooms or within an in-patient setting. Although this may be the most realistic environment to recruit participants, it does not provide an adequate picture of the self-harming population. Many self-harmers are never admitted to the hospital and are not involved in inpatient treatment. Thus, there is a definite need to examine self-harmers outside the confines of a hospital setting. With this being said, recruitment of self-harmers outside the hospital environment may be extremely problematic, especially in a school setting; issues of confidentiality may prevent researchers from gaining a large enough sample size. Given the inconsistencies between the target population and the accessible population, the reported research may not be generalized for application to outpatient intervention and counseling.

Current Trends in Treatment

Recently, there has been a shift in the discourse of treatment of self-injury, including a movement away from psychodynamic therapy, and a push toward pharmacological treatment and short-term approaches; this shift reflects more general changes in the mental health profession (Grob, 1994; Shorter, 1997; Naomi, 2002). In

recent years, selective serotonin reuptake inhibitors (SSRIs) have demonstrated consistently positive reports. However, researchers caution that the experimental studies are few and involve small numbers of patients (Favazza, 1996). In addition to SSRIs, Dialectical Behavioral Therapy has gained recognition for its success with individuals who self-injure. This cognitive behavioral approach, developed by psychologist Marsha Linehan, consists of both individual and group therapy. DBT targets problems behaviors and aims to teach more adaptive solutions (Strong, 1998). During counseling sessions, clients are encouraged to examine the events and emotions that lead up to the act of self-injury and consider what alternatives could be used to avoid future self-destructive acts. Behavioral skills, interpersonal skills, and goal setting are also addressed with DBT (Favazza, 1996).

Family therapy interventions are also gaining more popularity. Levenkron (1998) argued that “the more significant people in the self-injurer’s life who are involved in changing the patient’s expectations, the more effective the treatment” (p. 155). Stone and Sias (2003) introduced a bi-modal treatment approach to self-injury, which calls for a combination of individual and family system treatment modalities. In their work with a client who self-injured, they reported the successes of a psycho-educational approach with the family. This involved educating the entire family about this behavior and instructing the family members in ways to respond appropriately to their family member’s self-harming behaviors. Matthew Selekman (2002) also wrote about the importance of family therapy with self-injury in his book, *Living On The Razor’s Edge: Solution-Oriented Brief Family Therapy With Self-Harming Adolescents*. Selekman presented a multisystematic family assessment framework that considers the complex interplay among individual, family, peer-group, gender, cultural, and community factors.

Using this model, counselors are encouraged to adopt a collaborate stance, working together with other helping professionals in the self-injurer's life.

In spite of the new and diverse treatment options available today, counselors today are still left with a great deal of uncertainty and misunderstanding about what approaches work best for individuals who self-injure.

Counselor reactions to self-injury

Self-injury is a phenomenon in which where emotional wounds are brought to the surface and manifested in the form of visible wounds and scars. For counselors, the sight of these injuries can be alarming, disturbing, and gruesome. Many counselors feel uncomfortable working with this population and are subsequently quick to pathologize these behaviors. Other counselors lack a clear understanding of this phenomenon. For example, women seeking treatment have been sutured without anesthesia, scrubbed with wool surgical sponges on open wounds, and refused medical treatment because their injuries are self-inflicted (Favazza, 1989; Blessing, 1990; Pembroke, 1996; Shaw, 2002). Other clinicians erroneously associate all individuals who self-injure with Borderline Personality Disorder. Attitudes and behaviors like these can have wide-ranging implications for individuals who self-injure. Many who receive professional help indicate a high rate of dissatisfaction with treatment (Favazza and Conterio, 1998; Arnold, 1995).

Self-Injury: Experiences in therapy

Presently, there is little known about how individuals who self-injure view the treatment they are given (Pierce, 1986). Psychological interventions have generally built on evidence gathered from clinicians, rather than the young people themselves (Crouch & Wright, 2002). Over the past two decades, there have only been a few published studies

that speak to individuals' perspectives on the care they receive after their acts of self-harm and each study occurred within the context of a hospital or inpatient setting. For example, Pierce reported that patients who viewed their staff to be sympathetic demonstrated a lower rate of subsequent self-injury. Additionally, Treloar and Pinfold (2002) revealed that sympathy and listening by medical staff were viewed as important to individuals who self-injure. Finally, Croach & Wright (2002) discovered that participants expressed a fear of rejection from treatment providers in an inpatient treatment setting while also expressing a desire to be understood. While these findings are valuable to inpatient treatment of self-injury, there has been no investigation on self-injurers experiences within the outpatient counseling arena. A study with individuals beyond the confines of a hospital setting could guide future research on self-injurers' experiences within the counseling setting.

Adolescents' experiences in therapy

In the current literature there exist numerous articles outlining specific interventions for adolescents. Additionally, there are countless articles that illustrate adolescent development and speak to the unique developmental tasks of adolescents. In spite of this, there remains a lack of knowledge concerning adolescent mental health (Kazdin, 1993). More specifically, researchers have neglected to examine how adolescents perceive their counseling experiences (Smith-Jobski, 2003). Dunne, Thompson, and Leitch (2000) argue, "we know almost nothing about the experience of therapy for young people and about what within the therapy hour makes a difference to them" (p. 79).

The examination of the experiences of college-aged women in the counseling arena could provide therapists with a deeper understanding of the counseling process and

ultimately may result in more effective therapist interventions, which, in turn, may lead to improved outcomes (Buston, 2002). After all, “if adolescents remember their experiences (in counseling) in a negative way, they may be less likely to attend appointments to comply with advice or prescribed treatment, or to seek help in the future” (Buston, 2002, p. 239).

In a comprehensive review of the literature, Smith-Jobski (2003) examined research on adolescents’ experiences in counseling. In her exploration, she found only a total of seven articles related to the counseling of adolescents. Of the seven articles, only two addressed the subject of what adolescents say about the counseling services they received. The authors of these articles discovered the following information: adolescents place enormous value on an understanding and supportive clinical relationship (Buston, 2002); adolescents reported the perceived expertness of the counselor to be an important factor in their considerations of self-referral (Tatar, 2001), and adolescent clients believed that the trustworthiness of the counselor was the most important factor in whether or not the adolescent will seek counseling (Tatar, 2001).

Although Smith-Jobski (2003) discovered valuable information within these articles, she also noted that “the limited selection of professional articles addressing the subject of adolescents’ experiences with counseling is a clear indicator that there is work to be done in this area” (p. 10). She encouraged counselors to conduct more qualitative inquiries with adolescents to examine their overall experiences in counseling, to investigate their perceptions of the client/counselor relationship and their ideas about the perceived barriers to receiving counseling services.

A qualitative investigation on the counseling experiences of college-aged women with a history of self-injury would serve a variety of different purposes. First, it would

function as a venue for adolescent females' voices to be heard, an area that has been widely neglected in the research. Avis and Turner (1996) argued the importance of creating a forum for women's voices to be heard; they stated, "the need to create space for women's voices remains important and overdue" (p. 165). Secondly, the majority of literature focuses on the treatment of adolescents within an inpatient or hospital setting. In many ways, this environment pathologizes and presents a medical treatment model of self-injury. A qualitative inquiry, occurring outside of the inpatient/hospital setting, will provide in-depth knowledge and a more holistic understanding of this phenomenon.

Purpose of Study

The purpose of this study is to examine the individual counseling experiences of college-aged females with a history of self-injurious behavior and to explore how these adolescents make meaning of their counseling experiences. The results of this study will contribute to the field in two distinct ways. First, results from this research study will guide clinicians in their work with this population. Second, the inclusion of cognitive developmental theory will provide knowledge about how college aged women's levels of development may influence their perceptions of therapy and how they make meaning of their counseling experience.

Rationale for the Study

The research results from this study will benefit both researchers and clinicians and will have direct implications for the treatment of adolescents, specifically, college-aged women with a history of self-injury. As stated previously, 35% of college women report a history of self-injury. These rates are significantly higher than the general population. To date, the reason for this increased prevalence is unknown. Thus, there is a definite need for further research with this population. Additionally, research within

the mental health community has been conducted from the treatment providers' perspective or through quantitative experimental research designs; very few have sought to examine the adolescents' experiences within the counseling arena, and even fewer studies have investigated the counseling experiences of individuals who self-injure.

The use of a cognitive developmental framework, specifically ego development, provides an appropriate lens through which to view the participants' responses. In past research studies, ego development has been used to conceptualize a variety of different clinical disorders and fails to pathologize these behaviors. Ego development, in the context of this study, did the same; this study moved away from a medical or pathological model of viewing self-injury. Instead, it viewed self-injury and the experiences of college-aged women who self-injure within the framework of a developmental phenomenon. This conceptualization of self-injury is clearly unique and will contribute significantly to the current research.

Grand Tour Question and Sub-questions

Rossman and Rallis (2003) argued that research questions are critically important for guiding your research study. The grand tour question is broad and overarching, framing the study of interest. Sub-questions, which focus on a smaller unit of experience, follow the grand tour question and serve to delimit the study (Crabtree and Miller, 1992). The grand tour question for this study is: How do college-aged women with a history of self-injurious behavior experience counseling? The sub-questions are the following:

- 1) From the perspective of the college-aged females, what is the nature of the client-counselor relationship?
- 2) From the perspective of the college-aged females, how was their self-injury addressed in the context of the counseling relationship?

- 3) Using Loevinger's framework for assessing ego development, how did college-aged women make sense of their counseling experience?

Researcher as Instrument

When I first arrived at the College of William and Mary, I was enrolled in the School Psychology Program. During the third year of the program, I was involved in a full-year internship, where I worked under the supervision of a licensed and certified school psychologist. I was placed in two high schools where I began conducting psychological evaluations, consulting with teachers and counseling students. During the fall, my supervisor referred to me a fifteen-year old female who was having difficulties both at home and at school.

During my first session with the student, I discovered that she was actively cutting herself. I remember feeling that I did not know enough about this phenomenon to work effectively with her. Thus, immediately after the session, I began researching self-injury feverishly. I bought my first book that day, *Cutting*, by Steve Levenkron, and was immediately fascinated with what I was reading.

As my work progressed with this student, I began to feel more confident in my abilities to work with self-injury. I had regular meetings with my supervisor about the student, and I continued to delve into the research on self-injury. As the year continued, my supervisor referred a number of adolescent females with a history of self-injury to me. The school nurse soon caught on that I was working with this population and also began referring "cutters" to me.

Right from the start, I was overwhelmed with the amount of pain and turmoil that these adolescents were experiencing. I was amazed at their ability to reflect and intellectualize their lives, while, simultaneously, I was perplexed at their inability to

express their feelings outwardly. Many of these females had been involved in counseling in the past but were unhappy and skeptical about the services they received. On countless occasions, I remember hearing that “my past counselor didn’t understand me,” or “I couldn’t trust my past counselor with anything,” or “it didn’t help.”

My experiences with self-injury in my internship sparked my passion for working with self-injury. My hope is that my study will contribute to a better understanding of counseling services for this population and will ultimately guide clinicians in their treatment approaches for self-injury.

My interest in doing qualitative research developed from a doctoral level course in qualitative research methodology, taught by Dr. Judy Harris. From day one, I was immediately drawn to the methodology. The in-depth investigation of a phenomenon coupled with the rich data that emerged from the research was extremely exciting to me. Half-way through the semester, I was convinced that I would conduct a qualitative research study for my dissertation.

Finally, developmental theory has informed my doctoral studies and has influenced the way that I understand and approach individuals. In the context of counseling, I believe that if we understand where clients are coming from, we can better meet their needs and challenge them to grow and develop. Additionally, viewing self-injury through a developmental lens may provide researchers and clinicians with a new and different way of conceptualizing this phenomenon.

Delimitations and Limitations

This study was developed in order to examine the counseling experiences of a small number of college-aged women with a history of self-injurious behavior. Although findings from this study will be significantly useful, the results of this study cannot and

will not be generalized beyond the cases studied. Opponents of qualitative research argue that this is a weakness of such an approach. I argue that through this study, I have willingly sacrificed generalizability, in favor of the in-depth, rich investigation of a phenomenon largely ignored in the literature.

This research study has also been also subject to personal biases, a definite criticism of qualitative research in general. I recognize that I will never be free from bias or judgment. However, I have endeavored to be open and upfront with the biases I brought to this study. I documented them throughout the process within the reflexive journal. Additionally, data analysis in qualitative research is emergent and evolving; the direction and meaning may change throughout the process. Those who oppose qualitative methodologies view this unsystematic approach as a weakness. I, on the other hand, find that this approach is more consistent when studying individuals, who are continually changing, and who, by their nature, are complex and multi-layered.

Definitions

College-aged Women: Adolescent women between the ages of 18 and 23.

Grand-tour Question: In qualitative research, the broad, overarching question that frames the study.

Ogive: A cumulative frequency of item levels scores (Hy & Loevinger, 1996).

Reciprocity: In qualitative research, this term refers to a mutual give and take and exchange, which are especially important in field studies where the researcher is accorded the privilege of access to the lives of those whom he or she studies (Schwandt, 2001).

Reflexivity: In qualitative research, this term refers to the process of critical self-reflection on one's biases and theoretical predispositions, etc. (Schwandt, 2001).

Self-injury: The deliberate alteration or destruction of body tissue without conscious suicidal intent. The act of self-injury must be antithetical to culturally accepted forms of body modification.

Sub-questions: In qualitative research, a small number of questions that follow the central, or grand tour question.

CHAPTER 2

Ego Development: Rationale

Introduction

Researchers argue that self-injury is a developmental phenomenon (Simpson, 1975; Doctors, 1981; Conterio and Lader, 1988). In spite of this, self-injury has never been examined through a developmental lens. Researchers have only drawn tentative parallels between self-injury and human development. Future research is needed to expand on the link between cognitive development and self-injury. The following section first defines cognitive development. Subsequent sections outline how cognitive developmental theory, specifically ego development, is an appropriate theory to examine the counseling experiences of college-aged women with a history of self-injury and could subsequently provide researchers and clinicians with valuable insight into this phenomenon.

Cognitive Developmental Theory

Cognitive developmental theory is a comprehensive theory based on a unifying set of assumptions and separate stage theories about meaning making across different functional domains (Sprinthall, Peace, & Kennington, 1999). The basic premise of cognitive developmental theory is that reasoning and behavior are strongly associated with the level of complexity of psychological functioning. According to this theory, individuals at lower levels of cognitive complexity tend to exhibit concrete and less adaptive behavior in solving problems. On the other hand, persons at higher levels of development display more adaptive behaviors and are capable of complex reasoning in problem-solving situations.

A number of theorists have proposed models for describing the process of cognitive development (e.g., Piaget (1967) cognitive growth; Harvey, Hunt, and Schroeder (1961) conceptual development; Loevinger (1976) ego development; Kohlberg (1976) moral development). In many ways, these models appear different from one another. However, they share several basic assumptions about the nature of human development.

Cognitive developmental theory assumes that human motivation toward competence and mastery is intrinsic (Sprinthall, 1994). Individuals want to understand their environment and make meaning of their experiences. They are not the passive recipients of their experiences as behavioral theorists have implied. Cognitive development occurs in stages where each stage represents an individual's currently preferred style of comprehending the environment.

Within cognitive developmental theory, stage growth refers to a qualitative transformation rather than a quantitative transformation. Sprinthall (1978) compared this growth to the transformation involved in the metamorphosis of an egg to a caterpillar to a butterfly. Stage growth is hierarchical and sequential. Growth proceeds from the less complex to the more complex stages, and it is sequential, meaning that one stage builds directly upon the experiences of the prior one (Sprinthall & Collins, 1984). The direction of the developmental sequence is both invariant and irreversible. Individuals cannot skip certain stages in the sequence (Rest, 1983). Additionally, once an individual has achieved the level of complexity defined by a particular stage, she cannot return to the functioning of a less complex modal level.

Cognitive developmental theory assumes that growth is not automatic; it depends on the interaction between person and environment. Mosher and Sprinthall (1971)

argued that a series of significant experiences has to occur at key points in order for development to take place. There is a consistent relationship between stage and behavior. Cognitive development involves physiological as well as psychological transformations. For example, Sprinthall and Collins (1984) wrote, “no amount of social conditioning could transform a midget into a basketball center or a retarded child into a genius” (p.244).

Stage growth is domain specific. Domains refer to specific aspects of human functioning such as thinking, feeling, and moral reasoning. Individuals can function in different stages across the different domains. Growth in one domain does not guarantee development or growth across other developmental areas. Stage definition is modal rather than fixed. No person is completely in one stage at any particular instance (Sprinthall & Collins, 1984). Finally, cognitive development is universal across cultures and there appear to be no sex differences in cognitive development (Nassi, 1981).

Ego Development

Jane Loevinger’s ego development is one way of exploring college-aged women’s experiences in therapy. In fact, Swenson (1980) stated that ego development is an ideal developmental theory applicable to counseling. It is likely that college aged females at various levels of ego development may experience therapy differently. For example, women at lower levels of ego development may view their counseling experience to be either good or bad, while others at higher levels may view counseling as a growth producing experience.

Ego development, as described by Loevinger, is the master personality trait, organizing and integrating all other aspects of personality (Swenson, 1980). Loevinger’s theory of ego development presents the ego as the organizing framework in which

individuals view themselves and the world (Loevinger, 1976). It is the individual's level of ego development, which determines her frame of reference and how she views the world, especially the interpersonal world (Loevinger, 1976). Loevinger refers to the process of developing feelings about oneself, striving toward mastery, integration and making sense of experiences as the development of the ego (Jennings & Armsworth, 1992). The concept of ego development postulates a more or less organized unity of impulse control and character, style or interpersonal relations, and self-conception (Redmore & Loevinger, 1979).

Ego development occurs in a development sequence of qualitative changes consisting of nine separate stages. Additionally, every stage is more complex than the preceding one, and none can be skipped in the course of one's development. Loevinger's model is composed of soft-stage approaches, so named, because they refer to the content and function of personality rather than to the structures of cognitive operations (Noam, 1998). One strength of ego development is its roots in measurement. Loevinger and her colleagues developed the Washington Sentence Completion Test (SCT). This projective assessment measures nine stages and three transitional phases of ego development (Jennings & Armsworth, 1992). Evidence for the reliability and validity appear strong (Recklitis & Noam, 1999), and within longitudinal studies, retest scores remain relatively consistent (Redmore, 1983).

Stages of Ego Development

The Impulsive stage (E2) is the first stage, which is applicable to the examination of the counseling experiences of college-aged women with a history of self-injury. Dichotomous thinking and an inability to reflect inwardly characterize this stage. Within this stage, the individual is able to differentiate self from others, with a view of the social

environment as a source of either punishment or reward (Watt, Robinson, & Lupton-Smith, 2002). The individual at this stage is dominated by physical needs and impulse and is dependent on others for control. In the Self-Protective stage (E3), the main characteristics are protection of self-interest and pre-occupation with “getting into trouble.” Within this stage, blame is understood but assigned to others, to circumstances, or to a part of themselves for which they do not feel responsible (Loevinger, 1976).

The Conformist Stage (E4) is the first time that the individual begins to identify personal welfare with that of the group (Watt, et al, 2002). Rules are obeyed simply because they are rules, and there is a growing preoccupation with approval, appearance, and social acceptance. At the Self-Aware stage (E5), the individual becomes aware that not everyone, including him/herself, conforms to societal expectations. An individual at this level has increased self-awareness, an ability to appreciate multiple perspectives, and an increased ability to conceptualize inner life experiences (Loevinger, 1976). Growth to the Conscientious stage (E6) marks another shift in development. Within this stage, the individual is now able to internalize rules and develop her own personal list of rules that fit her own needs and experiences. An individual at this stage is able to recognize her own role and significance in making decisions. Morality comes from within, rather than from what the group decides. An individual functioning within this stage has an increasing ability to critically reflect, to consider alternative perspectives, and to live up to personally established ideals.

The Individualistic Stage (E7) marks the transition from the conscientious to the autonomous stages. Individuals at this stage are more concerned with their own individuality and have a rising tolerance for individual differences. The person becomes increasingly aware of the emotional conflict that accompanies interdependence. The

Autonomous Stage (E8) features an increased expression of feelings and heightened tolerance for ambiguity. Persons at this stage have developed the cognitive capacity to cope with inner conflict and recognize the complexities within interactions with others. The hallmark of this stage is the recognition of other people's need for autonomy. At the E8 level, there is a deepened respect for others and their need to find their own way and possibly make their own mistakes. The complexities and multi-layered aspects of people are recognized. At this stage, humor tends to be existential, rather than hostile (Hy and Loevinger, 1976). Within the Integrated Stage (E9), an individual is able to transcend conflict and differences and achieve an integrated sense of identity. Individuals are able to understand dilemmas from a variety of different perspectives. This stage marks the highest developmental level and is more theoretical than empirical; very few individuals have ever achieved this level of functioning.

Applications of Ego Development and Adolescent Self-Injury

Current research articles draw links between ego development and a variety of clinical disorders. This strengthens the rationale and applicability for examining the relationship between ego development and self-injury. The articles within the following section include articles that demonstrate the applicability of ego development to clinical disorders.

Recklitis and Noam (1999) examined the relationship among psychological development, coping strategies, and symptoms in a sample of 302 psychiatrically hospitalized adolescents. Participants completed the Adolescent Coping Orientation for Problem Strategies Questionnaire (A-COPE), which measured problem solving and coping strategies, The Washington Sentence Completion Test (WSCT), which measured

ego development, and the Achenbach and Edlebrock Youth Self-Report, which measured the participants' perceptions of social competence and behavioral problems.

An Analysis of variance (ANOVA) was conducted, and results demonstrated that males and females differed significantly in the following areas: girls reported significantly higher levels of social support, avoidance and friendship, while boys reported higher use of humor and strenuous activity. Additionally, a series of partial correlations correcting for age were performed to examine the relationship between ego development and coping behaviors. Results showed that self-reliance, social support, and family problem solving were all positively associated with ego development. Avoidance was negatively associated with ego development. Finally, the relationship between coping behaviors and psychiatric symptoms was examined using Pearson correlations. Results indicated that avoidance was positively associated with externalizing symptoms in boys and girls. Additionally, self-reliance and social support were negatively associated with externalizing behavior in girls, while there was no significant correlation with any of the symptom factors for boys.

Results from this study demonstrate that the behaviors children use to cope with stress have significant implications for their adjustment and mental health. Findings also indicate that the development of coping strategies is directly related to developmental organization; coping is tied to the ways in which individuals organize and make meaning of themselves and their relationships with others. These results have direct implications for this study, implying that maladaptive coping strategies may place one at a higher risk for adopting self-injurious behaviors.

In spite of these meaningful findings, the researchers noted the following limitations. First, the authors failed to employ a non-psychiatric comparison group.

Second, the authors relied heavily on self-report measures, which are likely to lead to biased results. Third, this study used a hospitalized psychiatric population. This study examined ego development within a population of college-aged women, beyond the confines of the hospital setting.

Evans, Brody, and Noam (2001) examined the relationship between ego development and clinical disorders, using a study of two groups of female psychiatric inpatients. Within this study, the authors explored the relationship among ego development, self-perception, and self-complexity. Within two weeks of their hospital admission, subjects were administered the following three self-report measures: the Washington Sentence Completion Test (WSCT), which measures ego development; the SPPA, which measures self-complexities and a global score; and the Youth Self-Report symptom checklist (YSR) which includes two broad-band scales related to internalizing and externalizing behaviors. Subjects were then grouped according to their ego development scores on the Washington Sentence Completion Test (WSCT) as pre-conformist (N=26) or conformist (N=26).

On the YSR, the two groups differed on only the delinquency factor; individuals with lower levels of ego development displayed higher levels of delinquency. Additionally, one-way analysis of variance demonstrated that individuals with higher levels of ego development reported higher levels of scholastic competence, job competence, and behavior/conduct. On all eight domains of the SPPA, the conformist/non-conformist group reported more positive self-perceptions than did the pre-conformist group. Finally, a multiple regression equation illustrated that the higher ego-level group did not demonstrate greater levels of self-complexity (as measured by the SPPA) than did subjects functioning at lower levels of ego development.

These authors fail to acknowledge weaknesses and limitations of their study. First, the study was limited to a sample of adolescents within a psychiatric inpatient facility in Boston, Massachusetts. The sample size was small, homogeneous, and not truly representative of the true population of adolescents. Second, this study relied on self-reports. Thus, responses from the adolescents are likely to be biased. Third, the authors failed to clearly operationalize self-complexity, which made the results section confusing and difficult to follow.

In spite of these limitations, the authors, Evans, Brody, and Noam, demonstrated that lower levels of ego development are related to more externalizing behaviors among adolescents, while higher levels of ego development are related to more internalizing behaviors. If this is the case, then self-injury, an internalizing behavior, should be associated with higher levels of ego development. The following study will seek to determine if this is the case.

The foregoing research studies demonstrate the applicability of ego development to clinical disorders, which has direct implications for this research study. More importantly, it establishes the rationale for using ego development with self-injury. The next section will include articles related to the unique characteristics of individuals who self-injure, as well as prevalence rates of self-injury.

Characteristics and Prevalence of Individuals Who Self-Injure

Using a convenience sample of 1,986 military recruits, Klonsky, Oltmanns, and Turkheimer, (2003) assessed the prevalence and psychological correlates of deliberate self-harm in a non-clinical population. Instruments used in this research design were the following: The Schedule for Nonadaptive and Adaptive Personality (SNAP), which measured personality disorder symptoms and self harming behavior, The Peer Inventory

of Personality Disorders (PIPD), which measured peer assessments of personality and pathology, and The Beck Depression Inventory (BDI) and The Beck Anxiety Inventory (BAI), which measures depressive and anxiety symptomology. All of military recruits were administered these instruments at the end of their 6-week long basic training.

When compared by gender, results indicated a no difference finding on both the SNAP and the PIPD. Additionally, recruits who engaged in self-harming behaviors reported significantly more personality disorders, as measured by the SNAP and PIPD and more symptoms of anxiety and depression as measured by the BDI and BAI. Post hoc ANOVAs indicated that gender moderated the relationship between deliberate self-harm and both depression and anxiety. Results of this study also showed that approximately 4% of the total sample of recruits reported a history of deliberate self-harm.

There were definite limitations to this study. First, the population of army recruits is not representative of the true population of self-harmers; this research study used a civilian sample. Second, each of the four instruments relied on self and other report, which is likely to be biased. In spite of these limitations, the results of this study creates a context for the examination of individuals who self-harm. The information garnered from this analysis will provide this study with a better understanding and conceptualization of the unique characteristics of individuals who self-harm.

Haines and Williams (1997) also conducted a study of the unique characteristics of the self-injuring population. They used a convenience sample to assess the coping and problem solving abilities of self-mutilators. This sample consisted of a total of 50 subjects within three independent groups. The first group (the self-mutilation group) was comprised of 19 male prisoners with a history of self-harm, the second group (the

prisoner controls), consisted of 13 male prisoners with no history of self-mutilation, and the third group included 18 male undergraduate university students with no history of either self-mutilation or criminal incarceration.

The researchers wanted to know if individuals who self harm reported fewer coping resources, more maladaptive coping resources, and fewer problem solving skills than individuals who don't self harm. Participants were administered the following instruments: The Coping Resources Inventory (CRI), which measured internal and external coping resources; The Coping Strategies Inventory (CSI), which measured coping cognitions and behaviors; and The Personal Problem Solving Inventory, which measures how individuals deal with problem-solving situations. A series of Fisher LSDs were conducted with the following meaningful results: self-mutilators demonstrated statistically significant differences between both comparison groups in the following areas: self-mutilators reported fewer cognitive coping resources, less availability of social support, and more problem avoidance.

Findings suggested that individuals who self harm may not have fewer coping or more maladaptive coping resources. Rather, they may have fewer coping resources, may have less social support within their lives, and may have the tendency to avoid problems that are presented to them. These results will provide researchers and clinicians with information regarding the role of coping and problem solving skills. However, results of this study should be used with caution. The researchers used a small, homogeneous sample. Additionally, the use of two groups of incarcerated men is not representative of the true population of self-injurers. The ensuing study intended to respond to this limitation by accessing a more representative sample of the true self-injuring population.

In an additional study that focused on the characteristics of the self-injuring population, Deiter, Nicholls, and Pearlman (2000) utilized a convenience sample of 233 adult participants, with an age range of 18 to 77 years, from an outpatient treatment setting. The authors were interested in examining the extent to which impaired self-capacities and a history of child abuse may lead to self-injury. For the purposes of this study, self-capacities refer to the ability to tolerate strong affect, the ability to maintain a sense of self-worth and the ability to maintain a connection to others.

The following self-report instruments were given to all participants: The Checklist of Self-injurious Behaviors, which asked questions concerning self-injury; The Traumatic Stress Institute Life Event Questionnaire (TSI), which measured abuse history; and The TSI Inner Experience Questionnaire (IEQ), which measured self-capacities. A 2 by 2 analysis of variance (ANOVA) was conducted and measured the relationship between self-injury and history of child abuse. Results indicated that individuals with a history of self-injury demonstrated greatest impairment in their self-capacities. Additionally, the greatest impairment was associated with both self-injury and abuse.

The mean age of the sample within this study was 38, with an age range of 18 to 77, not representative of the true population of self-injurers. The sample within the current research study will examine only college-aged women (18-23), the age range where self-injury is most common. In spite of these limitations, the authors, Deiter, Nichols, and Pearlman, enumerated characteristics of individuals who self-injure and creates a context that will help the researcher in the subsequent study to further explore the counseling experiences of individuals who self-injure.

Using a sample of 53 psychiatric patients, Stanley, Gameroff, Michalsen, and Mann (2001) also investigated specific behaviors of individuals who engage in self-

injury. For example, they examined the unique characteristics of suicide attempters who self-mutilate. All of the participants had a history of at least one suicide attempt and a DSM-III-R diagnoses of a cluster B personality disorder (i.e. borderline, antisocial, narcissistic, or histrionic). The authors divided the participants into two groups: Thirty suicide attempters with cluster B personality disorders who had a history of self-mutilation were compared with a matched group of 23 suicide attempters with cluster B personality disorders who had no history of self-mutilation. Their aim was to determine if individuals who self-mutilate are a greater risk for suicidal behavior and to delineate differences between suicide attempters with and without a history of self-mutilation.

Several instruments were used for this study: (a) The Suicide Intent Scale, which examines aspects of the participants' most recent suicide attempt; (b) The Scale for Suicide Ideation, which assesses thoughts, feelings, and plans regarding suicide; (c) The Brown-Goodwin Lifetime Aggression Scale and the Buss-Durkee Hostility Inventory, which both measure aggressive behaviors; (d) The Hamilton Depression Rating Scale and the Beck Hopelessness Scale, which both measure depressive symptoms; and (e) The Brief Psychiatric Rating Scale (BPRS), which assesses current psychotic symptoms. In addition to these instruments, interviews were also conducted. A semi-structured clinical interview was given to assess physical and sexual childhood abuse. Additionally, the following structured interviews were given to assign DSM-III-R diagnoses: The Schedule for Affective Disorders and Schizophrenia, The Schedule for Interviewing Borderlines, and a clinical interview that required information for converting research diagnostic criteria diagnoses into DSM-III-R diagnoses.

Two-tailed Student's *t* tests for continuous variables and chi-square analysis for categorical variables were used to compare the groups of patients with and without a

history of self-mutilation across the following areas: demographic, behavioral, and psychopathology measures. Results showed that suicide attempters with a history of self-mutilation underestimated their suicide attempts. They also had significantly higher levels of depression, hopelessness, aggression, anxiety, impulsivity, and suicidal ideation. In addition, they exhibited more behaviors consistent with borderline personality disorder and were more likely to have a history of childhood abuse. Finally, self-mutilators had more persistent suicidal ideation, and their pattern for suicide mirrored their pattern for self-mutilation, which was characterized by chronic urges to injure themselves.

Limitations were noted; a multitude of instruments was administered to participants; however, no reliability or validity values were given. Also, the ages of participants in this study ranged from 18-65. This wide age range is likely to skew the results because the research shows that at varying stages of life, self-harm may serve different purposes. In order to remedy these limitations, this research study used only one instrument and examined the experiences of only college-aged women who self-injure.

Presently, there exists conflicting research on the differences between suicide attempts and self-injury. Results indicate that clinicians should be careful not to overlook the suicide attempts of patients with a history of self-mutilation; a blurry line clearly exists between the two behaviors. This finding provided the researcher in this study with a better conceptualization of the population of individuals who self-injure.

In order to examine the prevalence and characteristics of self-mutilation in a community sample of adolescents, Ross and Heath (2002) surveyed a total of 440 students from one urban and one suburban high school. The students were administered the following instruments: (a) a screening questionnaire which was administered to all

participants and designed to address the presence or absence of self-mutilating behavior, (b) a semi-structured interview to confirm the existence of SM and to garner further information regarding the act of self-injury, (c) The Beck Depression Inventory to measure depressive symptomology, and (d) The Beck Anxiety Inventory to measure anxiety symptomology.

A chi-square analysis was conducted to determine whether the two schools differed in terms of the prevalence of SM. Results indicated no difference, and an overall prevalence rate of 13.9% was obtained for both samples. Demographic information was also obtained to determine the characteristics of the SM population. In terms of ethnic/racial composition, 77% of the SM sample were Caucasian, 6.5% were Asian, 5% were Black, 3.3% were Hispanic, and 8.2% were classified as other minority. In terms of family structure, 59% of the adolescents came from homes where parents were married, 36% came from divorced homes, and 5% came from homes with widowed parents. In terms of gender, a chi-square analysis indicated that girls were significantly more likely than boys to self-mutilate.

In an analysis of self-mutilative practices, 16.4% of the sample reported using more than one method to self-mutilate, while 83.6% indicated only using one method. Skin cutting was the most common practice, followed closely by self-hitting. In terms of the frequency of the behavior, the majority of self-mutilators (27.9) reported that they harmed themselves a couple of times a week. In terms of current practice, a total of 64% indicated that they no longer self-mutilate.

A two-by-two Multivariate Analysis of Variance assessing gender and absence or presence of SM was conducted. Findings from this analysis indicated that there was an overall difference in terms of anxiety and depression between adolescents who self-

mutilated and those who did not self-mutilate. Univariate f tests were conducted to explore the differences in anxiety and depression between the groups. Results demonstrated that adolescents with a history of self-mutilation reported higher rates of depressive symptomology and greater levels of anxiety when compared to adolescents who did not self-mutilate.

The researchers noted one limitation: the schools did not provide information regarding the ethnic compositions of their students. Thus, it was not possible to investigate whether the ethnicity of the self-mutilating students differed significantly from the population of the school as a whole. Another limitation to this study concerns the instrumentation. For example, no reliability or validity values were given on the Screening Questionnaire, which was developed exclusively for this study. Finally, all of the instruments relied on self-reports, which are likely to be biased.

Results from this study indicate that self-injurious behavior may be a prevalent problem within the adolescent population. The demographic characteristics discovered from this study provided the researcher in the current study with a better understanding of the unique characteristics of the self-injuring population. In spite of what is known about their unique characteristics, there is still a great deal more to know about this phenomenon. This study sought to gain a deeper understanding of self-injury, than can be captured with quantitative methods.

In order to promote understanding of self-injury across a variety of different discourses, McAllister (2003) sought to critically review selected literature by exploring their content. The purpose of the manuscript was to illuminate new dimensions about self-harm and suggest more enlightened health care practices. McAllister divided her paper into 14 sections, excluding the introduction and discussion sections. They are the

following: (a) a critical review which briefly mentions the different systematic, qualitative, and quantitative reviews of self-harm; (b) an unclear picture which refers to the conflicting views of prevalence of self-harm; (c) the debate on naming self-harm which refers to the differing definitions of self-harm; (d) self-harm and suicide and the difference between the two phenomena; (e) self-harm as a symptom of a mental disorder, which refers to the differing pathological labels related to self-harm; (f) limitations of medical constructions, which related to the medical model view of self-harm; (g) damage or identity, a section which focused on how self-harm is viewed as acceptable in different cultures; (h) childhood and trauma, a section relating to the impact of childhood abuse on subsequent self-harming acts; (i) a discussion of remaining silent or to secretly revealing, which focuses on how self-harm is kept private or communicated outwardly to others; (j) self-harm as a psychological disorder, which relates to different psychological theories to explain self-harm; (k) a gendered issue which focuses on women's unique experiences with self-harm; (l) self-harm as a social disorder, which relates to a social perspective of self-harm; (m) self-harm as a biosocial disorder, which focuses on the biological and psychological influences of self-harm; and (n) self-harm as a cultural disorder, which refers to different cultural theories of self-harm.

Results of this review demonstrated that self-harm may be related to psychological, cultural, or social phenomena. These findings have direct implications for therapists. McAllister (2003) argued that prevention programming and primary health care and community awareness programs could drastically reduce incidence of self-harm. Additionally, she contended that a social/cultural context would allow therapists to see the value in enhancing the therapeutic relationships, and building effective relationships and social supports. These findings provided the researcher of the ensuing study with a

wider context for viewing self harm, which may affect how clinicians approach treating this phenomenon.

Among the self-injuring population, particular risk factors predominate and distinguish this population from others. Gratz, Conrad, and Roemer (2002) demonstrated this within their quantitative research study. Using a sample of 133 students from undergraduate psychology classes within an urban university, the authors investigated the risk factors for deliberate self-harm among college students. Seven self-report instruments were used. They are the following: (a) Deliberate Self-Harm Inventory (DSHI), which measures various aspects of deliberate self-harm; (b) the Abuse and Perpetration Inventory (API), which measures type and frequency of physical and sexual abuse prior to the age of 16 (The API is composed of three separate sections, and two were used within this study. The Sexual Experiences History (SHE) and the Physical Punishment History (PPH) were used to measure childhood abuse); (c) the Disruptions in Attachment Survey is a self-report measurement which assessed childhood experiences with physical neglect, separation, and loss; (d) the Parent Bonding Index (PBI) which assesses recollections of the degree to which parent(s) were affectionate and controlling over the first 16 years of their child's life; (e) the Parental Attachment Questionnaire (PAQ) which measures perceived quality of attachment relationships to parents; (f) the Dissociative Experiences Scale (DES, which assesses frequency and severity of dissociative experiences; and (g) the Marlowe-Crowne Social Desirability Scale (MCSDS) which was used to control for response sets and biased responses.

Descriptive statistics were conducted, and the following results were determined: 38% of the participants sampled reported a history of deliberate self-harm. The percentage of these participants did not differ significantly across different racial groups.

Additionally, self-harm was not significantly associated with gender. Correlational coefficients were conducted to determine the relationship between frequency of self-harm and each risk factor. Physical abuse, sexual abuse, and childhood separation were significantly correlated with the frequency of self-harm. However, due to low rates of physical neglect and childhood loss, only tentative positive findings were detected.

A hierarchical multiple regression analysis was conducted to examine the unique predictive value of each risk factor. Two variables, childhood neglect and loss, were excluded from the model. The final model was significant, with the risk factors accounting for 21% of the variance of deliberate self-harm. Another multiple regression analysis was conducted with the sample of women. Again, childhood neglect and loss were excluded from the model. The final model was statistically significant, accounting for 29% of the variance of deliberate self-harm.

The researchers noted a few limitations within their study. First, they recognized that the reliance on self-report measures may lead to biased results. Second, they suggested that the examination of the relationship between self-harm and dissociation is difficult to measure. Many individuals are not aware of their dissociate acts. Thus, a self-report instrument based on this phenomenon may be difficult to assess. Third, the researchers were candid about the potential selection bias within their study; it is likely that the population of undergraduate students within a psychology class may not be representative of the true population of college students. Fourth, the researchers failed to note the following limitation: the authors of the study only assessed risk factors that were measurable within the instruments used. It is likely that other risk factors occurred.

In spite of the above limitations, findings from this study indicate that self-harm is prevalent among the college student population. Thus, the current study's investigation

of college-aged women with a history of self-injury is ideal. Additionally, results suggest that early family relationships may strongly influence later acts of deliberate self-harm. These results provide researchers and clinicians with a context for understanding the unique characteristics of individuals who self-harm. These findings provided the researcher in this study with a better a greater awareness and better understanding of the distinct characteristics of the self-harming population.

Qualitative studies have also provided useful information regarding the phenomenon of self-injury and the unique characteristics of this population. For example, in a qualitative study of six adolescents with a history of self-harm, Crouch and Wright (2002) investigated the phenomenon of deliberate self-harm (DSH) within a residential treatment setting. The researchers aimed to identify the personal and interpersonal processes involved in DSH. Through semi-structured interviews, the participants were asked about their perceptions of deliberate self-injury. Researchers observed the participants over an eight-week period during their group meetings. Using an interpretive phenomenological analysis (IPA), transcripts were analyzed, in a search for emergent themes. IPA is designed to explore in detail the participants' view and experiences of the topic under investigation.

Using this method, nine themes emerged: (a) precipitants of self-harm (particular triggers that motivate individuals to harm themselves); (b) effects of DSH on the individual, which included the emotional feelings individuals experience after their self-harming act; (c) copying of DSH, which refers to the imitation of this behavior within peer groups; (d) secrecy, which refers to the private nature of this phenomenon; (e) group definition and difference, which refers to the group norms and interpersonal relationship around DSH; (f) behavior tariff, which refers to particular self-harming behaviors that

defined entry into peer groups; (g) hatred of the attention seeking self-harmers, which relates to negative feelings directed to individuals who participated in DSH to allegedly gain attention from others; (h) competition, which refers to the rivalries that occur between peer groups of self-harming individuals; and (i) conflicted views of DSH, which refers to the conflicting views on how participants perceived self-injurious behaviors.

The majority of research available on self-injury relies on quantitative methodologies. However, Crouch and Wright's (2002) qualitative investigation of self-injury provided readers with an in-depth understanding of this phenomenon, a much needed medium of investigation. In spite of this strength, researchers used a small homogeneous sample. Additionally, the researchers failed to employ member checks with their participants. The current study on self-injury relied on qualitative methodologies. However, the researcher attempted to use a larger sample size and investigated this phenomenon outside of a residential treatment setting; the majority of self-injurers are not confined to an inpatient setting.

The information garnered from the Crouch and Wright (2002) study indicates that self-harm is indeed a cultural phenomenon. This study explored dynamics within a treatment facility. However, results of this study may be a reflection of what is occurring within mainstream society. Findings from this qualitative investigation may provide counselors with a wider, more comprehensive conceptualization of this phenomenon.

Before we understand treatment, researchers need to understand the unique characteristics of the population of individuals who self-injure. From the foregoing section, research indicates that self-harm is far more complex than an intrapsychic phenomenon. Additionally, individuals with fewer coping resources, larger risk factors, and a history of abuse are more likely to engage in self-injurious behavior. These

individual factors should guide researchers in their treatment approaches and case conceptualizations of self-injurers. The next section will relate directly to the treatment of individuals who self-injure.

Treatment of Self-Injury

Within the self-injury literature, treatment studies are scarce. More specifically, researchers have failed to examine the treatment of the specific population of interest—college-aged women with a history of self-injury. This section will highlight some of the seminal articles related to treatment. Because there are no articles directly related to self-injuring college-aged women, this section will examine related literature on the treatment of self-injury with psychiatric inpatients and individuals entering an emergency room in response to self-injury. The latter portion of this section will focus on the counseling experiences of adolescents, both males and females.

Treatment Models and Self-Injury

Hawton, Arensman, Townsend, Brenner, Feldman, Goldney, Gunnell, Hazell, Heeringen, House, Owens, Sakinofsky, and Traskman-Bendz (1998) conducted a meta-analysis reviewing studies concerning the treatment of deliberate self-injury. The meta-analysis consisted of 20 trials involving 2,453 patients. The purpose of the meta-analysis was twofold: to identify all randomized controlled trials evaluating the psychosocial or physical treatments related to deliberate self-injury, and to compare the effects of specific treatments on repetition of deliberate self-harm in order to identify the most effective interventions.

Hawton et. al. (1998) conducted their literature search using a variety of electronic databases. They included studies that met specific criteria: participants must have engaged in self-harm, trials must have reported repetition of self-harm as an

outcome measure, and study participants had to have been randomized to treatment and control groups. The researchers arrived at 20 total studies, and the trials were grouped into the following categories: problem solving therapy vs. standard aftercare, dialectical behavior therapy vs. standard aftercare, same therapist vs. different therapists, long term therapy vs. short term therapy, intensive care plus outreach vs. standard care, emergency care vs. standard aftercare, general hospital admission vs. discharge, and antidepressants vs. placebo.

Results from these treatment studies showed that there is insufficient evidence regarding the treatment of individuals who self-injure. Methods of self-injury were inconsistent (self-poisoning vs. other forms of self-injury), and many studies occurred within the inpatient treatment study, which is not necessarily representative of the true population of self-injurers. Additionally, results illustrated that antidepressants and behavioral therapy demonstrate tentatively positive findings, although future research is needed. The majority of the 20 studies included in this meta-analysis included only small sample sizes, and the dependent variable (repetition of self-harm) was not clearly defined.

The current study speaks to the limitations discovered within this meta-analysis. Adequate sample sizes were employed, and self-injury was clearly defined. The findings from this meta-analysis suggest that quantitative studies assessing the treatment of self-injury are insufficient; results are inconclusive and inform us little about what types of interventions work well with individuals who self-injure. These results suggest that qualitative methodologies may be more appropriate to investigate this phenomenon, an argument which strengthens the rationale for the subsequent study.

Inpatient Treatment of Self-Injury

Using a qualitative interpretive methodology with a social constructionist (SC) framework, Weber (2002) interviewed nine women in a locked state psychiatric state hospital over a three-month period. The majority of women had a diagnosis of Borderline Personality Disorder (BPD) and at least one Axis I diagnosis. The average age of the women was 32, with an age range of 21-48 years.

Weber (2002) aimed to define how women viewed self-abuse in the context of their lives and how they viewed the treatment they received. “Data obtained from the interviews were analyzed using Gubrium’s method of identification of the participant’s linkages to everyday life to answer the questions what and how” (Weber, p. 119). Data from the interviews were transcribed, analyzed and coded for categories and themes. Additionally, active interviewing was used throughout the research process. According to Weber, the active interviewer initiates and sets the structure and parameters for the interview. Four prominent themes emerged. The first two are the participants’ pleas to be listened to and receive help, and specific triggers for self-abuse.

The second two themes are the causes of self-abusive behaviors, and how to stop the abuse. Four categories emerged within these two themes: *talking to me*, *distraction*, *comfort*, and *hope*. *Talking to me* refers to the importance of professionals taking the time to talk to the residents during their times of crisis; *distraction* focuses on how staying busy and being involved in a variety of activities prevent women from self-abuse; *comfort* relates to the importance that staff provide the self-abusing women with privacy, dignity, and understanding of their self-abusing acts; *hope* relates to the feelings that recovering self-abusing women experienced during their recovery. Weber also talked

about how the concept of hope should be integrated into the treatment framework for this population.

The results of this study were powerful, in that they came from the voice of self-injurers. Weber's (2002) findings guided the researcher in the current study in her examination of self-injurers' perspectives of their counseling experiences. However, the sample of participants were selected from a locked state psychiatric hospital, and many of them had a diagnosis of Borderline Personality Disorder and additional Axis I diagnoses. This inpatient population is not representative of the true population of self-injurers. As stated before, the majority of self-injurers are never admitted to a psychiatric hospital. The current study, as stated in prior sections, accessed a population of self-injurers within an outpatient treatment setting. Finally, Weber's (2002) study did not investigate the role of counselors within the context of treatment. The current study examined only the role of the counselor and the outpatient counseling experiences of college-aged women with a history of self-injury.

Pinfold and Treloar (1993) also examined self-injury within a hospital setting. They utilized a convenience sample of 142 hospital patients with an age range of 15-82, in order to investigate the experiences of individuals who engaged in self-injury prior to their discharge from a hospital setting. The aim of this study was to examine the perceived therapeutic effectiveness of a variety of health care professionals that patients encounter during their hospital stay. Questionnaires developed for this specific study were distributed to all patients.

A statistical analysis used correlation coefficients to determine the relationship between the amount of help received and other measured attributes. Results showed that sympathy and listening by all medical professionals were important factors in the

treatment of self-injury. Analysis of the statistical significance of differences between professional groups used students' t-tests, and results demonstrated that nurses and social workers were viewed as most helpful when compared to doctors and psychiatrists. Findings from the questionnaire also demonstrated that there is a clear need for a wide range of follow-up options, including emergency numbers for individuals.

The limitations of the study related to the high attrition rates and the sample size. Of the 142 questionnaires distributed, only 105 were included in the study. Additionally, the participants were of ages, ranging from 15-82. It is likely that the experiences of self-harming adolescents are different from the self-harming experiences of the elderly. Thus, the current study examined self-injury with only college-aged females.

Participants in this study examined the perceived helpfulness of doctors, nurses, social workers, and psychiatrists; the role of counselors was not examined. Thus, the current research study interviewed college-aged women with a history of self-injury, to examine the perceived helpfulness of counselors and their experiences during the counseling process. Results from Pinfeld and Treloar (1993) study provided the current researcher with a better understanding of how individual self-harmers view their treatment.

An additional study by Haw, Houston, Townsend, Hawton (2002) utilized a representative sample of 106 patients over the age of 15, who presented to a general hospital in Oxford England, following an episode of deliberate self-harm (DSH). The study aimed to examine the treatment received by DSH patients with depression and their progress following this treatment. Researchers used the European Parasuicide Study Interview, which examines current and previous DSH episodes, life events, and contact with primary care and mental health services, the ICD-10 Diagnostic Schedule, which

examines the current and past psychiatric symptoms, and the Personality Assessment Schedule, a self-report instrument which assesses different personality areas. Researchers also conducted follow-up interviews with 86 of the 106 (81.1%) depressed patients.

Analysis was conducted using the Statistical Package for the Social Sciences (SPSS) and the χ^2 test was employed with Yates' correction. Results indicate that after the episode of DSH, 88% of patients were offered treatment with psychiatric services; the majority of these DSH patients also had high levels of depression. Of the patients who were followed up, only 36% remained in contact with psychiatric services, and 52% showed poor compliance with recommended treatment. Almost one-third reported a further episode of DSH during the follow-up period. The results of this study showed that antidepressant treatment for DSH failed to reduce rates of DSH in patients.

The authors noted the following limitations: the nature and quality of treatments were not investigated, and the definition of deliberate self-harm within this study included only acts of self-poisoning and self-injury, but excluded self-cutting. The subsequent study remedied these limitations both by seeking to investigate the patients' perspectives of the treatment they received and by focusing only on self-cutting, which is the most common form of self-injury. Additionally, the setting may also have been a limitation. As stated previously, a hospital may not be the ideal environment to assess the treatment of self-injury; the majority of patients may never be admitted to a hospital. The current study examined the phenomenon within an outpatient setting.

Results from Haw, Houston, Townsend, and Hawton's (2002) study indicate that the treatment self-harmers receive may be ineffectual. Findings indicate that patients have extremely low rates of compliance, and very few patients remain in contact with psychiatric services after their acts of self-harm. This reality demonstrates the need for

treatment providers to explore the specific needs of this population. The current research study sought to discover population needs through in-depth interviews about self-harmers' experiences in counseling.

In a study of 100 hospital patients in Britain with a mean age of 34, Pierce (1986) sought to determine how individuals with a history of deliberate self-harm (DSH) view their treatment. Patients were interviewed with a standardized form, which was used at the hospital for several years to lead to the measurement of suicidal intent, a psychiatric evaluation, and a decision about further management. At the end of the interview, patients were asked give their attitudes about the treatment that they had received within the hospital from the medical and nursing staff. Patients were then asked to provide their perception of the attitudes of their family to their self-harming behavior. Patients were followed up for one year.

Responses from the interview were analyzed using a Spearman Rank Correlation to measure the degree of agreement between the patient's rating of doctors, nurses, and families. Additionally, the Wilcoxon matched pairs test and the Mann-Whitney U tests were used to explore that relationships among various subgroups of patients. Results from these analyses showed that the patients' perception of the attitudes of hospital professionals differed significantly from the attitudes of different hospital professionals. This suggests that any lack of sympathy felt by staff treating DSH cases may not be apparent to their patients. Other results showed that 55% of patients thought that nurses were sympathetic to them. Additionally, 57% of patients viewed doctors are sympathetic. On the other hand, 14% of patients viewed nurses and 17% viewed doctors as unsympathetic toward them. When asked about familial treatment, one-third of patients believed that their families were unsympathetic towards them. Also, a strong

relationship emerged between perceived lack of sympathy on the part of the family and a history of earlier acts of DSH.

There were several limitations of this study, which weaken its overall generalizability. First, the mean length of stay for patients before their interview was just under 24 hours. For many of these patients, this time frame may have restricted them from responding. If admitted to an inpatient setting, it is likely that their responses regarding treatment would have changed. Additionally, Pierce (1986) utilized an interview form, which had been used at the hospital for several years. Other than an extremely brief description, little is known about this form, and it is not known whether or not the interview asks any questions specific to self-injury. Finally, the sample was not representative of the true population of self-injurers. For example, the majority of individuals who self-injure are in their teen years, and many are never admitted to the hospital. The current research study sought to examine self-injurers' experiences of outpatient counseling, a realm which has been neglected within the literature.

Hurry and Storey (2000) examined the psychosocial assessment of 12 to 24 year-old patients attending accident and emergency clinics following deliberate self-harm (DSH) and identified features of service management provided in this setting.

This study was conducted in two stages. Stage one involved a stratified sample of 118 accident and emergency rooms where senior doctors and nurses were asked to complete a questionnaire which assessed the health professionals' management of self-harming patients. Stage two of this study involved a stratified sample of 18 of the 118 hospitals. The staff were interviewed using a semi-structured interview schedule. The interview asked questions regarding their knowledge of hospital policy and guidelines, any training

they had received with this population, and factors that influenced their assessment and referral practices. Additionally, 50 case notes per hospital were examined.

Results of this study demonstrated that a specialist assessed 44% of the patients admitted to a hospital following an act of self-harm. Additionally, findings indicated that inpatient admission to the hospital increased the likelihood of receiving assessment by a specialist. In the case note study, 67% of admitted patients were seen by a specialist, opposed to 34% of patients discharged from A&E. A&E settings with an on-site psychiatric facility were more likely to perform assessments than those attending hospitals without such facilities. Finally, findings indicated that psychosocial assessments focused on short-term risk.

Hurry and Storey (2000) noted the following limitations: they relied on case notes for information on patient characteristics, their study lacked detail on the process of specialist assessment, and they did not include a measure of patient outcomes to evaluate the effectiveness of specialist assessment. The authors failed to mention several limitations to this study. First, the study failed to adequately define what they meant by the term “specialist.” Second, the methods section was extremely flawed; the authors failed to define how interviews were analyzed and how the case studies were examined. Third, the authors relied on the perceptions of the hospital staff, rather than asking the patients directly about the care they received.

Results of this study indicate that many individuals who seek treatment for self-injury are not getting the services they need. Although this study occurred within an emergency room setting, findings from this study may be a reflection of what is occurring within the larger treatment context of individuals who self-harm. This study sets the

stage for the current study, which sought to investigate the counseling services of individuals who self-injure, from the perspective of the self-injurers themselves.

Outpatient Treatment of Self-Injury

Using a case study of an adolescent female with a history of self-injurious behavior, Stone and Sias (2003) examined the effectiveness of a bi-modal treatment approach (individual and family therapy). Through their work with “Tammy,” the researchers administered the MMPI-A, which is a measure of personality assessment, the Beck Anxiety Inventory (BAI) and the Beck Depression Inventory (BDI), which measures anxiety and depression symptomology; all three measures were given prior to treatment.

“Tammy” received treatment over a 6-year period. The authors accessed her success throughout their time together. They reported that she graduated from high school and entered college. She slowly reduced rates of self-injury while adding healthier behaviors. “Tammy” also successfully developed self-monitoring techniques, which prevented her from repeating acts of self-injury.

Limitations to the study are noted. First, “Tammy” received treatment over a period of six years. In the present day of managed care, this lengthy treatment time may be unrealistic and improbable. Second, the authors failed to operationalize the MMPI, the BDI, and the BAI. Third, the findings from a case study are difficult to generalize. In spite of these findings, a qualitative approach to self-injury provides researchers with an in-depth understanding of the treatment of self-injury. The current study moved beyond the case study and examined a larger population of self-injurers—not from the perspective of the counselors, but from the perspectives of the individuals receiving treatment.

The articles in the above section provide valuable information regarding the treatment of self-injury. None of the above studies examined the treatment of college-aged women with a history of self-injury. Thus, the following section will include articles that are focused on adolescents' experiences in counseling.

Counseling Experiences of Adolescents

In a mixed-design, relying on both qualitative and quantitative methodologies, Dunne, Thompson, and Leitch (2000) investigated the counseling experiences of 11 male adolescents in an all boys' school in Ireland. Following a total of 23 individual counseling sessions, each adolescent completed the following four scales: The Global Evaluation Scale, which evaluated the satisfaction of a complete counseling session, The Session Evaluation Scale (ESQ), which measured a detailed account of each participants' in-session experience, an open-ended questionnaire which evaluated the client's experiences of helpful and hindering events within the counseling session, and the Helpfulness/Unhelpfulness Scale, which examined the clients' perceptions of what they identified as helpful or unhelpful during their counseling sessions. Twelve counseling sessions, involving five of the clients, were audio-taped; immediately following each session, the adolescent males were interviewed about their experiences in the session.

Descriptive statistics and a correlation of the SEQ indexes and the Global Evaluation Scale were obtained. Findings from this analysis indicated that emotional support and relief are significant to adolescent males, while cognitive task factors prescribed by the therapist (i.e. homework assignments, etc.) appear to be less important. Qualitative data analysis was conducted on helpful/unhelpful events form; the forms were transcribed, as were the tapes of the post-session interviews. One primary theme that emerged related to insight events; the majority of adolescents interviewed indicated that

their therapists' ability to make sense of what they were trying to say was extremely helpful.

The researchers noted limitations. They recognized their failure to consider adolescent development, and their reliance on self-report measures, which may lead to biased responses. They failed to recognize their deficient presentation of their qualitative methodology and analysis. The reader had a difficult time determining the themes upon which the researchers decided. Results of this study will provide researchers with a better understanding of adolescents' counseling experiences. While it was not specific to adolescent self-injurers, it created a context for adolescents' experiences in the counseling arena. Additionally, while Dunne, Thompson, and Leitch (2000) examined only the experiences of males, the current research study examined the counseling experiences of only females.

An additional study by Buston (2002) explored adolescents' experiences within the counseling arena. In a convenience sample of 32 adolescents aged 14 to 20 diagnosed with a mental illness, the author explored the health related views and experiences of adolescent users of mental health services. Buston conducted an in-depth semi-structured interview with each of the participants. In addition, the Offer Self-Image Questionnaire was administered, and case notes were accessed. Each interview was recorded, transcribed and analyzed qualitatively, utilizing a grounded theory approach, and using NUDIST, a computerized package aiding qualitative data analysis. The four themes that emerged were; (a) the doctor-patient relationship, which focused on the relationship between the adolescent and his/her doctor or other professional care-giver, (b) treatment, which referred to the adolescents' perceptions of the "form" of treatment they received, (c) the system, which related to certain aspects of the health care system, (d) and the

environs of the hospital/clinic, which focused on comments related to the overall environment at the hospital.

Results of this study indicated that adolescents value a clinically supportive relationship, and they appreciate being understood by their treatment provider. Additionally, findings illustrated the value of adolescents' remembering their experiences in the mental health setting in a positive way; if their memories are positive, they may be more prone to participate and follow through with future treatment. Although this study did not focus on self-injurers, the results could provide a framework for understanding what college-aged women view as important within a therapeutic setting.

The researchers noted limitations; the sample studied was not a representative sample, and the research questions would have been more appropriately answered by a smaller number of participants. In this study, only one interview was conducted with each of the 32 research participants. The current research study used a smaller sample, and research participants were interviewed on more than one occasion. Another limitation, which the researchers did not note, was their failure to define the construct that the Offer Self-Image Questionnaire assessed. The researchers also did not illustrate how this questionnaire was analyzed. Additionally, this study looked at the doctor-patient relationship, the health care system, and the environment within the hospital. The current study examined self-injury within a counseling arena, rather than a hospital system. Finally, the current study narrowed down the investigation to only the counseling experiences of college-aged women with a history of self-injury.

The articles in the treatment section illustrate that the majority of studies have been conducted within an inpatient setting, mainly an emergency room or inpatient treatment facility. While the articles provided useful information regarding doctors,

nurses, and social workers, the role of the counselor has been ignored. Additionally, only one article spoke to the counseling experiences of adolescents with a history of self-injurious behavior. However, this study was a case study, and the study was from the perspective of the researcher, not the client. The review of the literature on the treatment of self-injury demonstrates a need to conduct the succeeding research study.

Summary

The articles within Chapter Two clearly demonstrate that self-injurious behavior is an increasing phenomenon, affecting large number of individuals. In spite of this trend, the research available on treatment approaches for self-injury is insufficient and ineffectual. A comprehensive review of the literature illustrates that there is a gap in the research. There is a clear need to examine the counseling experiences of college-aged women with a history of self-injury. Research demonstrates that this analysis can be adequately assessed through the lens of ego development, which has been studied with various clinical disorders. It is likely that this investigation will contribute significantly to the field of counseling and the literature on self-injurious behavior.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

This chapter will open with a brief description of the purpose of the ensuing research study and will follow with the characteristics and rationale for a qualitative inquiry. Additional sections will include a description of the study's paradigm, strategy, sample selection, data collection methods, and data analysis. The researcher's role, ethical considerations and ego development data will also be included.

Purpose of the Study

Self-injurious behavior is an increasing phenomenon among women (Favazza, 1996; Levenkron, 1998). Because of the secrecy and privacy associated with self-injury, it is difficult to accurately assess the degree to which these behaviors actually exist. In spite of this emerging trend, self-injury remains misunderstood by the counseling profession (Favazza & Rosenthal, 1993). Consequently, the majority of treatment models fail to adequately meet the needs of individuals who self-injure; the efficacy of interventions are tentative at best, and the majority of those who seek treatment are dissatisfied with the services they receive.

The present state of research on self-injury occurs within the context of an inpatient treatment setting, mainly within emergency rooms and psychiatric inpatient facilities. The research is scarce regarding the treatment of self-injury within the outpatient counseling arena. Thus, given the rising context of this issue, qualitative research methodologies are well suited for studying the counseling experiences of college-aged women with a history of self-injury.

In the following section, I will introduce qualitative research and will include a description of the characteristics and rationale for a qualitative research design.

Characteristics and Rationale of a Qualitative Research Approach

Characteristics of a Qualitative Research Approach

The design of a research study begins with the selection of a topic and a paradigm. A paradigm is essentially a worldview, a whole framework of beliefs, values and methods within which research takes place. According to Cresswell (1994), a qualitative paradigm is defined as “an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting” (p.15).

Guba and Lincoln (1994) argue that the ontological question, the epistemological question and the methodological question define an inquiry paradigm. The ontological question asks, “What is the nature of reality?” The quantitative researcher views reality as objective, measurable, and apart from the researcher, whereas the qualitative researcher views reality as subjective, constructed by the individuals involved in the research. Therefore, there can be multiple realities in any given research situation, depending on the researcher, informants, and, ultimately, the stakeholders or audience for research. The epistemological question asks, “What is the relationship between the researcher and that which is being researched?” The quantitative researcher is to remain independent and objective from that which is being researched, using unbiased instruments or surveys, and systematic sampling procedures. For the qualitative researcher, the distance between the researcher and that which is being researched is eliminated as much as possible. This can take the form of spending prolonged amounts of time with the informants, extended in-depth interviews or collaborating with the people being studied.

The methodological question asks, “What is the process of research?” For the quantitative researcher, the process is based on deductive logic where theories and hypotheses are tested. In this approach, the hypotheses are chosen before the study begins, and the intent of the study is to develop generalizations that contribute to the theory or explain some phenomenon. The accuracy of the research data is determined by the examination of validity and reliability. Conversely, in qualitative research, the methodology is based on inductive research, and the patterns and themes in research emerge from the informants as the research process unfolds. These patterns and themes provide an understanding of the situation and are not meant to make broad generalizations. Accuracy of the information, unlike quantitative research, is verified by triangulation, which is gathering information from a number of different sources for comparison.

The factors that distinguish qualitative research from quantitative research are numerous. Rossman and Rallis (2004) define five characteristics unique to qualitative research. They are the following:

Natural setting: Qualitative researchers are oriented toward the natural world; research is conducted in the field. “Qualitative researchers go to the people; they do not extricate people from their everyday worlds” (p.9). This stands in stark contrast to quantitative research, which conducts research in laboratories, uses probabilistic sampling strategies, and employs control and experimental groups.

Multiple methods: Qualitative researchers use a variety of different methods to conduct research. For example, researchers employ interviews, conduct observations, read participant documents, and examine the material culture (looking at physical space, clothing, etc.).

Focus on context: Qualitative researchers value the natural context where life occurs, for example, settings where people live, study, eat, work, etc. A focus on context forces qualitative researchers to examine the participants' world holistically. This is in opposition to quantitative researchers, who rely on experimental conditions, where standardization procedures and systematic sampling processes dominate.

Emergent nature: Qualitative research is emergent, relying on inductive logic, where reasoning from the particular progresses to more general statements to theory. This is in opposition to quantitative research, which relies on the deductive reasoning, where the process begins with theory and tests its applicability.

Interpretive characteristics: Qualitative research is interpretive, meaning that it focuses on description, analysis, and interpretation. With qualitative research, the researcher attempts to make sense of his/her research findings and intends to interpret the world she enters. This is in direct contrast to quantitative research, which aims to predict and control research.

Rationale for a Qualitative Study

For several years, authors have argued for the use of qualitative designs in counseling research. However, very few studies have been published and even fewer have gained popularity in counseling journals (Heppner, Kivlighan, and Wampold, 1992). In spite of this, Moon, Dillan, and Sprinkle (1990) maintained that the qualitative paradigm offers a viable alternative to statistical research for the investigation and understanding complex phenomenon, like the human experience.

Creswell (1994) identified seven reasons to undertake a qualitative study. They are the following:

1. The nature of the research question necessitates it. In a qualitative study, the research

question generally begins with how or what, rather than why, which is common in quantitative research studies. Within this research study, the primary research question is, “What are the counseling experiences of college-aged women with a history of self-injury?” This question is best answered through a qualitative study.

2. There is little known about the topic, and the subject needs to be explored. This is certainly the case with this study; treatment of self-injury within the context of a counseling arena has been neglected thus far. Results from this study will contribute to theory and will aid clinicians who provide treatment to this population.
3. The view is best expressed in an in-depth investigation of the topic. In the current study a series of interviews with college-aged women provided the audience with a holistic and comprehensive understanding of the counseling experiences of adolescent females with a history of self-injurious behavior.
4. To study individuals within their natural setting. For the current research study, the researcher gained access and gather materials in a context familiar to the participants. This required meeting the women in an environment that is both familiar and comfortable to the participants — like their dorm room or apartment.
5. Sufficient time and resources are available to the researcher. For the purposes of this study, the researcher has dedicated a full year to the investigation of this topic.
6. The audience is receptive to the investigation. Due to the lack of research available on this topic, the audience (researchers, clinicians, and counselor educators) will benefit greatly from the research results, which will likely produce applicable treatment implications for clinicians.
7. The researcher assumes the role as an active learner. Adopting this role, the researcher can tell the story from the participants’ viewpoint. Within this study, this will certainly

be the case; the participants' voices remained intact and were the focus of the results.

The foregoing section explains in detail the unique characteristics of qualitative research and presents a rationale for conducting qualitative research. The following two sections will describe the succeeding study in detail in terms of the research paradigm and research strategy.

Research Paradigm

This study will use an interpretive paradigm to investigate the counseling experiences of college-aged women with a history of self-injury. The interpretive paradigm holds status quo assumptions about the social world and subjectivist assumptions about epistemology (Rossman and Rallis, 2003). According to Rossman and Rallis, interpretive research typically tries to understand the social world as it is from the perspective of the individual experience. The aim within this research study is to access the voices of college-aged women with a history of self-injury. This is particularly valuable for women. Avis and Turner (1996) argued the importance of creating a forum for women's voices to be heard; they state, "the need to create space for women's voices remain important and overdue" (p. 165). This will also potentially be beneficial for college-aged women who self-injure. Many mental health professionals have labeled this population as manipulative and subsequently they have been treated poorly by mental health professionals (McAllister, 2003). The opportunity for their voices to be heard and legitimized could be extremely powerful for the participants and for the larger mental health community.

The goal of the interpretive paradigm is to generate a "thick description" from individuals. Research methods are generally humanistic—face-to-face interactions in the form of in-depth interviews. The current study relied heavily on comprehensive

interviews with participants. Thus, the interpretive paradigm seemed appropriate.

Research Strategy

The phenomenological strategy represents the best fit for eliciting the data that will help to address this research focus. The focus of this study is on the lived experiences of college-aged females with a history of self-injurious behavior. Rossman and Rallis (2003) discussed the phenomenological genre as an assumption whereby “through dialogue and reflection, the quintessential meaning of the experience will be revealed” (p.97). Such a strategy presents a foundation for examining the counseling experiences of college aged women with a history of self-injury as they are constructing counseling experiences for themselves.

The phenomenological approach focuses on describing, interpreting, and examining (Rossman & Rallis, 2003). Phenomenological data analysis utilizes the methods of reduction, searching for themes within specific statements and searching for all possible meanings. Within a phenomenological approach, the researcher attempts to set aside pre-judgments. This is accomplished through the development of a reflexive journal and a researcher as instrument statement (see Chapter One).

By utilizing the phenomenological strategy, the emphasis is squarely on how this population understands and makes sense of their counseling experiences. Further, this strategy acknowledges the importance of considering how each participant constructs her own individual views of counseling, as well as how she has influenced the co-construction of the reality of the counseling experience as a whole.

Participants within a phenomenological study must have experienced the phenomenon under investigation and can speak in detail about these experiences. Speaking in detail about self-injury was extremely powerful for the participants in this

research study. To start, the perspectives and actual voices of women and adolescents have been largely ignored within the literature (Smith-Jobski, 2002). In many ways, they represent an invisible population. Additionally, self-injury is an extremely secretive phenomenon. For many individuals who partake in these behaviors, shame and embarrassment predominates and many shy away from counseling services altogether. Thus, it is not surprising that research on their experiences has been neglected in the literature. For these reasons, a phenomenological strategy, which seeks to investigate their lived experiences with self-injury and counseling, is extremely valuable.

This research study employed a phenomenological interpretive approach to investigating the counseling experiences of college-aged women with a history of self-injury. The following section will provide a detailed description of the sample and the setting.

Sample Selection

Participants and Sampling Procedure

Qualitative studies typically employ purposeful sampling, selecting information-rich cases that enable the researchers to discover information essential to the focus of the study (Rossman and Rallis, 2003). Therefore, the participants for this study were selected in a thoughtful and purposeful manner. The participants in this study had to fit a series of requirements. First, they had to be college-aged women, between the ages of 18-23. Second, they had to be female. Third, they must have had a history of self-injurious behavior, in the form of cutting. Fourth, they must have received outpatient individual counseling sessions, which addressed their self-injurious behavior. Fifth, in order speak in-depth about their counseling experiences, the counseling process must have lasted longer than five sessions.

Setting

A total of 8-12 participants were recruited from a small college in the Southeastern Region of the United States. I displayed flyers throughout the college. These flyers included information about the study, my personal contact information, as well as information about a monetary incentive for participation in the study. Additionally, I placed an advertisement online, on the *Student Information Network* (SIN), which is the college's personal website for students. This online advertisement included the same information as the paper flyer.

Throughout the study, I played an active role with all participants. The following section will describe my role, as researcher, in detail.

Researchers' Role

Entry

Entry is far more than physical entry or obtaining physical entry or obtaining permission to collect data. As researchers gain access to a population of interest, their objectives are to ensure both freedom and integrity for their participants, while also gaining acceptance.

For this research study, I anticipated that the entry stage would take a considerable amount of time. Establishing rapport with adolescents is difficult and requires a great deal of patience on behalf of the researcher. Additionally, self-injury is a behavior associated with privacy and secrecy. Thus, it seemed that many of these women might have a difficult time talking openly about their self-injury or their counseling experiences. Thus, as the researcher, I spent an adequate amount of time establishing rapport.

Students who are interested in the study contacted the researcher via phone or e-mail. During this initial contact, I provided them with a detailed explanation of the study and answered any questions or concerns. A copy of the Introductory Letter was also attached to the e-mail or sent to the student's campus address. Additionally, during the initial contact with the participants, I explained to each participant that her confidentiality will be protected throughout the study. Included in the informed consent was the explanation that participants' identities would be protected at all times, with no participants' names being used and all records and tapes of interviews being destroyed at the conclusion of the study.

I set up the first interview, at a place convenient for the student. The researcher also provided the participant with her office, if that was more convenient for her. During the first interview, I provided the participant with the Introductory Letter (Appendix B). Additionally, each student participant signed a consent form (Appendix B) prior to beginning and recording any interviews.

Reciprocity

Reciprocity relates to the mutual benefits of research. As the researcher, I wanted to gain knowledge and an understanding of the counseling experiences of college-aged women with a history of self-injury. At the same time, it was likely that the participants also wanted something in return. Thus, from the beginning, I made it clear what the participants gained from participating in the study. First, I explained that they received a \$30.00 monetary reward for their participation. I also explained that by participating in this study, they were providing the counseling field with valuable information which may eventually inform treatment approaches for college-aged women who engage in self-injurious behavior.

At the end of the study, I sent each participant a summary of the study's findings. Additionally, I plan on publishing my results in referred journals and presenting my findings at both regional and national conferences in hopes to share my knowledge with other researchers interested in this phenomenon or counselors working with this population.

The role that I assumed throughout the research study remained active throughout, especially as I collected data. The following section will focus on two primary forms of data, the interview and the reflexive journal.

Data Collection Techniques

The Qualitative Interview

According to Rossman and Rallis (2003), the qualitative interview is the hallmark of qualitative research. "Interviewing takes you into the participants' worlds, at least as far as they can verbally relate what is in their minds" (Rossman and Rallis, 2003, p.180). The quality of the interview is based largely on the interviewer's skill, and ability of the interviewee to bring the interviewer into his or her world (Patton, 2002). The interview within this research study was consistent with the phenomenological strategy. The purpose of a phenomenological interview is twofold; it allows the researcher to gain a deeper understanding of the person and it is used as a vehicle to develop a narrative about a particular personal experience (Rossman and Rallis, 2003). The interview questions were developed with these goals in mind.

This research study employed two face-to-face semi-structured interviews, composed of open-ended questions (Appendix D, Appendix E). By conducting two interviews with each participant, I gained an in-depth and meaningful understanding of the counseling experiences of college-aged women with a history of self-injury. An

interview guide was developed with a list of subject areas to be explored before interviews are performed. An interview guide affords flexibility and ensures that similar lines of inquiry are examined with all interviewees. However, the interviewer remains free to ask follow-up questions, to word questions in reply to participant responses, and to develop a conversational style.

Reflexive Journal

In order to address the expectations and values brought by researchers to the study and the possible influence of such expectations and values upon the data derived from the interviews, I kept a reflexive journal throughout the research process. According to Lincoln and Guba (1985), a reflexive journal is

...a kind of diary in which the investigator on a daily basis, or as needed, records a variety of information about self and method. With respect to the self, the reflexive journal might be thought of as providing the same kind of data about the human instrument that is often provided about the paper-and-pencil or brass instruments used in conventional studies. With respect to method, the journal provides information about methodological decisions made and the reasons for making them...(p.327).

The reflexive journal includes the following components, as suggested by Lincoln and Guba (1985):

1. The researcher's daily schedule and logistics of the study.
2. A personal diary that consists of reflections about one's values and speculation about growing insights.
3. A methodological log in which methodological decisions and rationales are recorded.

I created the format of the reflexive journal and committee members gave feedback at specific intervals throughout the research process. The interview and the reflexive journal were the central focus of the data generation, collection, and analysis, which will be described in detail in the foregoing section.

Data Generation, Collection, and Analysis

Description

Data generation, collection, and analysis are critical components to qualitative research studies. Throughout this process, the researcher aimed to create trustworthy and authentic results. According to Rossman and Rallis (2003), the trustworthiness of a qualitative research project is judged by two standards. First, does the study conform to standards for acceptable and competent practice? Second, does the study meet standards for ethical conduct for sensitivity to the politics of the topic and the setting? The four trustworthiness criteria are: credibility (truth value), transferability (applicability), dependability (consistency), and confirmability (neutrality). Authenticity, on the other hand, ensures that the research is meaningful, useful, and has the potential to enact social change. These criteria include the following: fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity (Guba and Lincoln, 1989). Several criteria for trustworthiness and authenticity were met within my study and will be addressed further in the following section.

Plans for Data Generation and Collection

The phenomenological strategy clearly points to the necessity of acquiring in-depth data to analyze in this study. As stated previously, the interview questions served as the main area for data generation and collection. These questions ideally led into the appropriate areas of exploration. As researcher, I facilitated the emergent nature of the

interviews by active/empathetic listening and by giving the participants freedom and control to discuss their perceptions of their counseling experiences. Dimock (2001) argued that creating a caring and trustful relationship between the inquirer and the respondents contributes to ontological authenticity. According to him, ontological authenticity is achieved when participants experience personal growth.

An additional data generation component is to analyze some part of the material culture of the participants. In this research study, I sent via e-mail a prompted journal reflection to each participant (Appendix H). This analysis afforded a more in-depth understanding of participants' counseling experiences and triangulated the data. Triangulation of data is a procedure that involves the use of multiple sources to examine a conclusion from more than one vantage point (Schwandt, 2001). Rossman and Rallis (2003) maintain that triangulation is one way to establish credibility, or how well the findings match the informants' perceptions.

These two techniques, interview and document analysis, represented excellent methods for ensuring the accumulation of thick, rich data and required diligent analysis in order to ensure that such information was utilized (to the fullest extent possible) in service to the study's focus. Guba and Lincoln (1985) suggested that obtaining a thick description of the data contributes to the transferability or applicability of the study. Transferability refers to how the findings can be applied to other contexts or with other informants.

The data collection and generation methods described in the above section provide evidence for employing an audit trail, which is a methodically maintained documentation system. I maintained an audit trail through my reflexive journal, my

transcribed interviews, member checks, and by staying in close contact with my committee members throughout the dissertation process.

The following section will describe the data analysis procedures for the ensuing research study.

Data Analysis

Using an emergent approach to data analysis, I aimed to understand and compare the multiple perspectives of college-aged women with a history of self-injury. This occurred through an inductive analysis—a review of the core content of data from interviews, observations, and document analysis. Rossman and Rallis (2004) referred to inductive analysis as a strategy to identify salient categories within the data; it allows for modification of concepts and relationships among concepts to occur throughout the process of doing research. I conducted a categorical analysis of the interviews and identified my unit of analysis as the paragraph. Rossman and Rallis (2004) explained that a categorical analysis identifies similarities and differences among data, coding and sorting them into appropriate categories.

Due to the phenomenological approach of this research study, the within case analysis was indigenous. Indigenous categories are those expressed by the participants; the researcher actually discovers them through analysis of how language is used. On the other hand, the across case analysis was interpretive; the researcher makes interpretation from the language the participant provides. Aside from the interviews, the documents were holistically analyzed. Holistic analysis does not attempt to break the evidence into parts, but rather draws conclusions based on the text as a whole (Rossman and Rallis, 2004).

After interviews were completed and transcribed, I member-checked my participants' responses. Member checking is a term for soliciting feedback from respondents; it is an important procedure for corroborating or verifying findings and for ensuring that the participant responses are valid (Schwandt, 2001). Additionally, member checking is another way to measure the credibility of the research findings. According to Dimock (2001), member checking contributes to the meeting the criterion of fairness. Fairness ensures that all participants in the study have an equal chance to express their voice during research and that the constructions presented in the study accurately reflect those voices (Dimock, 2001).

I member-checked my participants' responses at three separate points during my study. First, I member checked during the interview, asking for clarification or elaboration when needed. Second, I member checked my understanding of the participants' responses after the interview was completed and transcribed. The responses were summarized and given to the participants for them to review and correct as necessary. Finally, a grand member check was conducted. At this point, I gave my participants drafts of what I was planning to put in the report of study results. Again, participants' corrections and clarifications were encouraged.

The focus for my analysis was the voice of the women—how they constructed meaning of their experiences of the counseling process. Throughout the interviews, I searched for and finally included direct quotations from the participants, in case studies, to illustrate the nature of their counseling experiences. These quotations were used to highlight relationships (similar and different) among emergent themes and were used to compare different perspectives within the group of participants and among individuals.

Adhering to the principles of a phenomenological strategy, analysis began as soon as data were generated. I searched for themes in the participant's experiences. Broad categories were sought, with sub-themes to elaborate the topography of meaning expressed by the participants. More specifically, this phenomenological study searched for the deep ways in which people make meaning of their lives and their counseling experiences, how they integrate, differentiate, etc. While identifying these themes and patterns, I specifically looked for convergence and divergence across participants. Within my study, I used a variety of different methods to generate particular themes, such as creating concept maps and looking for recurring words. Throughout the study, the analysis of data was compiled in a manner which was clearly described and potentially useful and interesting to my intended audience.

Ethical Considerations

From the start of this research study until the end, I conducted my research in an ethically sound manner. Throughout the project, I was keenly aware of my role as a researcher and was mindful of not assuming the role of counselor with the interviewees. I made this role clear to the participants before the study began. At the same time, I recognized that the outcome of the interviews may have been therapeutic for many clients.

In order to be confident that my research followed ethical procedures, I did the following. First, I submitted my research questions to the Human Subject Committee for Institutional Review Board (IRB) approval. Secondly, I presented all research participants with an informed consent form and an introductory letter. Finally, I verbally informed that clients of the expectations and the scope of the research.

The foregoing sections of this chapter include information that is consistent with qualitative methodology. The following section will include data that is pertinent to this particular research study.

Ego Development Data: Sentence Completion Test (SCT)

After the interviews were complete, Loevinger's SCT was administered to all participants. Results from this instrument were analyzed independently from the interview data. Findings from the SCT provided additional information regarding where the participants were functioning developmentally. These results provided valuable information, which has direct implications for treatment for college-aged women with a history of self-injurious behavior.

The Washington University Sentence Completion Test

Loevinger (1970) and her colleagues developed the Washington Sentence Completion Test (SCT). This projective assessment measures seven stages and three transitional phases of ego development (Jennings & Armsworth, 1992). The SCT was developed with the premise that the ego is relatively stable and changes only slowly throughout the lifespan. The use of a projective assessment was designed purposefully. As Loevinger (1970) wrote, a projective assessment requires the subject to project his own frame of reference upon the instrument.

There are two versions of the SCT available, one for men and one for women. Both forms, which are not gender biased, consist of 36 incomplete sentence stems (Novy, 1993). Respondents are asked to complete all sentence stems in a general manner without any further prompting. An alternate form consisting of 18 items also exists and can be used without sacrificing validity, although reliability can decrease due to its brevity (Foster & Sprinthall, 1992).

This research study aimed to examine the counseling experiences of college-aged women with a history of self-injury and to determine the relationship between stages of ego development and descriptions of the counseling experiences. The even numbers of the long form of the SCT appeared to be most appropriate because the majority of these questions were applicable to women's issues. For this research study, each participant was administered the SCT after both interviews were complete. Respondents were asked to complete each sentence stem, with no other directives.

Evidence for the reliability and validity of the SCT appear strong (Recklitis & Noam, 1999) and within longitudinal studies over a significant period of time, retest scores remain relatively consistent (Redmore, 1983). Loevinger and Wessler (1970) reported an alpha coefficient of .91 for all items for the internal consistency and inter-rater reliability measures to be between .86 and .90 and the internal consistency

Scoring the SCT.

When scoring the SCT, the goal is for the researcher to assign a place on the scale of ego development to the subject. Every response is matched against the sequence of qualitative stages and assigned to the level it more closely matches. Thus, rather than scoring each individuals' protocol separately, individual items are scored for an entire sample. The assumption underlying the SCT is that each individual has some level of core functioning (Loevinger, 1970). Therefore, the task is to translate the distribution of ratings into one single score.

There are a number of different scoring paradigms. For example, one paradigm uses the mode, or most frequently occurring level of the distribution of item ratings, as the primary score. Another scoring paradigm uses the means of the items ratings as the total protocol rating (TPR). One commonly used scoring paradigm is the Automatic

Ogive, which yields one TPE. This method requires calculating a cumulative frequency distribution of item scores and comparing it with automatic rules in the scoring manual. The automatic ogive rule is the scoring method often used by inexperienced raters. Thus, this is the approach I used for this research study.

Demographics Questionnaire

In addition to the SCT, participants were administered a brief demographics questionnaire at the conclusion of the two interviews. The questionnaire asked questions regarding age, race, family of origin questions (see Appendix E). The inclusion of the supplementary data contributed significantly to the research results and, as stated before, these data were analyzed independently from the qualitative data.

CHAPTER 4

WITHIN-CASE ANALYSIS

Chapter 4 represents an account of the within case analysis from the research participants. The chapter is divided into ten separate case studies. Included in each case study are the words from the participants themselves, followed by a summary and brief interpretation. Ego developmental scores and interpretation of these scores are included at the end of each case description.

Overview of Analytic Procedure

Each participant was interviewed on two separate occasions. Approximately two weeks separated the first interview from the second. All interviews were tape-recorded and later transcribed by the researcher. At the end of the second interview, participants were given Loevinger's Sentence Completion Test (SCT). A reflexive journal was kept throughout the entire process in order to minimize the inclusion of judgment and bias into the analysis.

During the beginning stages of analysis the researcher read and re-read the first and second interview of each participant. Several readings allowed the researcher to better acquaint herself with the interview and allowed her to find patterns within each separate interview. The researcher's next step of analysis involved analyzing each interview by section or paragraph. Themes were then developed based on the frequency and meaning of ideas. All themes were indigenous in nature, meaning that they were named by the participants' own words.

After all themes and sub-themes are presented, ego development scores are displayed. All scores were computed using the automated ogive method and explanatory

ogive method based on the 18-item form, which is displayed in the following chart (Hy & Loevinger, 1996).

Table 4.1

Ogive and Item Sum Table to 18-Item Forms

Stage	Item Sum	Automatic Ogive	Explanation of Ogive
E9-Integrated	119 up	No more than 17 ratings at E8 or lower	1 or more at E9
E8-Autonomous	109-118	No more than 16 ratings at E7 or lower	2 or more E8 or higher
E7-Individualistic	101-108	No more than 15 ratings at E6 or lower	3 or more E7 or higher
E6-Conscientious	91-100	No more than 12 ratings at E5 or lower	6 or more E6 or higher
E5-Self-aware	82-90	No more than 9 ratings at E4 or lower	9 or more E5 or higher
E2-Impulsive	36-67	At least 3 ratings at E2	3 or more E2
E3-Self-protective	68-75	At least 3 ratings at E3	3 or more E3 or lower
E4-Conformist	76-81	Other cases	Other cases

The final section of each case study includes a brief interpretation of the findings.

Chapter 4 will begin with a chart, which presents the demographic overview of participants (Table 4.2), tabulated from the participants' responses on the demographic questionnaire.

Table 4. 2

Demographic Overview of Participants

PARTICIPANT	AGE	RACE	FORM OF SELF-INJURY	TOTAL TIME IN COUNSELING
Amy	20	Caucasian	Cutting	6-12 Months
Claire	21	Caucasian	Cutting	0-6 Months
Sam	20	Latina	Cutting, Eating Disorder	6-12 Months
Ann	20	Caucasian	Cutting	More Than Two Years ("Sporadically")
Juliana	22	Caucasian	Cutting, Eating Disorder	More Than Two Years ("8-9 years")
Katy	23	Caucasian	Cutting	6-12 Months
Calliope	21	Caucasian	Cutting	0-6 Months
Jane	22	Caucasian	Cutting	Two Years
Becky	22	African-American	Cutting, Eating Disorder	More Than Two Years
Kylie	18	Caucasian	Cutting, Eating Disorder	More Than Two Years ("4 years")

Analysis of Participant #1: "Amy"

Table 4.3

List of Themes and Sub-Themes

THEME	SUB-THEME
FEELING	Unhappy, Pain
HIDE	Differently, Shame, Private, Avoided
FAMILY	Mother, Parents
THE COUNSELOR	Relate To, Listen, Questions, Judge
WHILE I WAS IN COUNSELING	False Sense Of Happiness, Alternatives, Verbalizing Feelings, Concrete Answers, Switching Counselors, Avoid.

Introduction

Amy was a 20-year old, Caucasian student at a small southeastern public university. During the end of her senior year in high school she overdosed on a bottle of Advil in the school bathroom. A teacher with whom she had a close relationship, noticed that something was wrong and called emergency services. At the hospital, Amy was treated and spent a couple of hours talking with a counselor, who noticed cuts on her wrists. According to Amy, she had been cutting herself, using sewing needles, knives and razors several weeks prior to the incident at school. The counselor at the hospital recommended 72-hour observation, but Amy resisted strongly. Against the recommendation of the hospital, her parents supervised her closely at their home. According to Amy, her high school then gave her “special student status and medical leave,” and she spent two weeks, up until her graduation, in New Jersey with her aunt and uncle.

Following her time in New Jersey, Amy’s parents referred her to a counselor within their HMO. Her parents were not aware of her cutting, at this point. She saw this counselor for approximately four months, and stopped once she arrived at William and Mary. Amy then resumed counseling in November or December of her freshman year at the College of William and Mary. According to Amy, she told a friend that she was feeling depressed, and this friend helped her to get in touch with the counseling center at the college. At this time, Amy also started cutting again, although she did not share this information with her friend. Amy continued seeking counseling at the College Counseling Center until the end of her freshman year.

Amy returned to William and Mary for her sophomore year. However, according to Amy, she took the spring semester of college off, due to feelings of depression and

unhappiness. However, she did not attend counseling during this time. My interview with Amy was conducted in September of her junior year in college; she had only been back at school for approximately 3 weeks.

The following themes (with related sub-themes) emerged from the interviews (see Table 4.3): Feeling (unhappy, pain); Hide (differently, shame, private, avoided); Family (mother, parents); College (academic pressures, being in a sorority, expectations); The Counselor (relate to, listen, questions, judged); and While I Was In Counseling (false sense of happiness, alternatives, verbalizing feelings, concrete answers, switching counselors, avoid).

Themes

Feeling.

Amy talked at length about her history of self-injury, the influences upon her behavior, and the feelings associated with her self-injury. As she talked about the influences that contributed to her behavior, she stated, “I think it sort of came maybe from media and television influence and knowing that other people had done this to sort of like dull their pain or make themselves feel pain.” Amy also experienced pervasive feelings of pain and unhappiness. In our first interview, she shared, “I was sort of at a point where I felt like I couldn’t feel anything anymore, and I wanted to make myself feel in a way, and even if it wasn’t emotional, it was just rather physical.” She continued on, stating, “I really can’t even think of any other way to say it other than the pain inside is so much and like I don’t want to talk about it, so it is just easier to cut and feel some sort of physical manifestation of the emotional pain.”

In talking with Amy, she was able to identify her feelings prior to the onset of her cutting. When talking about her senior year in high school, Amy remarked, “I felt like I

was losing my place. I was very unhappy, started cutting and removed myself from all sort of social situations, sort of cut myself off from other people. I got into a very, very bad place in my head.” Amy clearly noticed a difference in her behavior and in her actions, isolating herself from others, consumed by the feelings and thoughts within her head.

In college, Amy revealed that her pain and unhappiness from high school resurfaced. However, before she took extreme action, she revealed her struggles to a friend. She stated, during “November or December of my freshman year I started to get depressed again.” For Amy, this was then the cutting re-started. She shared, “But very early on, when it started to get like that again I told someone and let them know about my previous situation...so, they helped me to get in touch with the counseling center.”

Hide.

Although Amy learned to share her feelings with others, she remained very private about her cutting, both in her everyday life and in her counseling experiences. We had the following dialogue about hiding her self-injury in the context of her counseling sessions:

I sort of hid it. I did it right here (shows me) on my wrist and I hid it. I would wear long sleeve shirts or a watch, or I would cover it with a ribbon around my wrist...It was like the focus of one of our sessions, but after that like I really didn't want to talk about it, so I sort of didn't.

For Amy, her self-injury was a private matter: “It is sort of something you never want to admit that you do to yourself, and I didn't really want to fess up to it or make it a very big deal because it is a very private thing.”

Beyond the counseling arena, Amy shared that very few people know about her self-injury. When talking about her friends at William and Mary, she remarked, “I am glad that my friends don’t know...or, I don’t know if they know. They have never said anything. Again, it is a very private thing for me and its...I don’t want to be seen as different or a psychological disorder to these people.”

Amy was concerned about being viewed as “different, especially within the context of a college setting:

It is something that I haven’t really revealed to many people. I feel like the only people who know are my counselors (who are the very few people who have actually seen it). I have not told anyone down here I feel like, other than the counselor, just because I don’t want to be looked at differently. I don’t want it to come up to come up in somebody’s conversation with someone else. I don’t want it to be spread around. Like, I am in a sorority. If I tell one girl, it will probably end up getting around, you know. I don’t want people to see me in that way.

Family.

Amy remained equally as private about her self-injury with her family. During my first interview with Amy, she shared that her mother was the only one in her family who was aware of her self-injury. She talked at length about her mother’s initial reaction to her cutting. She revealed, “It was really like one of the only times when I saw her cry. I felt really bad...I obviously got really upset because she was so upset...”

During the interviews with Amy, she expressed that she did not want to cause pain or hurt her parents in any way. Consequently, she was thankful that her counselors did not report her self-injury or her involvement in counseling to her parents:

I think it is a good thing. I wouldn't want to upset my parents...I don't want to feel like I am hurting them and I don't want to let them down. I don't want to make them feel like they have failed me, which is sort of like how my mother felt when she found out.

College.

During the time of the interview, Amy was in the first semester of her junior year. She reflected openly about her experiences in college. When asked about her experiences as a college student, Amy talked about the multiple pressures she encountered:

There are a lot of academic pressures, especially at this school. I remember being in high school and being told, "Oh, after high school, like college will be so easy for you." And, it really hasn't been. It has been a definite struggle. I guess academically and trying to stay focused has been extremely difficult.

Amy also talked about her experiences within the Greek community at William and Mary:

Being in a sorority there is a lot of pressure to act in a certain way and to associate with certain kinds of people, as well. I guess...it is a lot "cliquer" than I expected it to be...And, being in a sorority, you are expected to go out and you are expected to party and you are supposed to be visible and known on campus, and that is not necessarily always what you want to be doing.

Beyond Amy's experiences within her sorority, she also remarked about her experiences as a college student, in general.

I feel like there is a lot expected from us. And some really unrealistic expectations. And, this is something that hits really hard for me. Because, I did

take last semester off, which is something that people don't really expect. People definitely expect you to have the time of your life in college. And, I don't feel like that necessarily is what my experience has been.

The Counselor.

For Amy, *The Counselor* emerged as a substantial theme within her interview, as she remarked about the positive and negative aspects of the counselors with whom she worked.

During both interviews with Amy, she talked about feeling judged by her counselors. The following is Amy's description of the first counselor with whom she worked during the summer before her freshman year in college:

I felt like she was sort of judgmental and brought religion into the picture too much. I didn't really appreciate the handing out of the scripture verses to tell me that I am loved, no matter which way I am, and I have to accept myself for who I am. I can't really remember anything positive about going to see her. I didn't really like to talk to her. I didn't really feel like I could open up to her without being judged.

When asked specifically how her counselor demonstrated a judgmental stance, Amy shared, "I just felt she thought that I wasn't as good of a person because I had done this. And that I was somehow like a bad person because I had done this to myself, or whatever." Amy's experiences of feeling judged prompted her to give the following advice to counselors working with college aged women who self-injure: "I would definitely say to be sympathetic, and you definitely cannot judge because I think that was one of the hardest things for me. Just feeling that I would be judged if I tell them about this."

Amy viewed her first counselor's judgmental attitude as a negative. On the other hand, she felt that her counselor's ability to listen was paramount. According to Amy, her counselor at the counseling center "was definitely very sympathetic, and she was easy to talk to, and she was a very good listener, and I felt comfortable." She continued on and revealed, "She, I guess, was more active in the conversation. I guess there was more of a dialog between us. Rather than I talk and they sort of sit there and watch and write it down on a clipboard. She sort of sat there with me, and we just sort of had a conversation and she listened." Amy also talked extremely highly of the counselor with whom she talked for a couple of hours in the emergency room after she overdosed on a bottle of Advil. The following is an excerpt from this conversation:

I really liked her. She had a very placid demeanor. She was very calming, again not judgmental at all. She definitely seemed to sympathize with me. And she sat there with me and let me cry to her and let me get like months of pent up feelings off my chest and sort of was a good listener to me...just having someone listen to me was exactly what I needed at the time. Having someone tell me that you are going to be ok, and you are not the only one, and we are going to make sure that you are ok and that you are going to be taken care of, and it is not the end of the world. That was exactly what I needed, and I really liked that.

In addition to the value of a counselor who could listen, Amy also shared that the questions that the counselor asks are critical. During the second interview, I asked the question, "What could a counselor have done, if anything, to get you to that place to talk openly about things?" Amy responded in the following manner:

I guess I would have to feel definitely very comfortable with whoever I was talking with and...it just...I don't know...If I had been asked outright. Like, "Do

you cut?” Like, “Talk to me about this.” Specific questions, as you are doing now, that would be something that would help me to explore it.

Getting the counselor to ask the right questions appeared to be important to Amy. She stated, “I mean it can be just one simple thing that will set you off, and you might not be able to express yourself the way that you need to, or they may not ask the right questions to get you to open up and to find out why you are cutting.”

Finding a counselor to relate to was also essential to Amy’s happiness in counseling. Talking again about the counselor she saw briefly in the hospital in high school, she shared the following:

I felt like I could really relate to her...I felt like she really understood me, and she was very sympathetic and very comforting, and she wasn’t like so old that I felt like she couldn’t relate to me, but she wasn’t so young that I felt like, ok, “Who are they to tell me what is going on?”

Amy also talked about the first consistent counselor she worked with during after her senior year in high school:

I didn’t feel like she understood me at all. I felt like she was not getting me what I needed. I felt like she couldn’t really relate to my situation at all. I felt like I was being judged a lot of the time.

While I Was In Counseling.

Amy was in counseling on two separate occasions: once during the summer between her high school and her freshman year in college, and once during the second semester of her freshman year at The College of William and Mary. During my two interviews with Amy, she talked extensively about the experiences she had while she was in counseling.

As Amy reflected on her experiences in counseling, she realized, “I almost felt like I fooled myself into a false sense of happiness because I was in counseling. And, after it was over, I sort of just would get unhappy again because I would stop having the weekly verbalization of how I felt.” During the interview, Amy expanded upon the concept of her false sense of happiness. “Maybe I was giving myself a false sense of happiness because I thought that, that was expected of me,” she shared. “A lot of my issues were, “What do people expect of me?” I have to be what people expect of me versus like what do I feel really inside.” Although Amy struggled to determine whether her happiness was authentic, she explained that counseling was an arena for her to talk about her feelings:

While I was in counseling I did feel much happier and talking about things, just verbalizing things and sort of realizing things did tend to make me feel better and realize that was the place that I had been in, and I am not necessarily in that place all the time.

For Amy, counseling served as a vehicle for her to develop alternatives to her self-harming behaviors. She shared,

The one thing I started doing, when I was in counseling was I just would write down my feelings more. Like, if I felt sad I would like write it down and go and tell someone or try to be around other people. Or, trying to not isolate myself when I got unhappy and couldn't deal with the pressure...

While Amy was in counseling, she searched for an answer to her problems, although she now realized that was an unrealistic expectation. “I sort of expected for me to tell them [the counselors] what was wrong and for them to tell me, give me like a concrete solution, but it isn't that concrete.” Her lack of satisfaction with counseling

prompted her to give the following suggestions to women who were in counseling and still harming themselves: “I think that if they are in counseling, and they are still cutting, I don’t think that counseling is necessarily working for them,” she stated. Perhaps try switching to a different counselor or a different type of counseling.”

Ego Development Level

Amy scored at the E6, the Conscientious level, on the SCT. An individual scoring at this level is able to internalize rules and develop her own personal list of rules that fit her own needs and experiences (Hy & Loevinger, 1996). An individual at this stage is able to recognize her own role and significance in making decisions. Morality comes from within, rather than what the group decides. An individual functioning within this stage has an increasing ability to critically reflect, to consider alternative perspectives, and to live up to personally established ideals (Hy & Loevinger).

The ogive rule (see table 4.1) allows for some scores to be below and above the level ultimately assigned. Thus, not all of Amy’s scores were scored at E6. The automatic ogive criterion requires that she attain no more than 12 ratings at E5 or lower; she had exactly 12 ratings at E5 or lower. The explanation of the ogive criterion requires that she attain 6 or more ratings at E6 or higher; she had exactly 6 ratings at E6. Amy’s total item sum was 92. The following sentence stems and her responses reveal the E6 level:

Raising a family: “is extremely difficult and selfless.”

When people are helpless: “they are frustrated.”

A woman feels good when: “she is validated by people she admires.”

Summary

When asked how she initially got involved in counseling, Amy shared, “I felt like I was losing my place. I was very unhappy, started cutting and removed myself from all sort of social situations, sort of cut myself off from other people. I got into a very, very bad place in my head.” Her first counseling experience was precipitated by her overdose of Advil while she was a senior in high school.

Amy talked about the privacy associated with her self-injury. She attempted to keep in hidden from her family, friends, and counselors and often wore long sleeve shirts, a watch or would cover it with a ribbon around her wrists. Amy shared that she hid her self-injury from others and avoided conversations related to self-injury with her counselor because she didn’t want to be viewed “as different” or “a psychological disorder” to others.

Amy was a first semester junior when I interviewed her. She completed a year and a half of coursework at the College of William and Mary, taking one semester off due to her reported feelings of unhappiness. College emerged as a prominent theme in my interview with Amy. She talked about academic pressures and high expectations placed upon her. She also talked about the pressure to “act in a certain way,” “to associate with certain kinds of people” and the expectation to “go out” and “to be visible and known on campus.”

Different aspects of her counselors, both positive and negative, were talked about during both interviews. Amy talked about the importance of being able to “relate to” her counselor. She also expressed her experiences of feeling “judged” by her counselor, especially with the counselor who would “quote scriptures.” A counselor who was “easy

to talk to,” a “good listener,” and a counselor who would “let me cry to her and let me get months of pent up feelings off my chest” was extremely important to Amy.

While Amy was in counseling, she wanted to be happy. In spite of this, Amy talked about experiencing a “false sense of happiness” or fooling herself into being happy during her counseling experiences. While in counseling, Amy was searching for “concrete answers” to her problems, although she never received them. Amy did talk about the benefits of discovering alternatives in counseling. She learned to “write down my feelings more,” and tried not “to isolate” herself through her counseling experiences. Amy also found that the “weekly verbalization” she was afforded in counseling helped her to feel better.

Interpretation

It was important for Amy to keep her self-injury hidden from others. At the time of the interview, nobody in her sorority or within her circle of friends was aware that she harmed herself. Further, her mother was the only one in her family aware that she cut herself, and this reality still appeared to affect her. To me, Amy appeared to be not only concerned with how others would view her in light of this behavior, but she also worried that she would cause others pain or worry because she was harming herself.

In spite of her private nature, Amy was candid and open throughout both interviews. To me, this communicated her desire to share her story, in order to help others coping with this behavior.

It was evident to me that Amy wanted to feel better and hoped that counseling would be the vehicle for her to find joy in her life. Unfortunately, a false sense of happiness was the closest that Amy came to feeling happy. Upon studying this interview, I was awestruck by the level of importance that Amy placed on the counselor she saw in

the hospital after an overdose, for only two hours. Of all the counselors she worked with, she felt the strongest connection with her. Amy clearly responded to a counselor with whom she could open up, a counselor to whom she was able to relate, a counselor who listened to her, and a counselor who didn't judge her. This reality, to me, should speak loudly to counselors working with women who self-injure.

Amy scored at level E6, the Conscientious Stage, on the SCT. Her behaviors and attitudes were consistent with this level. At this stage, relationships with others are invested with more emotional affect (Hy & Loevinger, 1996). This was the case with Amy; she discovered that when she was feeling "unhappy" and felt like she was "losing her place," she subsequently "cut herself off from others." Amy's isolation from her relationships with others was a direct result of the strong feelings she was experiencing.

As indicative of the E6 level, Amy experienced feelings of guilt related to actions (Hy & Loevinger, 1996). This was certainly the case, as she talked about her mother's discovery of her self-injury; she felt extremely guilty and took her mother's reactions very personally.

The theme of honesty was also prominent throughout the interview. For an individual functioning at the E6 Level, being honest with one's self becomes as important as being honest with others (Hy & Loevinger, 1996). It was evident that this was emerging with Amy. As she reflected upon her experiences in counseling, she realized that she was not honest about the severity or frequency of her cutting with her counselor. She also talked about her current struggle with deciding to tell her friends that she had a history of self-injury.

As an individual functioning at the Conscientious Stage, Amy was able to think of her counseling experiences in terms of communication and expression, was able to reflect

upon herself in relation to others, and was capable of considering alternatives in therapy (Hy & Loevinger, 1996). In fact, she found a few different behaviors, other than cutting herself, that helped her express her feelings and prevent her from harming herself. Finally, she was able to make general references to roles, common at the E6 level (Hy & Loevinger). As a woman in a sorority, she realized that she had to uphold a particular standard, and revealing her self-injury to her friends or her counselor would result in people viewing her as diverging from that role.

Analysis of Participant #2: "Claire"

Table 4.4

List of Themes

THEME	SUB-THEME
SCHOOL'S POLICY	Handbook, Liability, Forced
MYSELF	Mom, Parents, Friends, Expectations
ONLINE	Online
SELF-INJURY	Heard About It, Hide, Stop, Symptom
COUNSELOR	Different Counselor, Understood, Listen
COUNSELING	Focus, Medication, Problem, Social Anxiety, Want To Change

Introduction

Claire, a 21 year-old Caucasian female, was a senior at a small southeastern public university at the time of the interview. Claire started cutting, using an exacto-knife, during her senior year in high school. The cutting progressed and became more visible during the second semester of her freshman year in college. Claire's close found out about her cutting and reportedly contacted her parents and the counseling center on

campus. Her parents made a referral to a counselor whom she saw briefly over Christmas Break. When she returned to college from break, she attended counseling sessions at the College Counseling Center. According to Claire, she was required to attend sessions for her self-injury; a refusal to seek help would result in her living off campus.

The following themes (with related sub-themes) emerged from the interviews: School's Policy (handbook, liability, forced); Myself (mom, parents, friends, expectations); Online (online); Self-Injury (heard about it, hide, stop, symptom); Counselor (different counselor, understood, listen); and Counseling (focus, medication, problem, social anxiety, want to change).

Themes

School's Policy.

Claire received an e-mail or "some kind of official communication" from the college, mandating her to receive counseling services, due to her self-injury. She mentioned, "There is some thing in the handbook that if you could be hurting yourself or causing danger to yourself, then you are not allowed to stay in campus housing or something until you see a counselor." Although she understood the liability involved with students harming themselves or "seriously endangering" themselves, Claire believed that it "came across kind of harsh how it happened to me." In response to this policy, she felt forced into counseling whether she "wanted it or not or whether it was helping or not." To Claire, being pushed into therapy was "a little annoying," "a little embarrassing," and "frustrating."

Myself.

Although a friend called Claire's parents to inform them about her self-injury, she never talked with her parents about it directly. According to Claire, her mom "seemed to

treat it like a symptom to a bigger problem. It was the anxiety, depression thing that we talked about.” An additional friend that Claire grew up with also knew about the self-injury, before “everybody else” and “she seemed upset about it but she didn’t do anything” about it.

Claire finished counseling at the end of her freshman year in college. When asked what it is like to be a college student today, she responded in the following manner: “There are a lot of expectations, not just academic but social. You are expected to be a certain way, to be interested in certain things. You know, hang out with certain people. For me, it was kind of hard to fit in exactly.” Now a senior, Claire was able to negotiate some of the expectations and pressures she encountered when she first arrived at the university. She stated, “I feel like I have a better perspective now, and I do what makes me happy and the things that I am interested in.” She continued on and stated:

There is space to negotiate within those expectations. I have learned where to find people who are interested in the same things as me, and stuff like that. Like, I am not into the whole sorority thing, but...you have to work a little harder to find...I don’t know the outsiders. You eventually can figure out something.

Online

During the second interview with Claire, she remarked that the majority of counselors are not “current with the self-injuring community.” Claire argued that one way of getting closer to the community is through the self-injury sites online. She maintained that these websites have wide ranging implications for both counselors and clients.” She shared that by reading on the internet, “You can really figure out what counselors are looking for and like, you can figure out what to tell them or what not to tell them.” In Claire’s mind, the people who engage in self-injury “these days, are a step

ahead of their counselors.” Claire felt strongly that, “Counselors should know about these things and even visit them sometimes. I know there were counselors on some of those boards, and it was probably helpful for them and the people they work with.”

When asked to elaborate more specifically on the content and description of the self-injury sites, Claire stated that some of the web-boards are aimed at “supporting each other if someone was trying to stop. Some of them were like support for self-injury. It was just like, sort of reinforcing the idea that it was an acceptable thing for upset young females to do.” She also talked specifically about the information within the web-boards. She stated that participants often were “comparing stories, and there were places where you could like put your pictures of like what you did.” People would tell their story about “what they were doing in counseling. It wasn’t necessarily like straight up, like here is what to do and here is what not to do.” But by reading between the lines, she commented, “you could pick up generally what happens...what to expect. So, if you want to control the direction things go, it is a little easier.”

Self-Injury.

Claire learned about self-injury during her senior year in high school.

She stated,

I don’t think I would have cut myself if I hadn’t of heard about it. My senior year in English they made us read *Reviving Ophelia* that talks about like girls with problems, and I was like, “I’m a girl with problems,” and it was like here is what people do when they have problems.

Claire identified with this book and believed that in many ways cutting validated her feelings. She also believed that she started cutting because she wanted to do something

that communicated, “I really am depressed,” and for Claire, cutting was the vehicle to communicate these feelings.

To Claire, her self-injury was not the main issue. In fact, she felt that it “was a symptom, and it wasn’t really endangering my life by self-injuring.” In spite of this, the topic of self-injury would often become the focus of her counseling sessions. Consequently, Claire found ways of taking the focus off of her and the self-injury. “Once I told them I was stopping, they were like, the symptom is gone so the problem must be gone, too.” She continued on, stating, “I kind of figured out that when I told them (the counselors) that I mostly stopped, I didn’t have to go as often.” Claire admitted that she was not completely upfront or honest about the status of her self-injury. Although she didn’t outright “lie,” she revealed, “I usually didn’t say I wasn’t doing it. I would just say it was a while ago.”

Counselor.

During the second interview, I asked Claire if she felt that her counselors understood her. She replied, “I don’t know if they understood me as a person, but I think they had some sort of understanding of what was going on, like the theoretical, the broader issues.” She also made the point that she never worked with either of her counselors “long enough” for them to truly understand her. Although she would have liked for her counselors to demonstrate a genuine understanding, she never witnessed this behavior in counseling. As a result, her advice to counselors working with college-aged women who self-injure was the following: “You have to know the person you are working with. And like listen to them, rather than like applying what you think you know or what you are expecting from the person.” Also, when asked what she would tell college-aged women who were self-harming, she responded, “I would say to you know,

try counseling. But if it doesn't work for you, then like try something else or find a different counselor."

Counseling.

Claire's overall counseling experiences were defined as "frustrating." In general, she felt that her counselor at William and Mary was "missing the point." Although she was "open" during sessions, her counselor failed to "focus on the major issues," meaning the anxiety or depression. In retrospect, Claire wished that her counseling sessions had specifically focused more on her "social anxiety." In addition to "missing the point" altogether, Claire believed her counselors took extreme approaches and either "focused too much on it (the self-injury) or put it aside."

During the counseling process, Claire's counselors recommended medication. The theme of medication emerged during both interviews, each time illuminated in a negative manner. Claire took medicine to address the anxiety and depression for approximately one year. "I never really noticed a big difference either on or off of it, she shared." Claire felt that the medication was particularly harmful because she "didn't have any personal input" whether she wanted to take it or whether or not she needed a high dose. She expanded upon this concept stating, "A few times when I didn't want to take it anymore, but both my parents and the counselor were like, "You have to keep taking it, you have no choice." Claire also believed that the medication implied, "Something was wrong with my brain that I have to like fix." This left Claire feeling that she was never in control of the counseling process.

Claire realized counseling was "admitting that you have a problem, and I wasn't sure about that" at the time she received counseling services. For Claire, counseling is only helpful if "you actually want to change or get help." Claire saw the value in

acknowledging your problem in counseling “as something that is real to you and the people who care about you and if you aren’t going to acknowledge it then it is even more difficult to deal with it.”

Ego Development Level

Claire scored at the E5 level, the Self-Aware Stage, on the SCT. An individual scoring at this level increasingly becomes aware that not everyone, including him/herself conforms to societal expectations. However, the Self-aware stage is essentially a version of Conformity, the E4 stage. (Hy and Loevinger, 1996). An individual at this level has increased self-awareness, an ability to appreciate multiple perspectives, and an increased ability to conceptualize inner life experiences (Loevinger, 1976).

The ogive rule (see table 4.1) allows for some scores to be below and above the level ultimately assigned. Thus, not all of Claire’s scores were scored at E5. Claire’s item sum was 81, which met the item sum criteria for E4. However, she met the automatic ogive criterion for E5; she attained no more than 9 ratings at E4 or lower; she had eight ratings at E4 or lower. She also satisfied the explanation of ogive criterion which requires that she attain 9 or more ratings at E5 or higher; she had 10 ratings at E5. The following sentence stems and her responses reveal the E5 level:

A man’s job: “should be what he makes of it.”

What gets me into trouble: “is not speaking up.”

When they talked about sex: “I wasn’t interested.”

I feel sorry: “for people who feel alone.”

Summary

Claire’s initial experience in counseling was precipitated by a friend’s phone call to her parents and the counseling center. Although her parents were aware of her self-

injury, she never talked with her parents about it directly. During the interview, Claire talked about the school's policy, which required her to attend counseling sessions; refusal to do so would result in her being forced to move off campus. In addition to the counseling services she received at the College Counseling Center, Claire also met with a counselor "at home" during Christmas Break. She completed counseling during the end of her freshman year in college. As a freshman, she struggled to "fit in" but now feels that she has "a better perspective," and she now does "what makes me happy," and she has learned "where to find people who are interested in the same things."

The theme "online" emerged strongly in both interviews with Claire. She revealed that by reading the web-boards, "you can figure out what to tell them or what not to tell" your counselors and to control the direction" that counseling takes. The online boards also allow many clients to be "a step ahead of their counselors," and Claire believes that it would be "helpful for them [counselors] and the people they work with" if they spend time navigating these sites.

Claire's initial experience with cutting was in high school. She heard about it in English class after reading a book entitled, *Reviving Ophelia*. After reading it, Claire remembers thinking, "I'm a girl with problems," and the book highlights "what people do when they have problems. Claire always viewed her self-injury as a "symptom" that "wasn't really endangering my life." In spite of this, self-injury would often become the focus of her counseling sessions. However, she quickly learned, "Once I told them I was stopping they were like, the symptom is gone so the problem must be gone too."

Claire saw two different counselors over the course of one semester. In general, she never really felt that her counselors "understood" her, although she did feel like they understood the "theoretical and broader issues." Claire's overall counseling experiences

were defined as “frustrating.” In general, she felt that her counselor at William and Mary was “missing the point” and failed to address what she saw as the main issue, her “social anxiety.” Claire also argued that the medications she took “weren’t really working” and only communicated to her that something was “wrong with my brain.” Upon reflection of her overall experiences in counseling, Claire realized that counseling was “admitting that you have a problem and at the time, I wasn’t sure about that.”

Interpretation

Claire was forced into counseling as a result of a school policy, which mandated she meet with a therapist. As a result, Claire was not personally invested in the counseling process. She also felt like she had no input in her sessions, and her counselors never really understood who she was as a person. Specifically, her counselors failed to address her social anxiety, which Claire viewed as the central issue in her life.

Claire scored at the lower end of the Self-Aware Stage (E5) on the SCT. As indicative of the E5 level, the individual sometimes experiences discomfort in social situations (Hy & Loevinger, 1996). This was certainly the case for Claire. She talked frequently about her issues related to social anxiety. At this stage, the individual also begins to think about appropriateness, what is right for the time, place, and situation (Hy & Loevinger). Although Claire understood the school’s policy on harm to self, and saw its utility in some cases, she believed that the school’s approach to her cutting episode was inappropriate for her particular case.

At times, Claire described her relationship with her counselor in simple terms. This is more indicative of the E4, Conformist Stage, rather than the E5 stage (Hy & Loevinger, 1996). However, since she scored at the lower end of the E5 stage, it is likely that aspects of the former stage emerged. In a short time, Claire learned that if she told

the counselor she had stopped cutting, she no longer had to attend sessions or meet with her counselor. Thus, Claire learned to alter her behaviors so she could get what she ultimately wanted: to be in counseling no longer.

At the E5 level, individuals demonstrate an desire for independence (Hy & Loevinger, 1996). For Claire, she wanted to be an active player in her own counseling and wanted to rely less on her counselor. When she was not able to give her own personal input, she became frustrated with the situation. Claire's description of her relationship with her counselor, in terms of feelings and actions, was clearly indicative of the E5 level (Hy & Loevinger). She defined her experience with her counselor as "frustrating" because of some of counselors, particular actions or lack of actions. For example, she wished that one of her counselors focused more on her social anxiety.

Analysis of Participant #3: "Sam"

Table 4.5

List Of Themes

THEME	SUB-THEME
MY LIFE	Columbia, Pressures, Friends
MY PROBLEMS	Stress, Pain, Suicide, Eating Issues
COVER IT	Shirt, Know
COUNSELOR	Understood, Sense of Humor, Stare, Friends, Partnership, Questions, Only One
COUNSELOR	Different Counselor, Understood, Listen
IN COUNSELING	Alone, Alternative, Talk

Introduction

Sam was a 20 year-old junior at a small southeastern public university at the time of the interview. A Latina, she was born and raised in Columbia and first entered counseling at the age of 15 for “confidence related issues.” Her mother, a psychologist in Columbia, suggested counseling and referred her to a counselor, with whom she worked for a few months. She later saw two additional counselors in Columbia for brief amounts of time. Sam then moved to the United States to attend a boarding school for the latter two years of high school; her parents followed shortly afterwards.

Sam’s first experience with self-injury was in college. She reported scratching herself repeatedly and progressed to cutting herself while feeling stressed in the library at school. In addition to cutting herself, Sam would also hit or bang her arms against inanimate objects, like poles or doors, often leaving bruises. Sam addressed her issues of self-injury in college. At the College Counseling Center she worked with a female counselor, also Columbian, for approximately one year. This marked her last experience in counseling.

The following themes (with related sub-themes) emerged from the interviews (see table 4.5): My Life (Columbia, pressures, friends); My Problems (stress, pain, suicide, eating issues); Cover It (shirt, know); Counselor (understood, sense of humor, stare, friends, partnership, questions, only one); and In Counseling (alone, alternative, talk).

Themes

My Life.

Sam was born in Columbia, and she spoke openly about the influence of her culture during both interviews. She stated, “I am really proud of it [my culture] and Columbia has given me so much and it made me what I am today.” Sam experienced

counseling both in Columbia and in the United States, and she noted the differences between the two. In Columbia, Sam remarked, “Most of them [the counselors] knew my family and where I had come from.” For this reason, Sam preferred counseling in the states because “no one knows anything” about her family. On the other hand, Sam made the point that counselors “need to know something about your background and where you have come from and how you have turned up like this. So, it is kind of like a balance thing.” Sam appeared to have discovered this balance with her most recent counselor, who is Columbian. She appreciated the fact that her counselor “knew more about the Columbian Culture” and was aware of the culture-specific “pressures that you have.”

Sam lived in the United States two years as a boarding school student, before attending counseling. When asked about what it is like to be a college student today, she stated that it was “excruciating,” and there were many “pressures” and “financial worries” that students encounter in college. She elaborated on these feelings and stated the following:

You have the big scheme of things, like, “How are you going to get that job?”

And then it comes down to, “How are you going to get through the month?” And the exams and midterms and everything piling up.

For Sam, Sam “social pressures” and the “social scene” were some of the “hardest things” for her to negotiate. She realized that “not a lot of people see it that way. Many people are like, “this is the best four years of my life.” I am like, “No, they are not.” You are in limbo a lot of times” as a college student.

The discovery of Sam’s self-injury by her college friends “helped” her tremendously. She shared that her friends made statements like, “You don’t need this. You have us to talk about shit like that.” For Sam, talking about her problems with

others was a novel approach. She candidly revealed, "I am not one to go up and talk to someone and say, look I am having this problem. Instead, I just bottle it up." During the time of the interview with Sam, she shared that she continued to talk to her friends about her problems, and they were very supportive of her.

My Problems.

For Sam, self-injury was related to different influencing factors. During our first interview, she shared that "eating problems" contributed to her initial involvement in counseling. She also talked about the impact of stress in her life and how stress precipitated episodes of cutting. The first time Sam cut herself she was in the library feeling "stressed" and started "scratching" excessively and progressed to cutting herself. In time, things would "build up," and cutting would allow her to "release all that stress and all that you're feeling." When asked about her reasons for cutting, Sam remarked that when she was cutting, "I was just kinda getting all the pain out, kind of transferring the pain to something else, which was me." Clearly, Sam preferred "to not have the pain inside." For her, cutting was a way to "externalize it."

During her freshman year in college, Sam talked about an incident in which both her friends and her college counselor got involved with. According to Sam, she had "too much to drink" and told a friend "something about taking major action" on her life. Her friend responded by calling school officials, who then contacted both the police and her therapist at the College Counseling Center. According to Sam, she and her college counselor then had a phone conversation where Sam had to convince the counselor that she "wasn't going to do anything" to seriously harm herself. Although there were no repercussions for Sam at school, she viewed this situation as a "turning point" in her life.

Throughout the interview, Sam argued that in spite of her pain and the problems

she was experiencing, “the cutting was never suicidal intention. It was just stress and pain relief.” For her, she never “thought about it [suicide]” and cutting “never went there.” She supported this statement, stating, if one wanted to, “you can easily [kill yourself] when you have a knife, like go straight for the wrists. However, for her she “never did it in a way that was going to end” her life.

Cover It.

Sam revealed her self-injury to very few people, especially when she first starting cutting. However, she learned that “people started to figure things out” and would ask her about the bloodstains on her t-shirts. Looking back, Sam believed that these encounters with others actually helped her, because she couldn’t “think of a story to tell to cover it,” and she would come up with “something that was completely dumb.”

Sam shared that she also kept her self-injury from her parents, although she thought that they knew or eventually “figured it out.” According to Sam, her parents “were perplexed about the whole thing,” they “didn’t know what to do” and they “worried a lot.”

Sam also avoided the topic of self-injury with her college counselor. “She saw what I was doing, but I never told her, and she tried to ask me questions about why I did it and how it made me feel to try to figure out why.” Sam was not comfortable with this approach. As she simply stated, “I didn’t want to talk about it. I was just my thing. It’s not something you want to talk about with other people.” On the other hand, Sam also made the following point:

Maybe on some subconscious level cutting is kind of saying out loud what you’re not saying in words. Since people are obviously going to see it, I guess deep down I wanted people to know in order for them to help you.

For Sam, she realized she and many others may “not really know how to ask for that help.”

Counselor.

Of the four counselors with whom Sam worked, she talked most positively about her most recent counselor, the counselor with whom she worked at the College Counseling Center. With this counselor, who had a great sense of humor, she formed “a partnership.” In Sam’s eyes, “It was like a partnership of the two of us against the cutting.” This relationship “was a mixture of a little friends but not friends. I can talk to her in any tone. I don’t have to be very formal.”

Sam shared how her counselors demonstrated, or failed to demonstrate an understanding to her:

I think that most of it was not something they did but how they reacted. I mean, you can tell a lot by someone’s eyes. You know when you just talk to someone and you look her in the eye, and you know whether they understand what you are talking about.

Although Sam recognized that some of her counselors understood her, she believed that many counselors understood her “situation” but not her, as an individual. In her experience, her counselors sometimes approached her with the attitude, “I have seen this a hundred times.”

Sam admitted that she made a “connection with very few of her counselors.” To her, making a connection is “the hardest part” of the counseling process. Additionally, Sam shared that she was often at a loss for words with her counselors. Sometimes, “I just don’t have anything. So, I just stare at the therapist, and I know she expects me to do something or say something.” But for Sam, who “is not talkative at all,” she relied on the

counselors to ask her questions, in order to “take the focus off” herself. For example, she shared one experience with her counselor at the College Counseling Center. According to Sam, she “knew” she was cutting; however, she “waited a long time to ask” her about it. Sam admitted, “Maybe I wanted her to ask me earlier or question me about the band-aids I wore.” Upon reflection, Sam realized:

She may have wanted me to take the first step to talk about it. But people who go to counseling don’t usually take the first steps to talk. They need someone to push them, and that was one of the problems with this particular counselor.

Sam wished that her college counselor asked her more questions. For example, she wished that the counselor had asked her to “talk about the people around her” or had asked her, “Why are you doing this?” Instead, she asked “a lot about right before” she cut, but Sam found this unhelpful because, in her eyes, this feeling “just goes, it doesn’t change before you cut or two minutes or an hour before.” Most of all, Sam expected her counselor to tell her that she was not the only one struggling with self-injury. She stated:

I think that is the best thing that counselors can say, because I never heard that. And, I was, you know, embarrassed. But, I never heard it from her. She never said, “these things happen, and you don’t have to be embarrassed about them. And, you are not the only one. Yes, I mean I know that I am not the only one, but she never said that.

In Counseling.

Reflecting upon her overall experiences in counseling, Sam commented on the “awkward silences” that occurred between her and her counselors. She remembered feeling “vulnerable a little too much” although she realized that the purpose of counseling

was to “say things I have never talked about.” To her, talking about these things this was “a little scary.”

Although soft spoken, Sam shared recommendations for counselors working with women who self-injure and for women living with self-injury. When asked what she would say to women living with self-injury, she stated:

Throw everything away, like scissors and stuff, and try not to be alone and go out to the gym. You don’t necessarily have to tell people because that is awkward. But just try to take your mind off of things. Like, try to constantly be busy and just be around people.

During the interviews Sam commented on the concept of alternative behaviors. Although her college counselor did not explore this with her, she would have liked that and definitely saw the benefit in counselors helping their clients find alternatives:

Counselors should give clients activities they can do. Or, like stuff on campus, you can suggest and somehow make sure they will be there. Make there be free food or something. Something that insures the counselor that you won’t be alone because that is the biggest problem. When you are alone, you don’t care.

Ego Development Level

Sam scored at the E7, the Individualistic Stage, on the SCT. An individual scoring at this level is able to internalize rules and develop her own personal list of rules that fit her own needs and experiences (Hy & Loevinger, 1996). At this stage, one is able to recognize her own role and significance in making decisions. Morality comes from within, rather than from what the group decides. An individual functioning within this stage has an increasing ability to critically reflect, to consider alternative perspectives, and to live up to personally established ideals (Loevinger, 1976).

The ogive rule (see table 4.1) allows for some scores to be below and above the level ultimately assigned. Thus, not all of Sam's scores were scored at E7. The automatic ogive criterion requires that she attain no more than 15 ratings at E6 or lower; she had 14 ratings at E6 or lower. The explanation of ogive criterion requires that she attain 3 or more ratings at E7 or higher; she had 4 ratings at E7 or higher. Sam's total item sum was 103. The following sentence stems and her responses reveal the E7 level:

A man's job: "doesn't necessarily have to be better than a woman's."

A woman should always: "be proud of who she is. She should always stick to what she believes in and never let others cajole her into doing things just because of the expectations of society."

Summary

Sam, a Latina Female, was born in Columbia and moved to the United States to attend boarding school for two years, prior to college. She worked with a total of three counselors in Columbia and one counselor in college; the college counselor was the only counselor with whom she addressed issues related to self-injury.

In college, Sam was aware of "the academic pressures" and high "expectations" placed upon her. She also struggled with the "social pressures" in college, where she struggled to "fit in." As a junior, Sam reportedly had close friends who were aware of her self-injury and were "supportive" of her.

For Sam, her self-injury was generally precipitated by "stress." The actual act of cutting allowed her to "get the pain out and externalized the pain to something else, which was me." Although there was an incident in college where Sam threatened suicide, the cutting to her "was never suicidal intention. It was just stress and pain relief."

Sam did not tell others about her self-injury, especially when she first started. However, people eventually “started to figure things out” after noticing the bruises or bloodstains on her t-shirts. In counseling, Sam felt uncomfortable talking about it with her counselor but also recognized that “maybe on some subconscious level,” she wanted people to know, although she didn’t know “how to ask for that help.”

Sam talked positively about her most recent counselor at the College Counseling Center. She appreciated her “sense of humor” and believed that they had developed “a partnership” against the cutting. Beyond this individual counselor, Sam talked about her counselors in general, and, at times, she questioned whether or not her counselor understood her. She relied on her counselors’ non-verbals. She stated, “You can tell a lot by someone’s eyes,” and “You know either they understand what you are talking about.” For Sam, “making a connection” with her counselor was the “hardest part” of the counseling process.

In general, Sam shared that she was often at a loss for words with her counselors. Sometimes, she “would just stare at the therapist,” knowing that she was expected “to do something or say something.” But, most of all, Sam expected her counselor to tell her that she was not the only one struggling with self-injury. Through her experiences, she “never heard that,” and looking back, wanted that from her counselor

Interpretation

Sam, a Latina woman from Columbia, first started cutting during her freshman year in college, in response to stress. In addition to cutting, Sam also banged her arms against poles and doors, which would leave bruises. Although she saw three counselors in Columbia, she talked almost exclusively about her counselor at the College Counseling Center. This counselor was the only counselor that worked with her self-injury, since it

emerged in college. Sam shared that her self-injury was an extremely private matter. However, on more than one occasion, Sam revealed that subconsciously she might have wanted others to know, in order to help her. For someone who is not particularly outspoken, this perspective is not surprising.

Sam scored at the E7, the individualistic Stage, on the SCT. She evidenced a strong sense of self and strived to achieve independence and a sense of individuality (Hy & Loevinger, 1996). At the E7 stage, individuals move from absolutism to relativism (Hy & Loevinger). This was certainly the case with Sam. Sam, who was born in Columbia, shared that she preferred seeing a counselor in the United States. For Sam, the counselors in the states didn't know much about her or her family. At the same time, Sam was also able to reflect upon the negative aspects of counseling in the United States, recognizing that counselors "need to know something about your background and where you have come from." These dichotomous statements clearly demonstrate a relative point of view.

As indicative of the E7 stage, interpersonal relationships are cherished and change over time (Hy & Loevinger, 1996). For Sam, her relationship with her counselor at the College Counseling Center developed over time. By the end of their journey together, she described their relationship as a "partnership." Sam was not a woman of many words; during both interviews, she did not talk in depth about her experiences with self-injury. Sam also shared that she did not talk openly about her self-injury with her counselor. However, during the interviews with Sam, I found her to be extremely thoughtful and introspective—two factors revealed at the E7 level (Hy & Loevinger).

Analysis of Participant #4: "Ann"

Table 4.6

List of Themes

THEME	SUB-THEME
FAMILY AND FRIENDS	Dad, Mom, Family, Friends
CUTTING	Cry, Scars, Suicide, Stop
SCHOOL	College, High School
COUNSELOR	Push, Check, Like Friends, A mother, Confidentiality
COUNSELOR	Different Counselor, Understood, Listen
COUNSELING	Here, Promise Weeks, Broke, Trust, Kid

Introduction

Ann, a 20-year old Caucasian female, was a senior in college during the time of the interview. She transferred to a small southeastern public university during her junior year after attending two years of a junior college. Ann first attended counseling at the age of 14, during her freshman year in high school, and her last counseling experience occurred during her junior year in college. During this six-year span, Ann attended counseling on a "sporadic basis" and worked with a total of six counselors.

According to Ann, her family owned a company which sold guns and knives, so knives for cutting were readily available to her. In addition to these knives, Ann also used box cutters and razors to cut herself. Ann's first encounter with self-injury occurred after her best friend was killed in a car accident. During the interviews with Ann, she also shared with me that she had two previous suicide attempts.

Ann had worked with a total of six counselors over the past five years. Dr. Callahan, her school counselor, was aware of her self-injury from its onset. This counselor played a significant role during Ann's high school years, working with her on a regular basis. Dr. Callahan contacted Ann's mother on a regular basis, informing her each time she discovered new cuts. Because Ann had a tumultuous relationship with her father, Ann asked Dr. Callahan to avoid calling her father, and she honored this request throughout their relationship. According to Ann, it was one of her high school teachers, who contacted her father, telling him about the scars she noted on Ann's arms. Her father then referred her to her first counselor, whom she saw for only three sessions.

After this counselor, Dr. Callahan referred Ann to an anger management group, run by two individuals, David and Joanna, from the county mental health services. David and Joanna came into the school twice a week to work with her group. In addition to this group, Ann also did volunteering in the community with Joanna and would see David for individual sessions at the clinic. At one point during high school, David and Joanna referred Ann to meet with another counselor, Karen. However, this relationship was short-lived, lasting for only one session. Finally, Ann met with a counselor in the College Counseling Center, during her junior year in college; she only met with this counselor for a few sessions.

The following themes (with related sub-themes) emerged from the interviews (see Table 4.6): Family and Friends (dad, mom, family, friends); Cutting (cry, scars, suicide, stop); School (college, high school); Counselor (push, check, like friends, a mother, confidentiality); and Counseling (here, promise weeks, broke, trust, kid).

*Themes**Family and Friends.*

During her freshman year in high school, after noticing scars on her arms, Ann's teacher called home and spoke with her father. In response, Ann's father made a referral to a counselor. Ann believed that her father was quick to get her help because, "he is really big on the image of the family, and having a daughter who cut herself was a bad image so he was trying to take care of that." After each session, her father picked her up and would ask her what she talked about in therapy. Ann stated, "I didn't want to talk about what I said in therapy so I would tell him that we went over Spanish." Her father was angered by this and decided after three sessions that he was no longer going to pay for her involvement in counseling. Therefore, her first experience with therapy was short lived.

Commenting upon her family's reactions to her self-injury, Ann shared, "My mom pretended that it didn't exist. My dad was very angry and tried to catch me in anything, not even in just hurting myself. He asked me, 'so are you going to cut yourself now?' He would make jokes out of it." In addition to her grandparents, Ann's grandmother and grandfather "pretended that it didn't happen."

Ann's first counselor attempted to get her family involved in her counseling. Her mother attended one session, and Ann described it as "awkward." According to Ann, "My mom was bound and determined that it was just a phase, and she was expecting like a two-week phase, not years." Additionally, her mother, in session, "always had really good excuses for why I cut, and she didn't really understand the concept so it just kind of hindered the process."

In addition to her family, Ann also talked about her friends, both from high school and college. In high school, Ann told her close friend about her self-injury and soon afterwards, she discovered this friend started cutting. She shared, “It was one of the worst days of my life when I saw her wearing a flannel shirt. I just knew...I realized what she had done.” After her friend started cutting, Ann decided, “We couldn’t talk anymore because I blamed myself for her doing it because she had never been exposed to it, and then she blamed me for her doing it.” In time, Ann learned that it was “more of a burden than necessary” to confide in others, so she made the decision to “stop talking” to her friends about her self-injury. As a college student, Ann revealed that only her “very, very close friends here know. I don’t talk about it unless the topic comes up.”

Cutting.

At the time of the interview, three years had transpired since the last time Ann cut herself. In spite of this, her scars reminded her of her painful memories of the past. “I know that I didn’t think about that [the scars] while doing it...” “I never thought, I am not going to have scars.” However, today, she stated, “I wake up in morning and I start crying because I see my cuts. I still have that reaction to my scars.” She continued on and stated:

It is hard to explain to people because they don’t understand. They are like, ‘it was 5 years ago’...and, I am like, that was a big clump of my life, and now I wake up every morning and I still have scars.

At the time of the interview, Ann continued to wake up in the morning, not knowing how she would react:

I might see one of the first ones and not get so upset because it is fading, or I will see the one that I slipped too much and had to go to the hospital. Or, I will have a welt. I will see that, then that is going to be a bad day from then on.

In spite of the time that has progressed, Ann shared that she “can’t escape this” pattern because her scars will always be with her.

During the interviews Ann was quick to distinguish her suicide attempts from her acts of self-injury:

Those two things are separate for me. The cutting was more because I couldn’t cry because I wasn’t alone enough, and like my dad always used to get really mad if I would cry. So, I kind of reverted back to not having to cry so I would just cut myself.

On the other hand, “The suicide was just like I couldn’t handle it. There was just too much stuff going on.” The theme of crying was present throughout both interviews with Ann. She talked at length about the difficulty she had crying and how that influenced and often precipitated her acts of self-injury. In fact, her high school guidance counselor often asked her, “Did you cry today?” If Ann did not cry, there were times when her school counselor, Dr. Callahan, did not let her leave school until she cried. Ann expanded upon this and revealed,

I wasn’t allowed to leave her office because she knew if I at least cried a little bit then it wouldn’t be as bad later on. It didn’t turn out that way all the time, but that was her plan to deal with it.

When Ann attended college, she stopped cutting herself. Upon reflection, she stated, “I didn’t stop until I decided that I just couldn’t do it anymore. I had way too many close calls that weren’t meant to be attempts and it was too risky.” In her eyes, she

didn't think, "counseling can stop self-injury because you have to decide that on your own. But, I think counseling does help make you feel that you are not alone." But, for Ann, her counselors helped to push her to stop, which she felt helped her tremendously. In Ann's experience, she "was never asked to stop" or "never pressured into stopping." For Ann, this approach "was the only reason that I ultimately stopped because nobody tried to throw me out of it before I thought I was ready."

School.

During my interviews with Ann, she talked about what it was like when students in her high school learned about her self-injury. She revealed, "It got around really fast and like telling my friends I thought it was really private, but it wasn't, and it spread around. It was bad. It didn't really help the situation." This situation colored her overall experiences in high school. She shared, "I hated high school and I hate the people here [in college] from my high school."

Ann carried her negative perceptions of school carried with her to college. When asked what it is like to be a college student today:

It sucks. It is a lot of pressure and not just from family and friends and all that. It is like you have to do well. You're paying to do well and then, despite what people think, there are cliques, still in college. So, it is like, great, back in high school but on a bigger level.

Ann also stated, "there is a lot more pressure than people think, especially here. So, it is crazy here."

Counselor.

During both interviews with Ann, she talked fondly about three counselors she worked with in high school: David and Joanna from the community services board and

Mrs. Callahan, her high school guidance counselor. According to Ann, “David and Joanna were like my best friends.” She also revealed, “They were always there.” Additionally, “Dr. Callahan was kind of like a mother. It didn’t matter what it was, she would take care of me and make sure everything was ok.”

Ann appreciated the fact that none of her counselors pushed her to talk about things she wasn’t ready to address. During the first interview, she talked about an encounter she had with Joanna after one of her suicide attempts in high school. She explained that Joanna noticed a bandage on her arm and asked her what happened. Ann lied to her, telling her that she got hurt at work. According to Ann, “Joanna dropped it. She knew I was lying.” Eventually, they picked up the conversation at a later time, when Ann admitted that she was lying. As Ann stated, “Joanna knew what had happened but she let it go until I was ready to talk about it. I really liked that.” On the other hand, the first counselor that Ann saw for only three sessions was “really pushy.” In sessions, Ann “would get really upset,” and the counselor “would just keep going.” For Ann, she “couldn’t really handle that [approach] too much.”

Ann also appreciated the way that David would check her arms often, looking for new cuts. On a regular occasion, Ann stated, David “grabbed my arm and checked them, just out of instinct.” For Ann, she appreciated this approach. She stated, “The way he went about it wasn’t like, “Let me see what you did.” It was like, “Come here, let me see something.” According to Ann, this method was completely “unobtrusive” and playful,” and she “didn’t mind it at all.”

The issue of confidentiality emerged as a prominent theme in both interviews with Ann. During her experiences with her counselors, she had both positive and negative incidences related to how her counselor upheld their confidentiality agreement. Ann had

only one session with a woman named, Alyssa. In spite of this short-lived relationship, Ann expressed very strong emotions about this counselor. She stated, “she sucked. She broke the confidentiality agreement.” According to Ann, Joanna made a referral for her to work with Alyssa. (Although she didn’t know at the time, Joanna was leaving the community services board and wanted to set up something for Ann before she left). During their first and only session, Ann remembered Alyssa asking, “How do you feel right now?” According to Ann, she shared with Alyssa that she felt depressed and towards the end of the session “she picked up the phone and called my mother without my permission.” Ann was extremely upset. She stated, “I didn’t say I was going to hurt myself. I didn’t say I was going to hurt anyone else. There was no reason for her to think I was.” In addition to contacting her mother, Alyssa also contacted Ann’s high school and informed them that she was “a severe risk.” Alyssa’s approach with Ann and her lack of confidentiality angered Ann, and she never returned to the counselor again.

Aside from Alyssa, her other counselors, David, Joanna, and Dr. Callahan also “broke the confidentiality agreement.” However, with these counselors, Ann understood why they had to notify her parents. When she was 17, Ann revealed that her counselor Joanna contacted CPS. In response to this situation, Ann stated the following: “I mean I understand why she did it. She had to. But it made me a little bit upset and everything.” Ann also talked about how Dr. Callahan contacted her mother because she was cutting. She shared, “I knew she had to call because of school, and I knew that I was forfeiting my right to confidentiality because I cut myself.” She noted the differences between this situation and the time that Alyssa broke their confidentiality agreement. She stated, “I hadn’t cut myself when I was with Alyssa. She had no reason to call home. I didn’t even have any new scars or anything. She had no reason to call the people that she did.”

Counseling.

Upon reflection, Ann benefited and enjoyed different aspects of the counseling process. For example, Ann and Joanna created something called “promise weeks:”

We would meet, and then we would set up a date the next week, and I would have to promise that I’d be ok until then. If I weren’t ok, then I would have to call her or write her an e-mail. And if it was at a point where I didn’t think I could stop myself, then I’d e-mail her and mark it urgent, and she would check it and call me and try to help me out or call me, or meet up with me or do something. So, it usually was a five-day span where I promised I would be ok where I wouldn’t do anything. But, if I hurt myself before then, I had to like clean her house, or she came up with some ridiculous thing that I never had to actually do.

In her eyes, the “promise weeks” really helped her to get through the weeks. At the same time, Ann also recognized, “ultimately it had to be my decision” to stop.

For Ann, counseling became a place where she could talk about things, based on her comfort level. With David, he allowed her to talk about things “at her pace.” As Ann revealed, “He would sit me down, and we would start talking about things” although she couldn’t “focus for that long” on a particular issue. For Ann, counseling with Dr. Callahan was a place where she could get to “get away from people.” With Dr. Callahan, she didn’t need to talk about serious things all the time; she could “sit there and talk about random things,” and Ann appreciated this approach. Although counseling became a venue for Ann to talk about a wide variety of things, there were still topics that she kept out of counseling. During my last interview with her, she stated, “I kept a lot of things out of counseling for fear of what would be said.” She elaborated upon this and shared, “I don’t want to talk about that. But, because I knew that I didn’t want to talk about it, I

also knew that it was a cause.” During the interview, Ann never clarified specifically what it was that she didn’t want to talk about in therapy.

Upon reflection of her overall counseling experiences, Ann stated that it was a time where she was “learning to trust somebody again.” Looking back, she felt that counseling helped her to “trust a little bit more, which was my main problem.” Ann was a bit surprised by this shift in how she viewed people:

With David, Joanna, and Dr. Callahan, it kind of blew me out of the water. I didn’t expect to not be put down by them. I didn’t expect to hear that it is ok, what I am doing. That despite what everyone is saying, and asking me to stop, like it is ok. They were not what I expected.

Ann’s experience was not quite as positive at the College Counseling Center. Although she only attended sessions at the College briefly, she talked in length about how these counseling services failed to meet her needs. She stated, “I don’t think it offers enough. Here, you are given one appointment every two weeks...” Although she recognized that they had a crisis line or nurse on call, Ann didn’t think that was “enough. I know that I wouldn’t call.”

For Ann, she felt like her counseling experiences at the College Counseling Center were ill focused. She revealed, “I didn’t go there for counseling and my self-injury, but they focused on it. I was like, I don’t want to focus on it.” For this reason, Ann gave the following advice to counselors working with individuals who self-injure. She shared, “You need to deal with everything to fix the one problem, and I don’t think that you can just focus on the cutting and think that it is going to be better.”

Ego Developmental Level

Ann scored at the E7, the Individualistic Stage, on the SCT. An individual scoring at this level is able to internalize rules and develop her own personal list of rules that fit her own needs and experiences. An individual at this stage is able to recognize her own role and significance in making decisions. Morality comes from within, rather than from what the group decides. An individual functioning within this stage has an increasing ability to critically reflect, to consider alternative perspectives, and to live up to personally established ideals (Loevinger, 1976).

The ogive rule (see table 4.1) allows for some scores to be below and above the level ultimately assigned. Thus, not all of Ann's scores were scored at E7. The automatic ogive criterion requires that she attain no more than 15 ratings at E6 or lower; she had exactly 15 ratings at E6 or lower. The explanation of the ogive criterion requires that she attain 3 or more ratings at E7 or higher; she had exactly 3 ratings at E7 or higher. Ann's total item sum was 104. The following sentence stems and her responses reveal the E7 level:

A man's job: "can be a woman's job too, if given a fair shot at it and with the same training."

The thing I like about myself is: "that I know how to hide my emotions enough to make people feel that I am secure and ok."

A husband has a right: "to his own life, but within that life he should include his family."

Summary

Ann was a senior, transfer student at a small southeastern public university during the time of the interview. Ann first engaged in self-injury when she was 14, a freshman

in high school. At the time of the interview she was 20 years old and had not harmed herself in more than three years. In her past, she worked with a total of 6 counselors, all of which in length of time and her satisfaction with therapy.

Ann reported a tumultuous relationship with her father. According to her, he was “very angry” when he learned about her self-injury and would make “jokes” about her cutting. Additionally, Ann’s mother and grandparents pretended that it “didn’t exist” and “it didn’t happen.” In addition to her family, Ann also talked about her friends. During the interview, she shared that one of her close friends started cutting after she confided in her about her own behavior. Ann expressed her feelings of guilt when she discovered her friend was now cutting. She also shared that her “very, very close friends in college” are aware of her past behavior. However, she made the point that she doesn’t bring it up, “unless the topic comes up.”

Although Ann had not harmed herself in over three years, her permanent scars constantly reminded her of her painful past. In her past, Ann had two suicide attempts. During the interview she stated that self-injury and her suicide attempts “were separate” for her. For her, she cut herself because she “couldn’t cry,” and her suicide attempts were because she “couldn’t handle it anymore.” By her senior year in high school, she finally stopped cutting. She stated, “I had way too many close calls that weren’t meant to be attempts, and it was too risky.”

In high school, Ann’s self-injurious behavior “got around really fast” with her classmates. As a result, she shared, “I hated high school, and I hate the people here from my high school.” Ann’s negative perceptions of school carried with her to college. When asked what it is like to be a college student today, she shared, “It sucks.” She

commented that there is “a lot of pressure.” “more than people think.” In her eyes, it was like “high school but on a bigger level.”

During both interviews with Ann, she shared her positive experiences with three counselors she worked with in high school: David and Joanna from the community services board and Mrs. Callahan, her high school guidance counselor. According to her, they “blew her away” with their approach; she never felt as though she was doing something wrong or that there was something wrong with her. On the other hand, she also shared her negative experiences in counseling. For example, she felt as though her first counselor, with whom she worked with for three sessions, was too “pushy.” Also, she talked in length about one counselor who “broke the confidentiality agreement.” According to her, Alyssa “went way too far,” and, as a result, she never returned to her.

Upon reflection, Ann both enjoyed and disliked different aspects of the counseling process. She appreciated the “promise weeks” that Joanna and her utilized in sessions and she enjoyed talking about “random things” with Dr. Callahan. Ann also talked about her negative experiences she encountered at the College Counseling Center. Attending only a few sessions, she shared, “I don’t think it offers enough; here, you are given one appointment every two weeks.”

Interpretation

Through both interviews, Ann’s discussion about her counseling experiences appeared to be different from a traditional counseling experience. (She worked with David and Joanna outside of the anger management group. With Joanna, she volunteered, and with David she met with, for individual sessions, either calling or stopping by to talk. At the times of the interviews, Ann was continuing to call him or drop by the clinic). In my view, these relationships can be viewed more of a mentoring

relationship and less of a counseling relationship. In spite of this, Ann referred to Joanna and David as her counselors.

The impact and influence of the family became evident right away from Ann. Because she did not have a positive or close relationship with her family, she became even more attached to her counselors. In fact, she shared that her guidance counselor, Dr. Callahan, was more of a “mother figure” than a counselor.

The theme of confidentiality emerged strongly throughout both interviews with Ann. She developed a strong relationship over time with the counselors and, she appeared to understand when they “broke the confidentiality agreement.” However, Ann appeared infuriated when Alyssa, with whom she met for only one session, contacted her parents. Clearly, each of Ann’s counselors interpreted confidentiality differently. These diverse experiences demonstrate that the rules of confidentiality for self-injury are not clear-cut and can be defined differently by many counselors.

Ann scored at the E7, Individualistic Stage, on the SCT. As evidenced at this level, she demonstrated a strong sense of individuality and personality (Hy & Loevinger, 1996). Although her language and tangential comments were often self-deprecating and critical, these statements did not prevent her from achieving or forming relationships with others.

As indicative of the E7 level, Ann’s interpersonal relationships were cherished (Hy & Loevinger, 1996). Her relationships with her friends were extremely important to her, and her friends served as an effective social support for her. Beyond her friends, Ann had extremely close relationships with three of her counselors in high school-- David, Joanna, and Dr. Callahan. For Ann, she thought of David and Joanna as “friends” and still occasionally updated David about her progress in school. Ann’s close

connection with these three counselors served as a vehicle for change. Although she credited herself for her own recovery, she also recognized the impact that these counselors have had and continue to have on her life.

Analysis of Participant #5: "Juliana"

Table 4.7

List of Themes

THEME	SUB-THEME
MY LIFE	Family, Parents, Friend, Graduate School
TREATMENT	Inpatient, College Counseling Center, Group, Eating Disorder, Medication
A GOOD COUNSELOR	Experience, Supportive, Cost
COUNSELING	Coping, Failed, Language, Category, Trick, Alternative, Manipulate, Cognitive Therapy
SOCIETY	Women, Gender, Pressure

Introduction

Juliana was a 22-year old Caucasian woman. At the time of time of the interview she was in the first year of graduate school at a small southeastern public university. She was involved in counseling, on and off, for a total of 8 to 9 years. At 12-years old Juliana was in treatment for anorexia and bulimia, within an inpatient setting. At this time, she observed other women engaging in self-injury and began harming herself at the age of 12. According to Juliana, cutting was a "learned behavior." Initially she scratched herself using her nails. She then progressed to cutting herself using scissors.

In addition to inpatient treatment, Juliana saw a series of psychologists, psychiatrists, and counselors. Although most of her experiences were in individual

counseling, she also was involved with group counseling and family counseling.

Juliana's last counseling experience was during her undergraduate years, at her College Counseling Center.

The following themes (with related sub-themes) emerged from the interviews (see table 4.7): My Life (family, parents, friend, graduate school); Treatment (inpatient, College Counseling Center, group, eating disorder, medication); A Good Counselor (experience, supportive, cost); Counseling (coping, failed, language, category, trick, alternative, manipulate, cognitive therapy); and Society (women, gender, pressure).

Themes

My Life.

Juliana talked about both her friends and family during both interviews. During the first interview, she talked about her mothers' reaction to her first encounter with self-injury:

I had a spider main band-aid on my forehead and my mom was like, "What the hell happened to you?" And, I told her, which was stupid. I learned to never tell her what actually happened. And, she got very angry. She did not handle it very well.

She continued on and stated,

That was sort of the family response. It was like the eating disorder. "Why do you lack the self-control and not be able to behave in like a normal sort of normal pattern?" So, they were angry and more confused.

When asked about their role in her treatment, she answered,

They just had no interest in participating in counseling because they didn't think that that was the issue. Their attitude was I had a problem because I lacked self-

control. And both of my parents have a whole bunch of theories as to why I lacked that self-control. Their attitude was, she is being poorly behaved and she is lacking will power. It was sort of a blame-centered system.

Juliana also talked about how her parents viewed her treatment and the expenses involved with therapy:

My parents used to tell me and complain about how much it cost. And the problem was when I was with someone good, it was always more expensive because they were good. And, I was always being reminded of how expensive they were. And, at one point I ended up going to a state school. I am from New Jersey...I went to Rutgers. And, so I went to a state school. I will never forget my mother saying, "We wasted all of that money for you to get better, for you to go to a state school."

In addition to her family, Juliana talked about the role of her friends. In college, Juliana shared that a select number of friends in college were aware of her-self injury due to "practical reasons." Juliana didn't have a car in college so her friend would drive her to the drug store to get rubbing alcohol and gauze. She shared, "I would call her and say, look the blood is dripping down my leg and I don't have a way of cleaning it up, and she'd be like "ok, we'll go now."

At the time of the interview, Juliana had only been in graduate school for a few weeks. When asked what it was like to be a graduate school student, she stated, "My responses would be the same thing that a freshman in college might say... It is isolating, it is difficult, it is confusing." Juliana also commented, "It is more competitive than I would imagine an average graduate school experience was going to be. It is

overwhelming because the workload is significantly different from an undergraduate workload.”

Treatment.

Juliana’s first counseling experience was in an inpatient treatment setting for anorexia and bulimia. At 12 years old, she was in treatment with women significantly older than she. After approximately eight weeks, she was moved to an outpatient program for “fear that being around seasoned anorexics would only cause her harm.” Released from the inpatient setting, she entered an outpatient-counseling program for a brief period of time. This marked the beginning of her treatment, which lasted for approximately eight to nine years.

During her inpatient treatment, Juliana participated in group counseling. Upon reflection, she learned about self-injury from watching a woman in her group session who would scratch her hands and pick her cuticles. According to Juliana, “I essentially picked up [this behavior] from watching her.” She continued on and stated, “The first time I ever engaged in self-injury as cutting was when I actually scratched my forehead during, I think it was a group therapy session.”

As Juliana was in treatment, both inpatient and outpatient, she observed that she would “switch coping behaviors.” For example, when her cutting stopped, she started smoking more. She shared,

As a person going through treatment, what was most common was that people who as they were “cured” of the eating disorder picked up some other comparable problem. Either they became a drug addict or they became a cutter or they became, or developed some other coping mechanism, essentially. So, as I quote “recovered” from the eating disorder, the cutting got worse.

According to Juliana, her counselors brought this to her attention and told her, “This is not the way to live because there will always be something else.”

After she was released from inpatient treatment, Juliana was first treated with medication, which she took for several years. Juliana felt that her medication was continually “mismanaged.” She stated, “They treated me with Buspar for anxiety which is ridiculous because nobody prescribes Buspar anymore.” She also stated, “They put me on the weirdest things. They like kept me on Prozac for like 6 years.” As a result, Juliana managed her own medication, at times. She admitted, “I never was actually given a prescription for Zanax but I would take other people’s Zanax. Not a lot...but I mean occasionally.” When asked if the Zanax helped, she revealed, it “helped with the cutting. Well, because it helps with everything. You don’t want to do anything. You know everything is fine [laugh]. It did work, temporarily.” In addition to taking Zanax, Juliana researched on the Internet and discovered that she was allergic to caffeine. She shared, “I am allergic not in the sense that I get sick but allergic in the sense that I have a severe psychological reaction.” She stated, “I have been caffeine free for like a year and a half and it has been significantly better.”

After several years of treatment through middle and high school, Juliana sought counseling in college, at her College Counseling Center. According to Juliana, she sought treatment at the College Counseling Center. She stated, “My parents didn’t want to really have to pay for it anymore. They wanted me to deal with it. So, it became easier to do it through the school and there were a variety of different people who were of minimal help.”

In Juliana’s mind, the counseling she received at the counseling center was not helpful:

It was mostly people taking notes and nodding their heads, because frankly they had so many people to deal with. The other thing was that they [the College Counseling Center] were so unwilling to treat me because I had such a long history of let's just say illness. It is very hard because of their limited resources. They do better with people who, you know, their grandmother just died, and they need like 6 weeks of therapy to talk about how much they miss their grandmother. You know, like that type of thing was really what they were geared toward or what they preferred.

For Juliana, the College Counseling Center was a place of “limited resources” and “limited space.”

A Good Counselor.

Throughout the interview, Juliana talked about the characteristics she preferred in her counselor:

Part of it for me, is that he be a man and that he be older, that he have a lot of experience with patients comparable to myself, that he has a fair amount of respect for his patients as individuals, that he is willing to work on both sort of behavioral aspect as well as sort of the talk therapy side.

She added that she would have liked to work with a counselor, who didn't have “too big of a caseload” and someone who was willing “to learn enough about the patient and “to be very frank about things.”

Upon reflection, Juliana talked about the positive aspects of her past counseling experiences:

The most helpful counselors weren't overly flowery and supportive...I think the best one I had was the one who was both my psychiatrist and my counselor

because he was actually....and it was interesting that he was a man, I thought. But, he was both supportive but not overly supportive. He wasn't like, 'let's talk about your feelings.' It was encouraging to me because it was engaging on an intellectual level while it was dealing with an emotional problem. So, I thought that was very beneficial for me in particular.

She continued to talk about this counselor and shared, "It was supportive. I felt like he understood me better, and he made an effort to understand me while the other ones were like, well, according to you know, the DSM, you are this, this and this." In her mind, she shared, "You could almost say that it was almost, parental. And so, very supportive but parental in a situation...I guess it was more paternal than parental."

As Juliana talked about these positive aspects of a counselor, she shared that these counselors come at a price. She believed counselors needed the following three things:

One, a collection of personality traits to be a good counselor and two, the right kind of training and three, a certain amount of experience using the things that you have learned, and there is a lot of financial cost with that. They are very expensive because they are very good, and they can be. I mean it is like any profession, you get paid at a higher rate, and I think that what happens is that I didn't always have access to them. So, really that sounds terrible. And not to say that I needed a more expensive counselor, but I needed a good counselor who was likely to be more expensive.

Counseling.

Over the course of eight or nine years, Juliana worked with several different counselors and had many different counseling experiences, both positive and negative. However, when asked if counseling, overall, changed the way that she thinks about

herself, she stated, “it makes me think that I failed at counseling. I mean it doesn’t change the way that I think about myself. It makes me think of...it is on the laundry list of things that I didn’t do well.” She continued on and stated,

My attitude was this is another thing that I did that I frankly failed. If you can fail at building a relationship with someone that you are paying to have a relationship, then there is a problem. And my attitude toward counseling and how I think of myself as sort of a failed project.

Through her diverse experiences in counseling, Juliana felt that the majority of her counselors failed to understand her. In her eyes, she stated, “they sort of tried to put you in a group and then sort of treat you based on...they would categorize you and then try to treat you based on your category or your collection of categories.” She elaborated on this concept and revealed, “sometimes counselors will put words in your mouth so you sort of fit their category in a neater way, and a lot of times, if the patient is not as self-aware they will just sort of go along with it. Yeah, that sounds right. That sounds like me.”

In addition to talking about the role of her counselors through her counseling experiences, she also commented about her own role in the counseling process. Oftentimes, she commented that she would “trick” her counselors or “manipulate” her counselors during sessions:

I had one convinced that I was fine. Oh, yes and it was great, except for I was getting worse. But to me it showed that like counseling can only be of limited help, one, if you are not willing, obviously (and this is hindsight) and two, if you can easily trick a person. And having an eating disorder, you know what I mean.

You are talking about two terribly secretive manifestations of illness. It is going to be easy to trick people.

Manipulating the counseling sessions was also something Juliana found easy to do. She shared, "I would frankly fuck around because I knew I could. I would talk about all kinds of ridiculous things. That had nothing to do with me, even."

During her experiences in counseling, Juliana found that the exploration of alternative behaviors were only short term solutions:

There were periods where I managed to sort of, assuage the need to self-injure by picking up another healthy or acceptable behavior, at the urging of a counselor...if that makes sense. It didn't really last too long because they were terribly simplistic behaviors that were sort of short-term answers. And, as long as I made the commitment to the short-term answer, it worked.

Juliana gave examples of alternative behaviors she learned in counseling:

Some of them were stupid. Some of it was chewing gum, some of it was...I pick my cuticles...was actually rubbing my...do you know, well they make moisturizers for everything now and they make cuticle moisturizers and I would just sort of use that. But, it was a compulsive behavior, and I would compulsively chew gum and I would compulsively....it didn't really help to fix the problem but it would stop me from self-injuring.

In general, Juliana found that her counselor's specific approaches got in the way of her counseling experiences:

I felt a lot of times, counselors speak in this sort of very coded language, and that coded language makes it very difficult for individuals who are the kind of people who are not sort of buying into sort of counseling and therapy as a field, as a

profession. I feel like a lot of times, the language they use is a big barrier. It was sort of this very therapy speak. Like how does that make you feel? And “the problem that it was in-genuine. And that sort of in-genuine sound to it made everything else ring hollow because what they were saying was just so abstract and so empty...language became a means of asserting power.

During the interview, I asked Juliana, “What would you have wanted to address in counseling?” She responded in the following manner:

Part of it would be cognitive treatment. Part of it would be why I am like this? Because there is a series of factors that have to come together to make them anorexic, to make them a cutter. Do you know what I mean? What facets of my life added up in such a way that the answer to the equation was eating disorder and cutting? That type of thing. So, there is a whole series of things. Part of it would be cognitive and part of it would be sort of figuring out why.

Juliana had only brief experiences with cognitive therapy. She shared, “I had a limited amount of it, sort of the behavioral elements in sort of the factors that add up to create these types of situations. But, I didn’t really have enough cognitive therapy.”

Society.

During both interviews, Juliana talked extensively about society, specifically about the role of women, the pressures women face, and the role of gender in counseling. As she talked about the role of women, she stated,

There was this big article about how women from elite colleges are opting to stay home instead and how this is their new mission in life to become mommies...And because there is sort of this conservative backlash throughout the country, it has sort of permeated all levels of society. Women are thinking, “Ok, I can go

back to doing this and it is ok now.” I think that because of the self-injury and my sort of behavioral issues and problems, I actually decided recently that I never want to get married and I don’t want to have children. And I am sort of offended and disgusted that so many women want to stay home and be mommies.

Juliana also talked in length about the pressures that women face on this college campus and beyond:

I think that there is a high expectation for women particularly on this campus to be attractive, which includes being thin and fit at the same time. Whereas here everyone is very homogenous. So, I feel like there is a tremendous amount of pressure here to be the same, in terms of appearance. But, I think that, that is sort of true for women across the board. Wherever you are there is a norm that you are supposed to meet in terms of physical appearance in addition to social pressures regarding the way a woman looks.

Gender, as a theme in counseling, also emerged as a prominent topic for Juliana.

She shared,

I think that there is so much that is not explored. And, I think that gender is a dynamic that when you are in counseling, isn’t explored a lot. Or, at least it wasn’t in any of the counseling that I was in. I think that gender was limited to sexuality in a lot of treatment. And, not just for myself but for other people who I know have gone to therapy. You know, your role as a sexual being. It is relevant, but it is not necessarily central to a wide variety of issues that individuals may be having. It may be that you feel the way that you are partly because of socio-cultural constructions of what gender is, and I think that, that is probably

something that isn't explored to the extent that it should be. And could be very helpful to a lot of people.

Ego Developmental Level

Juliana scored at the E5, the Self-Aware Stage, on the SCT. An individual scoring at this level increasingly becomes aware that not everyone, including him/herself conforms to societal expectations. However, the Self-aware stage is essentially a version of Conformity, the E4 stage (Hy and Loevinger, 1996). An individual at this level has increased self-awareness, an ability to appreciate multiple perspectives, and an increased ability to conceptualize inner life experiences (Loevinger, 1976).

The ogive rule (see table 4.1) allows for some scores to be below and above the level ultimately assigned. Thus, not all of Juliana's scores were scored at E6. The automatic ogive criterion requires that she attain no more than 9 ratings at E4 or lower; she had 5 ratings at E4 or lower. The explanation of ogive criterion requires that she attain 9 or more ratings at E5 or higher; she had 13 ratings at E5 or higher. Juliana's total item sum was 87. The following sentence stems and her responses reveal the E5 level:

If I can't get what I want: "I don't deserve it."

When they talked about sex: "I sat quietly."

A good mother: "is nurturing."

Summary

Juliana spoke about both her friends and family during both interviews. As she talked about her parents, she stated, "They just had no interest in participating in counseling." According to Juliana, her parents believed that she "lacked self-control" she was "poorly behaved" and she lacked "will power." Her parents also complained about

the cost of treatment; in fact, her mother complained, “We wasted all of that money for you to get better, for you to go to a state school.”

As a first year graduate student, she found it difficult, isolating, confusing, and competitive. According to Juliana, her classmates now are not aware of her past experiences with self-injury. This was not the case in college; she talked in depth about the role her friends played while she was in college. During the interview, she talked about one friend whom she would call on a regular basis who would drive her to get rubbing alcohol and gauze to clean and care for her wounds when she cut herself.

Juliana received a wide variety of treatment. Initially, she was placed in an inpatient treatment facility for an eating disorder-anorexia and bulimia. During her time in this inpatient setting, she was involved in group counseling, where she first learned to cut, after observing the behavior of another, older group member. When Juliana was released from inpatient treatment, her psychiatrist prescribed Buspar, which she took for several years. Juliana disagreed with the specific type of medication she was given and believed that her medication, in general, was poorly managed. After her high school years, Juliana sought counseling at the College Counseling Center, which marked her last experience in counseling. According to her, she found the center to be of limited resources and of limited help.

In spite of the negative experiences she had in counseling, Juliana did encounter some counselors whom she liked and found to be helpful. In her mind, a good counselor is “supportive,” has a “lot of experience,” a “fair amount of respect for his patient,” “a small caseload,” “is willing to learn,” and “is supportive.” Juliana recognized that these counselors come at a price; good counselors cost a lot of money, and she didn’t always have access to them because of their high costs.

During both interviews with Juliana, she talked extensively about the role of women, the pressures women face, and the role of gender in counseling. She talked candidly about the pressures that women face, especially on this campus. She revealed that there is a pressure for women to be “attractive,” “fit” and “thin.” She also talked about the homogeneity of campus. Finally, Juliana talked in depth about gender. She shared, “I think that gender is a dynamic that when you are in counseling, isn’t explored a lot.” And, for Juliana, she believed that if gender was explored in counseling, “It could be very helpful to a lot of people.”

Interpretation

Of all the women I interviewed, Juliana had the longest history of self-injury, as well as the lengthiest experience in counseling. She was well spoken, thoughtful, and talked in depth about her experiences in counseling. I believe that this was partly due to her extensive experiences in counseling as well as her age. As a graduate student, she was the second oldest of the women I interviewed.

Juliana scored at the Self Aware Stage, on the SCT. In my viewpoint, Juliana appeared to exhibit behaviors consistent with clinical depression. During our first interview, she appeared talkative and elaborated upon responses. However, during our second interview, I noticed a marked difference in her presentation; she was more critical of herself and failed to elaborate upon many of her responses. At the conclusion of the second interview, I administered the SCT. Her responses on the SCT were self-deprecating and extremely critical of herself. The following responses demonstrated this attitude:

The things I like about myself: “are minimal.”

If I don’t get what I want: “I don’t deserve it.”

For a woman a career is: “4 escape from a meaningless life.”

Research suggests that internalizing problems, like depression, are more salient at the conformist or self-aware levels. If this is the case, then it is not surprising that Juliana scored at the E5 level (Krettenauer, et. al, 2003).

Some of her responses were indeed reflective of the E5 level. At the self-aware stage the ability to conceptualize inner life expands (Hy & Loewinger, 1996), which was certainly the case for Juliana. For example, she openly shared that cutting served as a coping behavior, and her behaviors often changed: “As I quote recovered from the eating disorder, the cutting got worse,” she stated. Juliana was also beginning to recognize the impact and influence that her parents’ attitudes and behaviors had upon her present situation. During her treatment, they made statements that she “lacked self control and will power” and they “wasted money on her.” These messages were likely internalized by Juliana over time and likely contributed to a negative view of herself.

Analysis of Participant #6: “Katie”

Table 4.8

List of Themes

THEME	SUB-THEME
MY LIFE	Family: Mom and Dad, Friends
COUNSELOR	Friend, Liked, Not A Good Fit, Understood, Suggestions, Safe
EXPERIENCES THAT I HAD	Direct, Billing, On My Own, Open
APPROACH	Diagnosis, Medication, Contract, Alternatives
THAT THERAPISTS AND FAMILIES REALIZE	Coping, Tell Someone

Introduction

Katie was a 23-year old female at the time of the interview. During the time of the interview, she was in her second year of her graduate program at a small southeastern public university. From a very early age, Katie picked at scabs, her lips and her fingers. And, as early as three or four, she remembered taking pins and sticking them through the tips of her fingers because she was fascinated with how her skin peeled. Growing up, she repeatedly had infections in her fingers, and her dad tried to solve her problem by making her sit with her hands in a cup of hot water and salt. According to Katie, this approach didn't work; at the age of five she developed a staph infection from picking her cuticles and not letting them heal. Katie's parents were aware of this behavior, but they "always thought that it was innocuous enough that they would overlook it."

During Katie's senior year of high school, at the age of 17, she started having problems with depression. Katie shared that she tried to tell her parents that she was unhappy, but they told her that it was "normal." At this time, she began scratching her arms, would "open cuts up," and experimented with cutting. Katie's math tutor eventually saw the wounds during a tutoring session and encouraged Katie to talk about her behavior. The two spoke for a lengthy amount of time, and by the end of the day, her tutor brought her to her home and supported her as she told her parents.

After this encounter, Katie's parents initiated a referral to a counselor and a psychiatrist with whom she worked for approximately one year. In addition to individual therapy, Katie also participated in family therapy. Then, in college, Katie attended counseling on a sporadic basis, at her school's counseling center. Finally, in graduate school, Katie sought counseling the second semester of her first year. According to

Katie, her last experience with self-injury was about one year ago, where she gave herself a third degree burn on her wrist.

The following themes (with related sub-themes) emerged from the interviews (see Table 4.8): My Life (family, mom and dad, friends); Counselor (friend, liked, not a good fit, understood, suggestions, safe); Experiences That I Had (direct, billing, on my own, open); Approach (diagnosis, medication, contract, alternatives); and That Therapists And Families Realize (coping, tell someone).

Themes

My Family.

Katie's parents were initially very supportive of her when they discovered she was harming herself. "They were horrified and devastated but were just you know, 'we love you, we are going to take care of you, we are going to solve this,'" she shared.

Unfortunately, this reaction was short lived:

That next morning my dad was furious with me, and he sat me down and said, 'how can you do this to us?' and he took it very hard because a lot of my problems were due to the fact that from probably the time I was 7 or 8 he was starting to go through a bout of depression, and he never got help for it, and so that affected my Mom and Dad's marriage, and there were lots of instances where I would be in trouble, and I wouldn't know why, and Dad would be screaming at me, and that sort of unpredictability was really stressful...

Katie's mom, rather than getting angry, was more upset:

She said for along time after she couldn't look at my baby pictures because she said, you know, here was this perfect child who was unblemished in some ways,

and she wasn't just talking physically but also emotionally and how painful it was to not blame herself or dad for that matter.

After her parents discovered she was harming herself, they immediately got help for her:

I was in such a state of crisis that mom and dad didn't have time to find someone that was good. They [my mom and dad] were so desperate to locate somebody, and they both are very private people, and so they couldn't turn to their friends to say we need help. So, it was mostly just looking in the phonebook to find somebody whose schedule worked with theirs and mine after school.

During her senior year in high school, Katie and her family attended counseling sessions. When asked if this was helpful, she stated the following:

Not really because at that point, I was still very angry at my mom and dad. What was brought out during my sessions was more bringing to the surface things that I had withheld. So, I guess in the long term it was helpful, but in the immediate I didn't like those sessions; I didn't want to talk to my mom and dad, and I didn't want to deal with those issues.

According to Katie, familial issues were often the central theme in counseling, not only in her family sessions, but also in her individual sessions. She revealed, "The main focus in my therapy was family and how I felt about what was going with my family." When asked if this was a helpful approach, she shared,

It was helpful in that I was able to start adjusting other parts of what was going on with myself and my mom and dad, but it never got down to why this was happened or what had happened that drove me to do something so drastic.

Aside from her family, Katie also talked briefly about the role of her friends during high school and college. Many of her classmates and friends were aware of her self-injury because it was so visible and had occurred over a significant period of time. She shared, "I mean everyone...I mean me coming to school with like a bloody lip was nothing new." As her self-injury progressed, her best friend noticed it and according to Katie, "she got very angry at me." For Katie, her self-injury was a relatively private matter. "It was never me really sitting down and telling them someone that I hurt myself because as soon as I started doing it within a week, or two weeks I was in counseling and I wasn't really talking to anybody about it."

Counselor.

Katie commented on both the positive and negative aspects of the counselor with whom she worked with. Katie liked both her family counselor and the counselor she saw briefly in graduate school, at the College of William and Mary. For Katie, these counselors offered suggestions and resembled more of a friend to her. Katie spoke openly about her family therapist in high school, Dr. Curley:

I really liked her. She was very down to earth, and she would argue with me. She challenged me, and she found those just fundamental inaccuracies in how I perceived things or me feeling sorry for myself. She would and it wasn't in a way that hurt. It was, "Listen, you need to stop doing this and this is why," and it was that good balance of me coming to those realizations on my own. She was just putting things into perspective where I was able to take that final leap and make that connection.

Katie also shared that she appreciated how this counselor worked with her family:

She interacted really well with my Mom and Dad. She was the first person that I had ever met that who, when my dad started talking over my Mom, she told him to stop. And, that, I mean, he just had this look on his face, like, “Oh my God, you’re right. I am interrupting, and I have been interrupting for the last 15 years of my marriage.” And that was neat.

For Katie, her relationship with Dr. Curley grew over time and she began to see this relationship as more like a “friend or aunt.”

Katie also talked about her most recent counselor, Tammi, with whom she met at the College Counseling Center:

I was definitely surprised at how much I liked Tammi. Because I thought it was going to be the same...feeling very stifled and just icky and confined. But, I felt like I was able to get a lot of work done with her. Because she was able to convey empathy...With Tammi, it was still very positive and warm and I felt very comfortable and safe.

For Katie, she felt the following about Dr. Curley and Tammi: they “made me safe, and I felt like they did listen, that I was being heard, and they generally wanted to help me.”

Katie also appreciated the fact that her counselors would make suggestions during her counseling sessions:

I liked it when they would suggest stuff. It always bothered me when they would sit there and listen and at some point, I really didn’t have any more to say and I saw them as helpers, and so, me talking, only helps so much. So, when they would offer suggestions, or “the next time this happens, why don’t you try X.” That gave me something concrete to work on.

In contrast to her positive comments about counselors, Katie also talked about some of the negative characteristics of her counselors. To start, Katie believed that most of her counselors didn't truly understand her. She revealed, "I feel like they tried to understand me in the past, but that I was mainly a name on their calendar twice a week." When asked how she demonstrated this lack of understanding, she shared:

Dr. Keough, one my therapists in high school, reminded me kind of the typical "quack" counselor that you see on sit-coms. She had the really frizzy hair and was just really strange to me. And, I don't know, she also had a very soothing voice. I do remember that, but, she was a little...I don't want to say phony, because that sounds like too strong a word. But, she didn't seem as genuine.

She also talked about how Dr. Keough was more present focused, an approach she found to be unhelpful:

It wasn't a good fit for me. I wanted to know what could I do to make things better and ok, this is what I am feeling, but I don't want to feel this anymore. So, what can I do to stop it!

Experiences That I Had.

During both interviews, Katie talked about both the negative and the positive experiences that she had in counseling; these experiences were related to billing practices, her feelings of being on her own, and the direction that was provided (or not provided) in treatment.

Katie talked at length about her experiences related to billing with her counselor in high school, Dr. Curley:

Dr. Curley never had a secretary who worked regularly with her so billing was always a little weird. And so, what ended up happening was that she was trying

to charge my parents for sessions that never occurred or sessions that I didn't attend; she would charge us anyway, which I mean that is normal practice, but she was never upfront about what her billing procedures were and so that soured the entire thing for me.

This experience impacted Katie's future experiences in counseling and when asked to reflect upon what she would do differently in counseling, she made a strong statement about her counselor's billing practices. She revealed, looking back, "I would have tried not to let that one bad experience with the billing turn me off from therapy for so long."

Upon reflection, Katie believed that her own personality influenced her experiences in counseling:

I am a very concrete kind of person so I think that is why the style of therapy, whatever it was, that I had in high school wasn't helping me because it wasn't very directive and at that point in my life, I needed direction. I needed someone to tell me, "these are the strategies that you can use to stop hurting yourself."

"This is what you can do to help yourself." And for some people, I am sure that that [talk therapy] works. But, for some reason, it doesn't for me.

With her counseling experiences lacking direction, Katie often felt alone during sessions. When asked to reflect upon her overall experiences in counseling. She stated, "I remembered going through the motion and feeling like I was pretty alone and having to do work on my own. The help that I was getting wasn't really what I needed." In her eyes, a lot of the issues and conclusion she came to she stated, "I think a lot of it, I found out on my own." Katie now realizes that she would involve herself more in sessions, being an active player in her recovery. She echoes this statement: "I would be just as

open and up front about how I was feeling and what I was doing, i.e., not hide the fact I had been cutting.”

Approach.

Katie talked about different approaches her counselors utilized or failed to utilize, during her experiences in therapy. These approaches included, providing diagnoses and medication, suggesting alternatives, and administering no-harm contracts.

According to Katie, her first psychiatrist diagnosed her with a number of different psychological disorders:

She diagnosed me with everything from six days to Sunday. This psychiatrist was fresh out of med school, and so that first session she was a little too happy with the DSM and immediately diagnosed Borderline.

She talked further about her approach. “It was like a *Choose Your Own Adventure* Book. And so one month it would be Borderline. Another month it would be bipolar, dysthymia, cyclothymia.”

Her psychiatrists were also responsible for managing her medication. At the time of the interview, she was taking medication, and had been since the age of 17. For Katie, her improvement over the past years was, “directly affected by changing medication or not taking them.” Katie also talked about how she learned to manage her medication on her own:

I got frustrated that I had to use my own judgment and read up on the drugs that are being recommended to me. Like, the one that she wanted me to take was Klonopin, which is an anti-seizure medication, has a history of having a fatal rash, and a lot of side effects that she didn’t tell me about.

Katie also talked about another approach her counselor utilized in counseling--the no harm contract. Although she never signed a contract, she talked in-depth about the implications of using no harm or no cutting contracts in counseling. She stated, "I think that a no-harm contract takes that away and it puts the position of power back to the therapist. And, if you are hurting yourself, that is because you feel some sort of void and you can't do anything else." Katie also shared that it would have been a "joke" if her counselor made her sign a contract. "It would have made me just disrespect the therapist into thinking that this is going to stop me and that they were delusional enough to think that this was somehow going to be beneficial," she shared. Katie had friends who were encouraged to sign no-harm contracts during their experiences in counseling. "It only impacted their guilt later when they did hurt themselves. I just don't see what purpose it serves, other than for the therapist to be able to say, "Well, I have taken the steps from the very beginning," she stated.

A final approach Katie commented upon was related to exploring alternative behaviors in counseling. When asked if counseling helped her to develop alternatives to her self-injury, she answered, "I wouldn't say counseling directly [helped me to develop alternatives to my self-injury] because I was never taught any stress techniques...I mean, it was not directive at all. I mean there weren't any concrete suggestions." As she talked about one counselor, she shared, "I can't remember her ever saying, well, did you ever think of this? Or why don't we make a list of things you can do instead." At one point in the interview, Katie talked about how she used an ice-cube as an alternative to harming herself. According to the Katie, the melting of the ice-cube would simulate the feelings and overall experience of scratching or cutting herself. Katie, however, came up with this alternative on her own:

I read it online. There was a list of...I just “yahoo-ed” something like alternatives to self-injury so there was stuff on there. The only two I can remember were, and I had it on “my favorites” for a long time--holding ice-cubes and then using a red marker on your arms so that you can make a mark so you can visually see that. For me, it was more the pain aspect, so I never referenced back to that list after I found it because the ice-cube approach worked so effectively.

That therapists and families realize.

Katie spoke only about the suggestions she had for families, client, and counselors; her own experiences with self-injury and her experiences in therapy prompted these suggestions.

For Katie, her self-injury was a maladaptive coping mechanism as well as an issue of control. She stated, “I didn’t have any control in my life and that [self-injury] was the only way to exercise some kind of command over what was happening to me. And, then, as time kind of went on, it became a coping mechanism and more of just an outlet for frustration and. It started out as a control issue and then developed into coping.” When asked if she addressed these functions in her counseling sessions, she shared, “I can’t remember talking about that in therapy.” In retrospect, Katie wished that she had the opportunity to have these discussions with her therapist. “It is important that both therapists and families realize that self injury, is a coping mechanism in a lot of ways...don’t necessarily take away, something right now that is helping.” She also stated, “Maybe a good way to address that with someone who is self-injuring, just give them stuff to make sure the cuts or whatever stay clean because then you can still show that you still care...”

Katie gave suggestions to both counselors and clients. Katie gave suggestions to counselors working with women who are harming themselves. “The bottom line is to just try not to alienate them further. Because there is already the knowledge that what you are doing is very bizarre and not normal, and you need to be careful of inadvertently stigmatizing them further,” she shared. Katie talked in length about what she would tell women who were harming themselves:

It is important for them to be prudent about how they choose to do it and that they don’t end up causing themselves further harm by getting infections or anything like that. And to try and get help because there are better ways to cope there are more effective ways to cope. I think that there is a lot of “mystical” surrounding it, which is bullshit. There is nothing beautiful about it.

In fact, Katie stated confidently that self-injury is like a disease. “I think that it is a disease and a disorder in it of itself that brings in other complications.” At the same time, she also recognized that in order to receive treatment, you have to be ready and open to the process:

In order to hear and process that stuff you have to be ready to start recovery.

And, I am sure that if anyone told me that when I was in the thick of it, it would have just been, you know, “Shut up, leave me alone.” Which is why I think any kind of counseling with anyone has to be coupled with the acknowledgement that they will continue to choose to do it. And, to respect that choice and to at least, prevent them from harming themselves further.

In terms of the client-counselor relationship, she talked about what she would say to college students who were harming themselves. She shared, “Keep with the counseling, and if you don’t feel like it is working, try and figure out why and see another

counselor to determine if it is a mismatch between the therapist and yourself.” Katie also pondered the idea of different modes of treatment within the college setting. For example, she believed that a support group on campus would be helpful. She stated, “I don’t know if there is one. There wasn’t at my old school but I think that would really help. But, how to bring that about, I don’t know how that would be possible to maintain anonymity.”

Ego Developmental Level

Katie scored at the E6, the Conscientious level, on the SCT. An individual scoring at this level is able to internalize rules and develop her own personal list of rules that fit their own needs and experiences. An individual at this stage is able to recognize her own role and significance in making decisions. Morality comes from within, rather than what the group decides. An individual functioning within this stage has an increasing ability to critically reflect, to consider alternative perspectives, and to live up to personally established ideals (Loevinger, 1976).

The ogive rule (see table 4.1) allows for some scores to be below and above the level ultimately assigned. Thus, not all of Katie’s scores were scored at E6. The automatic ogive criterion requires that she attain no more than 12 ratings at E5 or lower; she had exactly 12 ratings at E5 or lower. The explanation of ogive criterion requires that she attain 6 or more ratings at E6 or higher; she had exactly 6 ratings at E6. Katie’s total item sum was 92. The following sentence stems and her responses reveal the E6 level:

Raising a family: “is something that I am afraid of.”

What gets me into trouble is: “reacting too quickly to anger and being self-centered.”

When people are helpless: “I feel frustrated because I can do nothing.”

Rules are: “confining.”

Summary

For Katie, her self-injury was a relatively private matter, which she didn't talk about often with her friends and family. In fact, after a week, or two weeks into counseling, she "wasn't really talking to anybody about it." When Katie's parents first found out about the extent to her self-injury, they were initially very supportive and sought help for her immediately. However, this soon changed as her father became very angry and asked her, "how could you do this to us?" On the other hand, her mother was so upset that she couldn't look at her baby pictures for a long time.

In addition to individual therapy, family therapy was one component of her therapy, although Katie didn't find it particularly helpful at the time. Although looking back, she does see the benefits of involving the family in the long term.

Katie commented on different aspects of the counselors she worked with during her time in therapy. She talked in a positive tone about the counselors she liked: the counselors who offered suggestions, and the counselor who resembled more of a friend to her. In contrast, Katie spoke negatively about the counselors who didn't understand her. She also shared that one counselor "didn't seem as genuine" while another one "was much more present focused, and in the now", an approach that "wasn't a good fit" for her.

During both interviews, Katie talked about the various experiences she had in counseling, both positive and negative. For example, the manner in which her high school counselor dealt with billing left a sour taste in her mouth, influencing her future experiences in counseling. Katie also talked about the lack of direction in her counseling experiences. She wanted someone to give her "strategies" to use so she could stop

hurting herself. As a result, she often felt alone during sessions and believed that many of the conclusions she came to, were “own her own.”

Several different treatment approaches were utilized during her counseling sessions. She was continually receiving different diagnoses; sometimes it would be borderline, while other times she received the diagnosis of dysthymia and cyclothymia. In addition to these different diagnoses, Katie was also prescribed different medications through her experiences in therapy. She often felt that the medication that was prescribed to her, “she didn’t need,” which made her extremely “frustrated.” Katie also talked about another approach in counseling, the no harm contract. Although she never signed a contract, she believed, “a no-harm contract takes that away and it puts the position of power back to the therapist.” Finally, Katie spoke about the exploration of alternative behaviors in counseling. However, it was Katie, herself, whom researched alternatives on her own and found that using an ice-cube rather than harming herself was very helpful. According to Katie, her therapist never explored this with her.

For Katie, the interviews served as a vehicle to offer suggestions to therapists and families working with women who self-injure, as well as women who were currently self-injuring. Self-injury served as both a maladaptive coping mechanism, as well as a control issue. She realized that at the time she was harming herself, she “didn’t have any control in my life and that [self-injury] was the only way to exercise some kind of command over what was happening to me.” She also found that her self-injury “became a coping mechanism and more of just an outlet for frustration.” With a strong awareness of herself, she talked in length about what she would tell women who were harming themselves and the counselors that were working with them. Many of these suggestions came from her own experiences, both good and bad, in therapy.

Interpretation

For Katie, she was prescribed a variety of different medications, many of which she disagreed with and refused to take. When her psychiatrist recommended a particular drug, she would go out and do the research on her own, in order to find more about the medication she was going to take. Katie wished to be a more active participant in the management of her medication and became frustrated when she had to do this research on her own. For Katie, she would have liked her psychiatrist to talk to her in depth about the medications that were recommended to her and would have appreciated her psychiatrist informing her about the side effects of all medications prescribed to her.

In addition to medicinal interventions, Katie also researched possible alternatives to self-injury on her own. On the one hand, I believe that it is unfortunate and regrettable that she didn't receive this knowledge in counseling. However, on the other hand, it forced Katie to find this information out on her own, which I believe was empowering for her.

Katie scored at the Conscientious stage (E6 level) of ego development. Katie evidenced a strong awareness of her self and a keen ability to look back upon her experiences with self-injury and the counseling process, which is common at the E6 level (Hy & Loevinger, 1996). For Katie, her self-injury served as both a maladaptive coping mechanism as well as an issue of control. Excessive control is a characteristic of the E6 level (Hy & Loevinger, 1996). At the time of the interviews, I believe she resolved many of her issues of control. However, it was evident that control remained a theme within her life.

At the E6 level, decisions are made for reasons and the person strives for goals, and to improve one's self (Hy & Loevinger, 1996). For Katie, she felt a particular

responsibility to get better, for herself. Thus, she attributes her recovery ultimately to herself; coming to realization on her own accord and evaluating progress according to her own standards. Also indicative of the E6 level, Katie was also able to see many possibilities in her overall counseling process (Hy & Loevinger, 1996). Her reflections upon her experiences in counseling were neither all good nor all bad. She was able to view both the positive and negative aspects of her counselors and the overall counseling process.

Analysis of Participant #7: "Calliope"

Table 4.9

List of Themes

THEME	SUB-THEME
MY LIFE	Died, Mom/Dad, Friends, Boyfriend
REASONS	Disappointment, Cut Myself, Upset, Don't Understand, Drug, Mad
COLLEGE	Counseling center, College, Pressures
COUNSELOR	Question(s), Helped, Listener
COUNSELING	Talk, Do Something, Scared, Trust, My problem, Downward Spiral

Introduction

Calliope, a Caucasian woman, was a 21-year old senior at a small southeastern public university at the time of the interview. As a teenager, she began harming herself using safety pins and razors. Her first experience with self-injury occurred after a violin recital, where she "messed up" and began "poking" herself with a safety pin because she

was unhappy with her performance. During her high school years, she was not involved in counseling, with only a couple of her close friends aware of her behavior.

During her freshman year in college, Calliope experienced the untimely death of a friend and her cousin. Around the same time, her boyfriend broke up with her, and as a result, she cut herself. According to Calliope, a friend in the dorm found out about it and told her R.A. According to Calliope, her R.A. intervened, her dean got involved, and school professionals mandated that she receive counseling services at the counseling center. Calliope attended sessions for approximately six months and worked with one counselor during this time.

The following themes (with related sub-themes) emerged from the interviews (see Table 4.9): My Life (died, mom/dad, friends, boyfriend); Reasons (disappointment, cut myself, upset, don't understand, drug, mad); College (counseling center, college, pressures); Counselor (question(s), helped, listener); and Counseling (talk, do something, scared, trust, my problem, downward spiral).

Themes

My Life.

In the beginning, Calliope was very private about her self-injury, keeping it from her parents and the majority of her friends in high school. In college, however, she told her mother after the incident of self-injury in her dorm room. According to Calliope, her reaction was warm and accepting. In fact, her mother told her that she also “had done it once when her boyfriend in high school had broken up with her.” In addition to her mother, her father also found out about her self-injury and was supportive, although she did not talk with him about her behavior. For Calliope, “It seemed like a girl issue

anyways, and I didn't want to talk about it with my dad." Although her mom's reaction was positive, she didn't talk about the self-injury with her beyond that initial moment.

In high school, Calliope was aware that many of her friends also harmed themselves:

I had a lot of friends that did it too, a lot of girlfriends and so, I guess it seemed normal because a lot of my friends were very smart girls, so I thought it must be kind of normal for smart girls to cut themselves.

In fact, she initially learned about self-injury from one of her friends. She revealed, "I went to a nerd camp. I loved it. It was such a great time. I was really happy there. But, I remember my friend showed me her arm...it was horrible." Although she didn't cut herself immediately after this incident, she believed it impacted her early experiences with self-injury.

Although Calliope first harmed herself in high school, her self-injury peaked during her freshman year when she experienced two unexpected deaths: a high school classmate whom she had a crush on and her cousin. These experiences were extremely painful for Calliope, and as a result she reportedly "kind of lost it." Calliope's experience with loss was compounded when her boyfriend broke up with her. She shared, "I guess the worst one [cutting incident] was freshman year when my boyfriend broke up with me. I didn't even like the guy that much!" It was this break-up which prompted her to cut herself in her college dorm. According to Calliope, a friend in the dorm found out about the incident, which initiated her first experience in counseling. According to Calliope, it was relatively normal for her to harm herself in response to a relationship in which she was involved. She shared, "a lot of the times, when I would get in a relationship with a boy, I would cut myself kind of in the first two weeks. I don't know why."

Reasons.

“Some people punch pillows, I just happened to cut myself,” shared Calliope. During both interviews, she explained that there were several reasons why she cut herself, and she talked about these candidly during both interviews. She shared, “A lot of the times, I don’t understand why I cut.” Other times, Calliope understood the reasons, attributing her cutting to feeling disappointed, upset, and mad at herself. “I think a lot of that was just trying to be perfect. I wanted to be good at school, I wanted to do well in my extracurricular activities, and then when I got disappointed in myself, I cut myself.” In many ways, cutting was her way of punishing herself for doing something wrong. She stated, it was “very almost catholic, now that I think about it. Like when you think about Catholic people in the middle-ages doing things like that.” For Calliope, “it was like my emotions needed to come up somewhere and for some reason they came out there,” in the form of cutting.

When Calliope was mad at herself, it was common for her to engage in self-injury. “I would get really mad at myself. I’d be like, ‘You did really bad on your test,’ and I would cut myself when I would get upset.” She also stated, “I would get upset in school, and I would cut myself and um, and a lot of times, I would use a safety pin. I would take it and drag it across my arm...”

Through counseling, Calliope learned to assuage some of the feelings that prompted her to cut herself:

I shouldn’t get mad at myself. Because, I am always getting mad at myself and sometimes I just need to step back and say, “Ok, it wasn’t your fault.” I mean sometimes like really aren’t my fault, but I feel like I could have done more to avoid them. And then, sometimes it is my fault, and I just have to look back and

say, "Ok, you've messed up where can you go from here?" Instead of saying, "God, you are so stupid."

Calliope related her experiences with self-injury to be similar to being addicted to drugs:

It is like drugs or something. You have relapses and it happens. You just have to get through them and eventually the relapses will get fewer and fewer and then you won't have them anymore. I felt like a drug user.

As time progressed and her self-injury persisted, Calliope decided that she didn't "want to be a user," and she ultimately wanted to get better.

College.

Calliope's experiences with self-injury were influenced by her experience as a college student, especially her freshman year in college. As a freshman, she stated, "I was really excited about coming to college and I really liked it, but at the same time I felt very isolated." Calliope continued to comment on her early experiences in college:

Especially like the first year, everything is so in flux. It is good to have something stable, and I think that loss of stability contributed to my cutting, and I know that I've heard other people talk about their stresses and stuff, and I think a lot of it is that, it's just lack of stability they feel.

At the time of the interview, Calliope was a senior and her perspectives about her experiences as a college student shifted. "I always thought that you came out of college with this fountain of knowledge and you were well prepared for the real world," she shared. For Calliope, this wasn't necessarily the truth. She shared, "On the one hand I feel like people mature, but on the other hand, I really feel like people get younger because I think that they are allowed to indulge more in childish things." She concluded

her comments about being a college student and remarked, college is “really a time to find yourself and mature and grow.”

As a college student, Calliope encountered many academic and social pressures. For example, she remarked, “I feel like the professors have really high standards.” She talked most extensively about the social pressures she encountered in college:

I think that there is a lot of pressure to go out and party and stuff like that. I mean there are a lot of people who spend their Friday and Saturday nights in their room. I always felt that when I lived on campus, if it was a Friday or Saturday night, I had to be out.

She expanded upon these social pressures, talking specifically how these pressures are related to women:

When you go to like frat parties in your freshman in sophomore year...the girls, and I used to do it to when I was a baby. You know, you feel that you have to dress up, and you have to show your cleavage, and you have to wear a short skirt. Because if you're not, then you aren't going to get in the party, if you are not pretty enough. I think that this is just really a wrong way to go about it.

Calliope's experiences in college were also impacted by her involvement in counseling at the College Counseling Center. In her mind, she believed that the counseling center should make itself more visible, especially for freshman. She shared, “I think that it is very important for freshmen. Maybe, to make it known that the counseling center is there and it is not this like horrible experience or anything.” In her mind, she believed that it “is really good to get them more in the public school community so people aren't afraid, you know. I think that a lot of people are afraid.”

Counselor.

Unlike other interviewees in this study, Calliope only worked with one therapist. During the interviews, she talked about the questions her counselor asked, her ability to listen, and how this counselor ultimately helped her.

Calliope had divergent opinions on the types of questions that her counselor asked her. On the one hand, Calliope liked the specific questions directed towards her. She shared, “I really liked that she just, she asked me how it made me feel, and she asked me questions about how...she went deeper into the issue, like things that I didn’t think of, that she made me realize.” On the other hand, Calliope felt that her counselors’ questions were repetitive and she would sometimes ask the “same questions” over and over again. She shared, “It just felt like the same question just phrased a different way. Like, ‘How often do you cut yourself?’ and ‘How many times per week?’”

Calliope was thankful that some of the work she and her counselor did ultimately helped to improve her relationship with her mother. For example, during sessions Calliope talked about her relationship with her mother, which was sometimes stressful. According to Calliope, her mother placed a lot of pressure on her to succeed. Towards the end of therapy, she told her mother some of the things that she addressed in therapy. She shared, “I am really glad that my counselor helped me out with that.”

Calliope also appreciated her counselor’s genuine ability to make her feel special. She shared, “She made me feel like I was a valuable person, and that really helped out.” She also talked about a time when her counselor commented that she heard her name on the radio after playing in a concert. She shared, “That made me feel really happy...she remembered everything, and that is impressive.”

Finally, Calliope liked the fact that her counselor talked about the reality of relapse with self-injury:

The thing that helped me was, first of all, that she stressed the relapse bit.

Because, I thought, you know, I have gone two weeks and now I have cut myself and now I am back where I have started...

Calliope's counselor made it clear to hear that relapse was normal, it was expected, and she was not a failure of a client because she had cut again during her time in counseling.

Her counselor's ability to listen was extremely important to Calliope. When asked what she liked about her counselor, she shared, "She was just really, a really good listener, and I think that was very beneficial." Additionally, she stated, "It was good to have a person who could listen, and I didn't have to feel guilty." For Calliope, counseling helped her, because "there was someone who had an hour and could just listen to all of your problems."

Counseling.

For Calliope, counseling was initially scary for her. However, in time it became a place where she could talk about different things with her counselor, where she learned to trust, where she became aware of when she was heading towards a "downward spiral," and where she learned to "do something else" rather than harm herself.

For Calliope, the idea of counseling was scary to her. She shared, "I was really scared of counselors because when I was young, I was taken to one and it wasn't a good experience..." Calliope's fear only grew when her R.A. and the dean found out about her self-injury. Calliope regretted the way this was handled. She revealed, "I just really wish that the dean wouldn't have been involved. Like, if someone from the counseling center

could have come and been like, 'Hi come and talk to us, please.' It was just too scary for me.”

Counseling became a place where Calliope could come and talk about things that were bothering her. In fact, she believed that she would still be cutting herself if her friend didn't alert her R.A. She stated confidently, “I would still would probably cut. I may have gotten help on my own, but I don't think so.” Through her experiences in counseling, Calliope learned one lesson that remained with her at the time of the interview:

There will still be ups and down but I just have to go through with it. I shouldn't be so hard on myself. I think that is the thing that she really, really talked to me about...acceptability. It is ok if I made a mistake. I think that is really one thing that we talked a lot about. It is ok. You are not a horrible person because you messed up a test.

In counseling, Calliope learned to trust others. Upon reflection, she wished that she could have trusted her counselor “a tad more in the beginning.” However, by the end of her counseling experience at the college, she definitely felt that she was “more in control,” and she generally “learned to trust people more.”

For Calliope, counseling became a place where she could identify when she was getting worse. During the interviews she referred to this as her “downward spiral.” For Calliope, one way of avoiding the “downward spiral” was to explore the reasons behind her self-injury or what drove her to this behavior. “Once I knew the reasons, I could try to stop it. Sometimes, I would notice myself on sort of a downward spiral,” she shared. However, through therapy she learned “to focus on getting back up before I hit the bottom.”

Calliope also discovered that certain alternative behaviors prevented her from harming herself. In her words, she learned to “do something else” rather than harm herself. At the beginning, she shared, “Once I knew that it [the self-injury] was coming, I could make myself not do it or just you know, try to make myself do something else so I wouldn’t, like, go in the bathroom.” The bathroom, in Calliope’s case, was where most of her cutting occurred. So, avoiding this area appeared to reduce her rates of self-injury. Calliope also talked about other alternative behaviors she discovered in counseling:

My counselor really stressed because she knew that I was really artistic, to write a poem about what I was feeling...or just do something. And, that is what I do now. Like, when I get sad, I play my violin, and that is good. Or, call someone. I can always call my mom.

Summary

For Calliope, her self-injury was private, keeping it from family and friends throughout her high school years. During her freshman year in college, she told her mother about harming herself, and “her reaction was warm and accepting.” In fact, her mother revealed to her that she had also harmed herself in high school. Although her father knew about her self-injury, she chose not to talk about it because it was “a girl issue anyways.” Although it wasn’t talked about often in high school with her friends, many of them also harmed themselves. For Calliope, she thought that it was “kind of normal for smart girls to cut themselves.”

Calliope’s experiences with self-injury began in high school but progressed during her freshman year in college. According to Calliope, she experienced the death of a close friend and a cousin. She also broke up with her boyfriend. This break-up led her

to harm herself, which was eventually found out by school professionals, who mandated her to attend therapy sessions at the College Counseling Center.

There were several reasons why Calliope cut herself; In retrospect, she learned that she cut herself when she was disappointed in herself. She often strived to “be perfect,” and when she failed to achieve these high standards, she often cut. Calliope would also harm herself when she was feeling upset. Finally Calliope, cut herself when she got mad. In time, counseling taught her that she needed “to step back and say, ‘Ok, it wasn’t your fault all the time.’”

It was her freshman year in college when Calliope’s self-injury came to the forefront. In her early experiences as a college student, she reported a “loss of stability” which ultimately “contributed” to her cutting. In her senior year, she appeared more stable and reflected candidly upon her experiences in college. For Calliope, she saw college as a “time to find yourself and mature and grow” although many indulge themselves in more “childish things.” Calliope also talked about the pressures that she encountered in college, including both academic pressures, where the professors hold high standards, and social pressures, which dictate the importance of “going out” and for women, dressing in short skirts. Her experiences as a college student were impacted by her involvement in counseling at the College Counseling Center. In her mind, she believed that the counseling center should make itself more visible, especially for freshmen and to make itself less scary to students.

Calliope was involved with only one therapist. She talked extensively about her experiences with this counselor. Calliope liked the questions that her counselor asked, which allowed her to get “deeper into the issues.” However, sometimes, she noted that she would ask her the “same questions” repeatedly. Calliope also liked the fact that her

counselor helped her to talk with her mother about their relationship, and she also appreciated that she was a good listener. Finally, Calliope was thankful that her counselor talked about the reality of relapse and the likelihood of her recurrence of her self-injury.

In response to her self-harming incident at school, Calliope learned that she was required to attend counseling sessions at the counseling center. Initially, the idea of counseling was scary to her because of her negative experiences in counseling as a child. However, counseling soon became an environment where she could talk openly about things. For Calliope, the focused on “acceptability” and being aware of triggers that would precipitate self-injurious behavior. Through therapy, she learned to trust people more and learned alternatives, or in her words, “to do something else,” rather than cutting herself.

Ego Developmental Level

Calliope scored at the E7, the Individualistic Stage, on the SCT. An individual scoring at this level is able to internalize rules and develop her own personal list of rules that fit their own needs and experiences. At this level, one is able to recognize her own role and significance in making decisions. Morality comes from within, rather than what the group decides. An individual functioning within this stage has an increasing ability to critically reflect, to consider alternative perspectives, and to live up to personally established ideals (Loevinger, 1976).

The ogive rule (see table 4.1) allows for some scores to be below and above the level ultimately assigned. Thus, not all of Calliope’s scores were scored at E7. The automatic ogive criterion requires that she attain no more than 15 ratings at E6 or lower; she had 14 ratings at E6 or lower. The explanation of ogive criterion requires that she

attain 3 or more ratings at E7 or higher; she had 4 ratings at E7 or higher. Calliope's total item sum was 105. The following sentence stems and her responses reveal the E7 level:

A man's job: "should be to reconsider the implications of sexism in our society."

For a woman a career is: "necessary, just as it is for men. Motherhood can also be a career, if one views it that way. People must always strive for something, at least."

If I can't get what I want: "I sulk a bit. Sulking can be nice, but then, I realize it was not to be had, and move on."

Interpretation

As a child, Calliope had a negative experience with a counselor. Consequently, she learned to be afraid of counselors. In college, her fears were exacerbated when her friend contacted her R.A. in response to Calliope's self-injurious behavior in the dorm. Her R.A. then alerted the dean, who then involved the counseling center. Knowing Calliope's personal background with counselors, this approach seemed to be inappropriate and unhelpful. However, on a broader stage, self-injury is a very secretive behavior, often associated with shame for those involved. It is likely that Calliope was bothered and embarrassed immensely by this approach. This belief is supported by the fact that Calliope made an appointment to meet with her dean, since she knew the dean was now aware that that she had harmed herself.

Calliope scored at E7, the Individualistic Stage, on the SCT. Her responses on the SCT as well as her interview dialogue evidenced a strong sense of individuality and personality (Hy & Loevinger, 1996). She spoke of her emotions with depth, insight, and intensity (Hy and Loevinger). Also indicative of the E7 level, Calliope demonstrated a keen sense of self and critically evaluated herself from many different perspectives (Hy

& Loevinger). For example, at the time of the interviews Calliope finally understood why cut herself; she was disappointed, upset, or mad at herself.

Calliope cherished her relationships with her friends, family, and particularly her counselor. Through this close relationship, she learned to share her feelings openly with the counselor and explored the underlying feelings that drove her to harm herself. This reality is evidence of psychological causality; one of the primary characteristics of the E7 level (Hy & Loevinger, 1996). Additionally, Calliope talked in depth about stereotyped gender roles in the college setting and within society, in general. She spoke fervently about this topic; in fact, she shared with me that she had recently written a paper on the topic and was interested in exploring gender stereotypes beyond college.

Analysis of Participant #8: "Jane"

Table 4.10

List of Themes

THEME	SUB-THEME
MY LIFE	Died, Mom/Dad, Friends, Boyfriend
REASONS	Disappointment, Cut Myself, Upset, Don't Understand, Drug, Mad
COLLEGE	Counseling center, College Pressures
COUNSELOR	Question(s), Helped, Listener
COUNSELING	Talk, Do Something, Scared, Trust, My problem, Downward Spiral

Introduction

At the time of the interview, Jane, a Caucasian Woman, was a 22-year old senior at a small public southeastern university. She cut herself a total of four times, at the age

of 17, before meeting with her first counselor. Her junior year in high school, after telling her mother about her self-injury, she met with both a counselor and a psychiatrist. According to Jane, she did not like either the counselor or the psychiatrist and terminated sessions after approximately one year. As a result, she met with a different counselor during her senior year in high school, as recommended by her school counselor. She enjoyed working with this counselor and met with him until she left home for college.

During her freshman year in college, Jane met briefly with a counselor at the College Counseling Center. Around this time, she cut herself, leaving a significant wound on her wrist. Her injury was treated at a local hospital and then, according to Jane, she was “basically kicked out [of school] for suicidal gesturing.” Following her dismissal from the college, Jane attended a day treatment program briefly. She remained out of college for a total of five semesters, and upon her return, she was mandated to work with a counselor at the College Counseling Center. She met with this counselor for only a limited number of sessions.

The following themes (with related sub-themes) emerged from the interviews (see Table 4.10): *Myself* (depressed, mom/dad, suicide); *Cutting* (attention, T.V., cut myself); *School* (liability, girls, high school, college); *Counselor* (friend, understood, liked, switch counselors); and *Counseling* (stop, alternatives, help, symptoms, cut myself).

Themes

Myself.

When asked about her families' reaction to her self-injury, she shared that her mother was “worried” and “felt badly,” because she knew that a lot of her behavior was influenced by her tumultuous relationship with her dad:

A lot of my discontent with life was living with my dad. We didn't get along at all. He was a control freak. I spent a lot of my teenage years just in my room just so I could be away from him. So she, [my Mom] felt bad because she didn't realize that he was affecting me that much. She felt like she should of mediated things a little more between us or helped out somehow.

When she was mandated to leave the college, Jane went home for a brief period of time, a place where she dreaded to be. However, within weeks, she returned to the university, renting an apartment, to finish a photography course that was not affiliated with the college. Jane shared, "I finished my photography class; then I worked at a summer camp for a summer. I have never really gone home for more than two weeks it seems since I graduated high school."

At the time of the interview, Jane was a senior in college. She commented on the current status of her relationship with her father. "My dad and I are still not close. I mean, we get along on the surface," she shared. Although their relationship was slightly improved, she shared that she continued to be affected by her father:

I still have dreams about my dad. I guess I would call them nightmares: Like doing stupid things. I don't remember them in a lot of detail. I remember the ones that counselors would probably have a field day with. But one time, I remember in the dream that he wouldn't let me go the bathroom. I am sure that is very Freudian. One time, just a couple of weeks ago, I had a dream about him sexually molesting me even though that never happened. Nothing like that ever happened. But, you know, something in my head is still very traumatized, almost, by my teenage years.

Jane also talked about her current boyfriend, whom she visits regularly on the weekends:

I am dating a guy who is 22 years older than me, and, well, I have a lot of characteristics of my dad and so does he. They say that you date someone that is like your dad or the total opposite and, well, he is just my father. But that is because I am in love with him, not because I am trying to put in my father's face.

Jane shared that self-injury and suicide were two separate and distinct behaviors. "I guess just the fact that blood is involved makes everyone on their toes about it. It is really far away from the spectrum of suicide," she stated. Self-injury was "more of a life-affirming thing" for Jane. "Just exactly the opposite of wanting to kill yourself. It is to just give yourself something else to do rather than commit suicide. It is totally different than suicidal behavior." At the same time, Jane admitted that her gesture during her freshman year in college was "more suicidal:"

It is hard for me to remember. But, I remember not caring how far it went. So, it wasn't that I want to kill myself, but I am just going to go with it and see where it goes. If I die, fine. If not, it will be more of the same. So, it wasn't... Well, it would be hard to classify. It wasn't an all out suicide attempt, but it wasn't not a suicide attempt, either.

Whether it was a suicide attempt or not, Jane was clearly struggling with feelings of depression. She talked at length about these feelings: "I feel that I like my depressed self because I was always thinking, I was always thoughtful, contemplative, and so, I was always thinking about life, and me." For Jane, she also experienced an "existential crisis:"

You know I am not religious, but when I was 13, my parents enrolled me in this confirmation class at our Methodist church, and so I did that, and everyone that was religious seems really happy, and I was like, “I am going to try this, too.”

And, it never really worked. So, what is the next thing, you know? I am just, here on this earth for no reason? And that was hard to get used to. So, if you are here on this earth for no reason, and you are happy that is one thing, which is kind of how I feel about it now. But, if you are here on this earth, and you are depressed, then why are you here at all? You should just get it over with.

For Jane, these feelings were in the past, and she shared that she is now “happy again, through, just becoming more independent and leaving my dad behind and making my own choices, you know, deciding that school wasn’t for me.”

Cutting.

Jane initially learned about cutting after watching a television show in high school:

The place I really got the idea from was really an episode of 7th Heaven, the T.V. show. I had never heard of it, before then. And it wasn’t immediately when I saw it, I said, “Oh, I want to do that.” But I think that was the first place I heard of it.

When she started cutting, her self-injury was very purposeful. She stated, “I think one of the main reasons I started cutting was because I felt I needed counseling. I felt maybe my problem wasn’t real, but if I was cutting, it was real, and I deserved real help.” Jane’s self-injury clearly validated her feelings of pain, and it also served as a distraction:

Maybe I would be sitting there with thoughts just going through my head and everything that was going on my life, and I would, you know, if I was cutting

myself, the only thing I had to think about was this one thing. I couldn't really think about anything else.

Jane's self-injury also served as a release. "So, it was kind of a release, I guess. I am sure that there is a lot of adrenaline that goes with it." Aside from these personal reasons, cutting finally was a way for her to get "enough attention."

School.

"Most of my spree of cutting was my junior year in high school," Jane stated. Her episodes were rare after that, although she cut herself during her freshman year in college. Jane talked in length about her experiences both in college and within the College Counseling Center:

Jane was aware of the pressures and expectations of being a college student, especially being a woman in college. "Being a college girl you are supposed to be attractive and thin and have a great, you know, romantic or sexual life, in addition to all your studies, and there are certainly girls here who chose, you know, that is not for me," she shared. For Jane, college was sometimes stressful:

It is stressful because of the intense competition, either in the job market or for grad school. It is also stressful because everyone who is here got excellent grades in high school and expects to keep getting them and to be on top of their own performance level and usually on top of everyone else.

Jane also spoke about the academic pressures she encountered as a college student. She shared,

It is hard sometimes to balance the importance of grades in college with what or how important you know they will be in ten years, which is not at all. And even

though you are told that, and you even believe it yourself, you still can't just let go and enjoy things because there is too much work to do.

For Jane, college was only the beginning, not the end of her education experiences in life:

I plan to start learning as soon as I get out of college. College for me is something to get through and to get the piece of paper when you get done, and to take all these ideas that you have put on little pieces of note paper during your classes and to actually go out and explore, you know, because too much of college is putting out what other people want. I think that it is a good starting point.

Counselor.

Although Jane worked with several counselors over the course of two years, she talked mostly about the second counselor she worked with during her senior year in high school and her school counselor, with both of whom she had a great relationship. When asked what it was like to work with her second counselor, she stated that it was “very liberating...hopeful, I guess and just fun. Even when there were not a lot of things in my life that I was having fun with, at least I could talk about it, and he seemed to always understand.” She also shared, “My second counselor was a little more confrontational. He made me...he made me sometimes mad. And, I thought that was good because that was really getting me involved and not just sitting on a couch talking.” She also stated, “He would make jokes. He was irreverent. You know, he didn't treat it like it was this serious thing.” For Jane, she felt close and connected with this counselor. “It was like almost friends...you know, the second one I feel like I could stop by his house or something. He was kind of a mentor or friend, who was really almost a savior. The first

counselor with whom Jane worked approached things differently, which she didn't find to be helpful:

My first counselor, I remember she was a woman and she was more passive. She would say, "Let's talk about things," and "Have you cut this week?" and I would say, you know, "Get off of it." I remember one time when she read me the serenity prayer and I was like, "Oh God!" Just, way too docile.

Jane's positive accolades continued for her school counselor. During her sophomore year in high school, she was assigned a different counselor. However, she protested this placement, and as a result was allowed to stay with her prior counselor. For Jane, he went above and beyond his role as a school counselor. She shared, "One day he actually took me out for a hike...and, he would just talk. And, it wasn't all about me. He would talk about him, too." For Jane, she appreciated working with him and viewed his role to be similar to that of other influential adults in her life.

For Jane, her school counselor in high school also understood her unique needs as a gifted student:

He was a counselor specifically for gifted students, or gifted kids and adults, and he was very intelligent himself, so I always felt like I could talk about...I didn't have to worry about saying things that smart kids would say...And, I guess he understood more the problems that smarter kids have. I always felt that I needed more independence earlier because I was more intelligent. And, I could say things like because I am more intelligent without, feeling like that was impolite.

Jane's experiences with these two counselors were extremely positive and in many ways, outweighed her negative experiences with counselors. For these reasons, Jane believed in the importance of finding a good match between the counselor and

client. She revealed, if someone “didn’t feel like there was a good dynamic or if they didn’t feel like the counseling was going well, then they shouldn’t hesitate to switch counselors.”

Counseling.

As a teenager, Jane remembered feeling compelled to get involved with counseling:

I always had so many things that I wanted to discuss...but I couldn’t decide if I was just feeling the normal teenage angst thing or if it was more. So, that’s why I didn’t want to just go to counseling and say, “I have a problem,” if I was just going through what everyone else is going through, maybe not handling it as well as everyone else. I really needed confirmation that something was going on worse than just normal teen growing up.

Jane was willing to take drastic measures to get involved in counseling. “I remember thinking that I wished that I could get raped so that I could go to counseling,” and “I think one of the main reasons I started cutting was because I felt I needed counseling.”

In counseling, Jane had a diverse range of experiences. During sessions, the majority of Jane’s counselors focused primarily on her self-injury, and their “first priority was to stop her” from cutting:

One counselor would just always make it a big issue. She would ask how my last week had gone and acted like the most important indicator about how my week had gone was whether I had cut myself or not, and I just felt my week could have been worse than a week when I would cut myself, and I just chose not to, or I wasn’t in a position to or something like that. I just felt like that, that shouldn’t just be a huge indicator for her.

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In Jane’s view, cutting was more of a symptom of her underlying pains and emotions.

I just felt like it [cutting] is more of a symptom than anything else. And, I mean you wouldn’t go to the doctor and he wouldn’t say, “How much have you sneezed this week?” You know, he would ask you overall, “How are you feeling?” “Are the drugs working?”

Further, Jane shared, “I felt like it was all intertwined so you shouldn’t just have this one goal to stop the outward symptoms when the inward symptoms were just as important.”

When asked if her counselors provided her with alternatives to her self-injury, she shared that this was not a focus of her counseling sessions. For Jane, she did not see the value in alternative behavior. She argued, “Alternatives are just that. They are

record for doing” something. When she briefly worked with her college counselor, she shared that she had to carefully decide what to include in sessions and what to leave out:

I talked with him, and I was honest with him. But, if I was having...if I had felt bad that week, which was more rare than I had been certainly, but I usually didn't tell him about it because, you know, my first priority in that, with that counselor, was to let the school know that I wasn't a liability anymore.

Jane's own experiences related to self-injury in college prompted her to make the following recommendations for women who harm themselves:

On the one hand, I would want the girls to know that they were getting into by going to a college counselor if they are self-injuring, because it is really risky to being able to stay in school. You are there for counseling, but you also have to have a strategy, because the college system is political. It's associated with the Dean's office, and they all talk. And so, when you go to a College Counseling Center, you have to figure out what your first priority is, and, kind of, maybe, keep certain things back.

Jane wished that counselors at the College Counseling Center were open with their clients about the limits of confidentiality. She wanted counselors to say, “you know this is what I have to do if you tell me that you are cutting. So, you need to make the choice about what to tell me and what to leave out.”

Ego Developmental Level

Jane scored at the E7, the Individualistic Stage, on the SCT. An individual scoring at this level is able to internalize rules and develop her own personal list of rules that fit their own needs and experiences. At this stage, one is able to recognize her own role and significance in making decisions. Morality comes from within, rather than what

the group decides. An individual functioning within this stage has an increasing ability to critically reflect, to consider alternative perspectives, and to live up to personally established ideals (Loevinger, 1976).

The ogive rule (see table 4.1) allows for some scores to be below and above the level ultimately assigned. Thus, not all of Jane's scores were scored at E7. The automatic ogive criterion requires that she attain no more than 15 ratings at E6 or lower; she had 14 ratings at E6 or lower. The explanation of ogive criterion requires that she attain 3 or more ratings at E7 or higher; she had 4 ratings at E7 or higher. Juliana's total item sum was 109. The following sentence stems and her responses reveal the E7 level:

Raising a family: "is something I am not sure is a good idea in today's world. Not that I don't love my life, but I already worry that any child I might have will be an unnecessary addition to the population and constantly struggling to get away from violence, crime, bad government, pollution, etc."

A man's job: "might require more strength (physical) than a gender-neutral job, but that would also mean that some men would be unqualified and some women would be qualified."

When people are helpless: "they aren't pathetic and undeserving—they could use someone to pull them up. Unless they are helpless all the time--That's different. I've been entirely helpless before, and you just want someone to put you in a stroller, push you around, and make you ok again."

Summary

Both Jane's Mom and Dad were aware of her self-injury. Her mother reportedly was "worried," "felt badly," and somewhat responsible that she didn't mediate things between her and her father. According to Jane, her father was controlling of her

throughout her childhood, and the two had an extremely tumultuous relationship. In addition to her parents, Jane talked briefly about her 44-year old boyfriend, who shared several similarities with her father.

Jane first learned about self-injury through a television show. As she stated, “one of the main reasons I started cutting was because I felt I needed counseling.” The act of cutting served as a “release” and was a way for her to get “attention.” Additionally, it was the “ultimate distraction,” forcing her to forget about all the things that were going on in her head. Self-injury for Jane was distinct from suicidal behavior, although she did harm herself to a point that others classified as a suicide attempt.

Jane began harming herself during her junior year in college, although her most serious encounter came during her freshman year in college, which prompted her departure from the college. She believed that the college’s response was motivated more by the school’s liability rather than a personal investment in her welfare. For this reason, she would often be careful of what she brought into the counseling sessions after she returned from her dismissal.

Jane talked openly about her experiences as a college student and shared that as a “college girl” you are supposed to be “attractive” and “thin.” She also shared that college is not the “ultimate educational experience;” Jane hoped to “start learning” as soon as she left college. When asked specifically what she would tell college-aged women who were harming herself, she shared, “I would want the girls to know what they are getting into by going to a college counselor, if they are self-injuring. It is really risky to being able to be in school,” she shared.

Jane believed in the importance of having “a good dynamic” with her counselors and encouraged women who didn’t have this relationship to switch counselors. During

her counseling experiences, she worked with several counselors. However she talked extensively about her relationship with her school counselor and the second counselor with whom she worked during her senior year in college. When asked what it was like to work with her second counselor, she said, it was “very liberating” and “fun.” For Jane, her relationship with this counselor was almost like “friends.”

Jane’s experiences in counseling were both positive and negative and were largely dictated by the counselor with whom she worked. Many of her counselors focused primarily on her self-injury and worked hard to try “to stop” her behavior. Jane disagreed with this approach; in her eyes, “it was all intertwined,” and her cutting was just a “symptom” of underlying issues. During counseling, she also talked about the lack of focus on alternative behaviors to self-injury, which she appreciated. For her, “Alternatives are just that. They are alternatives, and I don’t think that they are, and nothing that I have heard of this far is really going to substitute.”

Interpretation

Jane was willing to take drastic measures to get into counseling; she eventually cut herself and dreamed of getting “raped” in order to receive counseling services. In many ways, her self-injury was a cry for help, and she wanted to be heard by her counselors. During the interviews, Jane repeatedly said that her self-injury was only a “symptom” of a larger problem, so, for Jane it was the underlying issues, not the self-injury, that she wanted to address in counseling. After all, her cutting served mainly as an admission ticket into counseling.

At the age of 22, Jane was still suffering from a poor relationship with her father. Growing up, he controlled many aspects of her life, and at the time of the interview, she continued to be haunted by him in dreams. As a result, she avoided coming home for a

prolonged period of time. She spoke openly about the characteristic of her father, which she strongly disliked. With this being said, she chose a boyfriend who is 22-years her senior, who possessed many of the same characteristics of her father.

Jane scored at the higher end of the E7 level. A strong sense of individuality was important for Jane; she strove for independence within her family, especially from her father (Hy and Loevinger 1996). As indicative of the E7 level, Jane's evaluation of her emotions was insightful and in-depth (Hy & Loevinger). For Jane, she believed that cutting herself was confirmation that she had a legitimate problem.

At the E7 level, individuals begin to think in terms of psychological causality (Hy & Loevinger, 1996). Jane recognized that her father strongly influenced and negatively impacted her life. Interestingly enough, Jane did not feel that her counselors in college influenced her in any way. In fact, while at the College Counseling Center, Jane learned to be very savvy during sessions; she learned quickly what things to share with her counselor and what information to leave out. For her, she never had a genuine relationship with her counselors in college because she knew that what she said was contingent on her enrollment in the school. It is unfortunate that Jane did not develop a closer connection with these counselors; considering her advanced level of ego development, a close connection may have been a catalyst for growth and change.

As indicative of the E7 level, Jane challenged stereotyped gender roles within the context of college-life and society as a whole (Hy & Loevinger, 1996). She also evidenced strong perspective taking skills, was able to see alternatives to solutions, and demonstrated keen awareness and insight into her own emotions.

Analysis of Participant #9: "Becky"

Table 4.11

List of Themes

THEME	SUB-THEME
MYSELF	Eating disorder, Depressed, Movie, Sister, Mother, Black
TREATMENT	Relapse, Collaborative, Recovery, Learned, In-Patient
DIDN'T HELP	Jesus, Didn't Understand, Acknowledge, Addressed, Effort, Contract, Betrayed
HELPED	Matching, Pace, Cared, Understand, Right Match, Patient

Introduction

Becky, an African-American woman, was a 22-year old woman at the time of the interview. She was in her second year of a Ph.D. program at a small southeastern public university. Becky entered counseling at the age of 18, as a result of an eating disorder. According to Becky, her friends in high school informed her guidance counselor, whom "interfered" and referred her to a counselor. Sometime after the onset of her eating disorder, Becky started cutting, using whatever she could "get her hands on," including her own nails, a thumbtack, staple, a razor, or a knife. Over the course of 4 years, Becky worked with several counselors, in both inpatient and outpatient settings.

During her high school years, Becky lived with her mother and her sister; she never knew her father. Becky's sister and mother were both aware of her self-injury, although they truly didn't understand her behavior. Her mother passed away while Becky was in college and according to Becky, never fully supported her during her

struggles. On the other hand, her sister eventually became more involved in her life and learned to understand and support her.

Becky's timeline in counseling is as follows: Becky's first counselor was named "Jesus Lady" because she brought religion into the counseling sessions. Her second counselor worked at her undergraduate institution's counseling center. For the purposes of clarity, I will refer to her as "Ruth." After Ruth, Becky worked with a few other counselors intermittently and was also in an inpatient treatment facility on two separate occasions.

The following themes (with related sub-themes) emerged from the interviews (see Table 4.11): *Myself* (eating disorder, depressed, movie, sister, mother, black); *Treatment* (relapse, collaborative, recovery, learned, in-patient); *Didn't Help* (Jesus, didn't understand, acknowledge, addressed, effort, contract, betrayed); and *Helped* (matching, pace, cared, understand, right match, patient);

Themes

Myself.

At the age of 18, Becky was struggling with an eating disorder and feelings of depression, and was actively cutting herself. During high school, Becky took laxatives, "restricting a lot, bingeing/purging, exercising, and vomiting." She experimented with cutting after her eating disorder emerged. Becky initially learned about self-injury from a movie called *Secret Cutting*, on the USA Network. "I started to cut after I saw a movie about it, and then I tried it out, and it worked for me," said Becky. "It was magic."

Becky also grappled with depression:

If you've never been depressed like that you can't understand. With depression, it's not even empty...it's past empty. It's worse than empty. It's like an

unidentifiable pain that you have. Something that's so intangible which makes you even more confused. But it's because you hurt so badly but there's no manifestation of it. So it's like the cutting was the physiological manifestation of the psychological angst. That's what it did for me. It helped to give me something else to focus on...or something to focus on...to represent the pain. The endorphins worked too. It's just like with purging.

Becky's sister and mother were both aware of her self-injury. At first, she said, "My sister would just straight up call me names, call me crazy, call me stupid." Over time, her sister "eventually started to understand," and "now she's cool with it." In contrast, she said, "My mother never really grasped it. I don't think she wanted to at any level and understandably so." According to Becky, her mother was ill at the time she learned about her self-injury:

My counselor told her over the phone, and I spoke with her afterwards, and she just didn't understand. She was like, "So that's what you've been doing upstairs in your room. I just don't understand," and she didn't mention it after that.

Becky talked about her race and ethnicity during both interviews, and how they impacted her as a person. When asked what it is like to be a Black female in today's society, she shared,

It is kinda of hard to say, considering where I fit in. I mean society sees me as an African-American female or Black woman. But, then in the Black Community I guess because I am educated, and I don't come from the same culture, they see me as not Black enough. So, I am kind of in this weird limbo. I have never quite filled in either place. So, I don't really feel pressure on each end to conform, and I can't do anything but be me.

Being herself and fitting in was something she constantly struggled with, and Becky noted this was particularly difficult in graduate school:

Especially with my classmates, just about proving myself. Not like I feel like I have to prove myself to them, but because I know, I know what could happen if I don't. I could be easily overlooked. Just because of who I am.

She continued, expanding these viewpoints to the larger society:

I don't know...society in general just sucks. There is so much more that I have to deal with...I mean, it is not only because I am Black, and I don't want to put that label on, because of the experience that I have had in my life on top of being Black. Like, not having a mother, not having a father.

Treatment.

Becky's experiences in counseling were largely influenced by her time in an inpatient treatment center, which Becky shared was "the worst experience of my life." On two separate occasions, she was admitted to the facility, which addressed her self-injury and her eating disorder:

The first time I stayed a month, and the second time I stayed three weeks. And they were both separated by a month. And it didn't work because they didn't know anything about anything. I knew more about my problems than they did.

And they were upset because I was educating the girls about eating disorders and this, that and the other. They didn't like me, and I didn't like them.

While in treatment, Becky disliked the treatment approach and overall attitude of the staff at the facility. "I hated the fact that I felt like I was punished for having an eating disorder and for cutting", she shared. "It was like I was there to get treatment but they were upset with me if I resisted."

Becky's experiences at the inpatient treatment facility were not representative of all of her counseling experiences. Becky talked fondly about her work with Ruth. "She made me take a lot more responsibility for my recovery and everything," she shared. She talked about one incidence in particular that illustrated this:

I had these trigger pants...as I called them. They are the itty-bitty tiniest pants they've ever made. I don't know why they even have anorexic pants. They sell them in the store. But they did. And I had an idea that as long as they were around I needed to fit into those pants or actually lose enough weight so that those pants were three sizes too bit ...but yeah, when I couldn't do it, then I got all depressed. So I'd get all depressed and I'd cut even more, so yeah, I had an idea that I'd burn my trigger pants, and she assisted me in burning my trigger pants. I have pictures of me burning my trigger pants.

Ruth let Becky "control everything" during the counseling process. "She never pushed me to do anything I was too uncomfortable doing," and she "respected my boundaries," Becky stated.

For Becky, her experience with Ruth "was very collaborative," and "that's what I liked about it," she revealed. As Becky stated, "I got a lot better with her. I stopped blaming myself like a crazy nut and stopped restricting so much of who I was." In spite of her improvements, Becky admitted, "I relapsed again but not badly, and then I just sucked it up and just stopped. With Ruth, I learned I had the skills to do it myself," said Becky. She also stated, "With the cutting I learned that...and with the eating disorder, I learned that it was just a way to be numb and avoid all the shit that had happened to me in my life." Upon reflection, Becky learned the following lesson in therapy: "I was like,

‘Fuck everybody else, I am going to be me.’ That is what I learned in therapy. ‘Fuck everybody. I am going to be me.’”

Helped.

For Becky, Ruth, her second counselor helped her because she was patient, matched her emotions, allowed her to control the pace of therapy, cared about her, and understood her.

A helpful counselor, to Becky, was a counselor who matched where she was during the course of therapy:

Ruth was really good at matching my attitude, about matching my emotions that I was feeling that day, and it just showed me that she had that empathy. Cause so many times I would come into a counselor’s office, and I would be so depressed that I thought about killing myself in the parking lot, and they’d be laughing in session. You don’t laugh when I feel like I’m going to kill myself and you, too!

So yeah, she was really good about matching my emotions.

Becky explained one situation in particular, where Ruth matched her feelings during a counseling session:

I remember there were certain times when I came in, and I was so depressed and I mean, she matched me...or, she tried to match the way that I was feeling...I remember one time when I was depressed. There was not much to talk about because I didn’t have much energy. I just wanted to curl up in a corner. And, she didn’t discuss it till later and I didn’t figure it out. But, yeah, since I was feeling so low, she was trying to match where I was and she actually...well, I didn’t understand it then, but she got on the floor. And, kind of spoke to me from there

so there wouldn't be that hierarchical difference, and it helped. I understand it better now.

For Becky, she appreciated a counselor who understood her. Ruth demonstrated her understanding through her concern for her welfare. "She was really understanding," she stated. "She told me actually how she felt about it [her self-injury] and that she was concerned and that if I wanted to do something about it, she was going to help me, and basically it was like that." Ruth also "took time to understand the dynamics that were happening in the room." Through her diverse experiences in therapy, Becky learned that this was not the case for many counselors. She stated, "A lot of therapists really didn't clue into those small, very subtle details that could have a lot of meaning." Finally, Becky shared that Ruth "didn't allow me to become overly dependent on therapy, which was good. It wasn't like some passive, aggressive, manipulative borderline relationship...I really liked that. She helped me to better understand the boundaries of therapy."

Determining the pace of therapy was very helpful to Becky. She talked about how Ruth did this often in sessions. Becky stated, "She let me determine the pace of everything. Therapy was based on my subjective issues." She also shared, "She let me come up with a lot of innovative things that I thought would help me with recovery. So I was running the show, and I liked that." With Ruth, "Everything was about me, and that just showed me that she respected where I was," Becky stated.

For Becky, she appreciated a counselor who cared and demonstrated that caring attitude in counseling. "If I didn't feel like talking she would pay attention to my body language and ask me about that...which served as a vector to get to what I was feeling," she shared. "Yes, she was very...it actually seemed like she cared." For Becky, she also

found it helpful that Ruth “accepted where I was.” So, that was one thing that she did that showed that she cared,” Becky revealed.

From her own experiences in therapy, Becky gave the following advice to counselors working with women who self-injure:

Take yourself out of the equation and try to see what purpose it [the cutting or eating disorder] is serving them, and just be patient, be consistent, don’t get wrapped up in your own emotional reaction to what you are doing...And, work on their timetable.

Becky also gave the advice to women who were self-injuring. “Go to counseling...crazy,” she shared. “Yes, go to counseling, and also you can’t discount counseling just because of the rep that it has. Just like buying a pair of jeans, shop around.” She also talked specifically about the counselor’s personality:

There are a lot of other factors when it comes to counseling, other than the technique and you. There are factors...personality factors about you and the counselor, matching between you two---many things. Counseling can be effective, and it is. You just have to find the right match. And, don’t be ashamed to go, or shop around. They may think you are crazy, but oh well. Your health and well being are more important.

Didn’t Help.

For Becky, it didn’t help her when her counselors did the following: brought religion into the counseling sessions, failed to understand or acknowledge her self injury, showed little effort, betrayed her, and had her sign a no-harm contract.

Becky’s first counselor was a woman. During sessions, she talked about God and Jesus. Therefore, Becky referred to her as “Jesus Lady” throughout both interviews.

“She told me I needed God,” Becky shared. Furthermore, she continually told her that she simply needed to stop her behavior:

She was like that with everything. With the eating disorder “You just need to stop.” And “With the cutting, she didn’t even acknowledge it.” She didn’t even know the extent of the eating disorder. She didn’t know I was purging all the time because she made a comment about purging before she knew that I was purging so I figured I’m not going to tell her something else so that she can think ill of me. During sessions, she would say things like, “Well, where’s that going to get you?” And “You just need to stop.”

In Becky’s view “Jesus Lady”, was mainly there to “take her money.” Becky stated, “she didn’t care to understand me. ‘Just shut the fuck up and pay me.’ That is what I felt with her.”

In Becky’s viewpoint, “The Jesus Lady was a robot. Jesus Lady was just there to pick up her check.” She continued and stated, “She didn’t know what the fuck she was doing in counseling. So, yes that was terrible.” To her, “Jesus Lady was like she was a friend but not a very good one.” She also made Becky feel like she was a child. She shared the following:

Jesus Lady didn’t understand how families could reinforce problems. She didn’t follow up with the whole idea to invite my mother in for counseling. She was supposed to call my mom and never did. And then Jesus Lady, she didn’t help me as much as I needed. I just felt like her child. Her failure child at that.

For Becky, many of her counselors failed to understand her. For example, she talked about the counselors at the inpatient treatment facility:

They hated my fucking guts. They didn't try to understand me. They thought I was a smartaleck, know it all, little girl who was just there to disrupt things and cause problems. But, they didn't understand me...they didn't understand shit.

That is why I left.

In college, Becky worked with one counselor at the College Counseling Center. When asked if this counselor understood her, she responded, "I think she tried to make me fit a mold so that she could understand me because she only understood the mold." Becky also shared that this counselor "wasn't educated about the disorder, and I don't think she really made enough of an effort to understand cutting or to understand anorexia or understand my depression. I don't know. It seemed like coming off the street she was hired."

A final element which Becky learned didn't help her was the "no harm contract." Although she signed them a few times with her undergraduate counselors, she shared, "I told them what a joke it was when I was signing it." She never understood why, "when a patient stays they're going to cut themselves or kill themselves, you whip out your handy dandy piece of paper to make them promise that they're not going to do anything." In contrast, Becky's view of the contract shifted, when talking about a counselor whom she liked and formed a relationship with over time:

With the counselor who was actually decent...I don't know. I guess I respected her more because she seemed to respect me more. That...yeah I had to sign something once. Just once. And I think that was pretty good and yeah I think it actually kinda worked. I thought twice."

Ego Developmental Level

Becky scored at the E7, Individualistic Stage, on the SCT. An individual scoring at this level is able to internalize rules and develop her own personal list of rules that fit their own needs and experiences. At this stage, one is able to recognize her own role and significance in making decisions. Morality comes from within, rather than what the group decides. An individual functioning within this stage has an increasing ability to critically reflect, to consider alternative perspectives, and to live up to personally established ideals (Loevinger, 1976).

The ogive rule (see table 4.1) allows for some scores to be below and above the level ultimately assigned. Thus, not all of Sam's scores were scored at E7. The automatic ogive criterion requires that she attain no more than 15 ratings at E6 or lower; she had 12 ratings at E6 or lower. The explanation of ogive criterion requires that she attain 3 or more ratings at E7 or higher; she had 6 ratings at E7 or higher. Becky's total item sum was 104. The following sentence stems and her responses reveal the E7 level:

Raising a family: "is difficult; foreboding task that requires commitment and discipline tempered with love and respect."

A man's job: "is not a task that can be delineated simply on the basis of gender."

A good father: "is one who not only acknowledges the importance of his involvement in his children's lives to ensure their optimal health, but also takes measures to actually be a genuinely committed and loving father."

For a woman a career is: "whatever she is devoted to & provides a sense of meaning and fulfillment in her life."

Summary

Becky was a 22-year old African American woman who was currently in her second year as a graduate student at a small southeastern public university. She shared, “Society sees me as an African-American female or Black woman. But, then in the Black Community, I guess, because I am educated, and I don’t come from the same culture, they see me as not Black enough. So, I am kind of in this weird limbo.” As an 18-year old, Becky was “restricting a lot, bingeing/purging, exercising, and vomiting.” In addition to an eating disorder, she also started cutting and was struggling with feelings of depression. Becky’s mother and her sister were both aware of her self-injury although they didn’t fully comprehend it. Unfortunately, her mother passed away before she learned to understand Becky’s behavior. However, over time, her sister “eventually started to understand” her behavior.

In terms of her own treatment, Becky shared that her time in an inpatient treatment facility for her self-injury and eating disorder was “the worst experience of my life.” In her words, “They hated me.” In spite of these negative experiences, she also had many treatment experiences which were positive. Becky, appreciated the fact that her counselor, Ruth, let her “take responsibility for her recovery,” “control everything,” and “respect my boundaries.” She also liked the fact that her work with Ruth “was very collaborative.” Through her diverse counseling experiences, Becky learned on overarching goal: “Fuck everybody. I am going to be me.”

Becky’s counselors, specifically Ruth, helped her because “she was really good at matching my attitude and behaviors during sessions.” Additionally, she found it helpful that her counselor understood her. Ruth was also “concerned” about her harmful behaviors and she helped Becky “to better understand the boundaries of therapy.”

Determining the pace of therapy was also very helpful to Becky. She shared that Ruth “let me determine the pace of everything” and “she let me come up with a lot of innovative things that I thought would help me with recovery.

From her own experiences in therapy, Becky suggested that counselors be “patient,” and consistent” and work on their clients’ “timetable.” She also gave advice to women who were self-injuring. “Go to counseling...crazy,” she shared. She also said, “Find the right match, and don’t be ashamed to go, or shop around” to find a good counselor.

In contrast to the counseling experiences that helped, Becky also talked about her experiences which didn’t help. Becky found that the following factors didn’t help; a counselor who brought religion into the counseling sessions, didn’t understand or acknowledge her self injury, showed little effort, betrayed her, and had her sign a no-harm contract.

Interpretation

It is important to consider Becky’s life in context. Her family and her ethnicity largely influenced Becky’s experiences in counseling. During high school, Becky lived with her sister and mother; her father was absent from her life. In college, her mother became ill unexpectedly and passed away in college. As a result, Becky’s treatment and recovery occurred essentially on her own. As she struggled alone, she became fully responsible for her personal recovery and sought control of different aspects of the counseling process. She wanted to control the pace of therapy; she wanted to make suggestions in counseling, and she wanted her counselor to possess certain characteristics to her liking.

Becky scored in the upper end of the E7 stage. She evidenced a strong personality and sense of her self, which is a theme within the E7 level (Hy & Loevinger, 1996). For Becky, the pursuit of independence emerged as a prominent theme, which is demonstrated at the E7 level (Hy & Loevinger). In counseling, she wanted her therapist to see her as an individual, rather than forcing her into a specific mold. One of her counselors, Ruth, adopted this approach and Becky felt a strong sense of connection with her. In my professional opinion, this relationship served as a powerful vehicle for Becky's growth and development. At the time of the interview, it was clear that Becky continued to cherish this relationship. Her overall description of Ruth and their relationship was consistent with an individual functioning at the E7 level (Hy & Loevinger).

Becky demonstrated a strong criticism of stereotyped gender roles, which is indicative of the E7 level (Hy & Loevinger, 1996). She also was able to reflect on her life and the impact her past experiences had on her current functioning. As evidenced at the E7 level, Becky recognized that relationships are seen as continuing and changing (Hy & Loevinger). For example, her relationship with her sister was at one time, hostile but developed into a closer, meaningful relationship.

Finally, Becky possessed a strong will to achieve academically, which is evidenced at the E7 level (Hy & Loevinger, 1996). As a graduate student, she took her studies seriously and worked hard to succeed. Beyond her education and future career, Becky appeared to be striving for self-fulfillment, as well as her own personal development as a Black woman in this society.

*Analysis of Participant #10: "Kylie"**Table 4.12**List Of Themes*

THEME	SUB-THEME
MY LIFE	Family, Parents, Brother, Friends
COLLEGE	College, Women, Pressure
SELF-INJURY	Eating disorder, Pain, Control, Cope, Power
MY COUNSELOR	Friend, Objective, Connect, Guide, Trust, Right Questions
COUNSELING	Ready, Communication, Alternatives, Confidentiality, Contract, Underlying issues, Hostile
RECOVERY	Recovery, Presentation, On My Own, Medication

Introduction

Kylie, an 18 year-old Caucasian female, was a freshman at a small southeastern public university during the time of the interview. Kylie first entered counseling in the 8th grade, after a friend "found out" she had an eating disorder and contacted her school counselor who ultimately informed her parents. During this time, she worked with a counselor for approximately one year. She terminated counseling because she reportedly "convinced" her counselor that she was better, even though she was still struggling. After 6-months, Kylie returned to counseling. After briefly working with this counselor, she was referred to Gwen, the last counselor with whom she worked, before attending the college at a small southeastern public university.

The following themes (with related sub-themes) emerged from the interviews (see table 4.12): My Life (family, parents, brother, friends); College (college, women, pressure); Self-Injury (eating disorder, pain, control, cope, power); My Counselor (friend, objective, connect, guide, trust, right questions); Counseling (ready, communication, alternatives, confidentiality, contract, underlying issues, hostile); and Recovery (recovery, presentation, on my own, medication).

Themes

My Life.

According to Kylie, she never told her parents about her self-injury, although she believed they knew that she cut herself. “I have never been like, ‘I cut myself’, she shared. “I have told my church but I haven’t told my parents. I guess it is easier because you know, an eating disorder was hard enough for them, you know. I guess I didn’t want to disappoint them.” During high school, she would often hide her self-injury, keeping it from her mom and dad:

I got really good at hiding it...One time I had my pants rolled up and someone saw my scars and I was like, “Oh yeah, I was running through the woods and my pants pulled up, and thorns scratched at me.” And, that worked with my family—they had no idea.

For Kylie, involving her family in counseling sessions was both positive and negative, depending upon the counselor. If a strong client-counselor relationship was established, she saw the value in involving her family. On the other hand, she didn’t like when her counselor conducted sessions “without getting to know me first.” In Kylie’s view, “That was bad.”

Kylie's brother played a significant role in her experiences in counseling. According to Kylie, he was born with disabilities and died in December of 2005. Kylie shared that "he was at the hospital a lot his whole life." Last year, the doctors told her family that he had a degenerative disease of which he would ultimately die. However, this wasn't the case:

It turns out he didn't have that disease. We found that out three months before he died. And, then he died unexpectedly. So, that was like a...you know, your emotions are being shot down and, oh wait, they are being uplifted. And then, oh wait, no, and they would plummet to the ground. So, our emotions were up and down that whole year.

Prior to his death, Kylie made a promise to him:

When my brother died this December, I basically made him a promise that I wouldn't do it [cut myself] anymore, because I knew that if I didn't make that promise, right then, it would get so much worse; because I had so much more grief to handle. And, so basically, I made him that promise, and I haven't done it since.

In addition to her family, Kylie's friends played a significant role both in high school and in her early college experiences; some friends were supportive while others were more confrontational:

Some of them were very, very supportive and they were just like, "Let me know if you need anything." They didn't push anything on me. They were very standoffish but they were very supportive in a "if you need me to be" sort of way. On the other hand, other ones were really up in my face about it. They were like,

“Why are you doing this?” “What is wrong with you?” “Why are you trying to kill yourself?” “Why are you being so selfish?”

Just a few weeks into her freshman semester, Kylie shared that she had already made close friends. She explained her process of making and choosing friends:

I am really extreme with my friends. I don't use the terms friends loosely.

Because, friends are someone who you would like die for...and so basically, you are an acquaintance up until that point. You can be a really good acquaintance who I love spending time with, but until you are that point, you are not really a friend...I bond very easily, very quickly with some people, whereas with some people, I just will never make friends with.

College.

At the time of the interview, Kylie was in the first semester of her freshman year in college. She shared, “College is a very liberal place...Like you look at it, as compared with normal society, and it is a much more liberal place to be, generally.” On the other hand, she recognized that “it can be really scary for some people. Like basically, I have had to be an adult and be a parent for so much of my life that it is not that big of a change for me.”

For Kylie, she believed that college “is a point of change. You are walking on a tight rope and you can go either way. And I think the first year of college, especially.”

Kylie also stated,

College “is a really good bridge. You get to grow into yourself as a person and you get to discover yourself, emotionally, intellectually...it is a place of guided introspection, I think. Because, there are so many resources, just at your fingertips.

When asked what it was like to be a woman in college today, she shared the following:

It's even scarier. Cause basically, at least from my point of view, there is so much stereotyping and so many generalizations that are made about college aged women, stemming from things like "Girls Gone Wild."

She continued, "When you think of college-aged women, you think of girls taking their tops off. Or, at least I did before I came here, you know." Additionally, Kylie recognized the amplification of gender roles on college campuses:

On a whole, I think that the stereotypes are much more exaggerated, and I think that the gender roles are much more exaggerated here than in real life. Like, you wear long shorts out to a park or whatever at home and it will be like, "Oh yeah, she is working out." But, if you wear long shorts here, it is like, "Oh, she is boyish." If I don't dress up and wear heels, I am lazy or I am a tomboy.

Kylie also talked about the pressures that she has encountered already, only a few weeks into her career as a college student.

There is pressure to get good grades. Obviously, you are at this school, you know. You can't really escape that. Also, there are pressures like to maintain the honor code. And that one is a big one...It is a big one. It is probably at the same scale or higher than drinking.

Kylie shared that people take the honor code here seriously, and "if you put faith in people to be true to something that they agreed do, then generally they will. Even if it is just for the purposes of avoiding guilt." In addition to the academic pressures, Kylie talked about the social pressures in college. For example, she shared, "Drinking in

college, “is a huge, huge pressure.” Also, “There is always the pressure to have sex. But, that is everywhere.” Finally, she admitted, “There is some pressure to like try pot.”

Self-Injury.

Kylie categorized her cutting *and* her eating disorder as forms of self-injury. In her mind, both behaviors caused harm to herself, although the eating disorder was “less obvious” or visible to others. Her eating disorder, in the form of anorexia and bulimia, prompted her first experience in counseling. As Kylie recounted, when her bulimia became increasingly problematic, her parents eventually took the door hinges off her bathroom door to prevent her from purging. It was at this time when Kylie first cut herself:

There was some, like, intense intervention going on in my house. So, basically, I would get like really upset for something, and I would go into the bathroom, and I was like, well, “Shit” and I couldn’t do it [purge], and I didn’t know how else to cope, and so, basically, one time I cut my ankle, and another time I cut my ankle and it progressed.

In high school, Kylie was actively purging and actively cutting. For Kylie, her behaviors varied according the circumstance:

It just depended on my surroundings. If I was alone, and I had just eaten a lot, and I just felt really gross, I would throw up. If I was in a crowded place, and I was upset, I would cut myself. It really depended on my emotional status at the time, depending on if I was more hating myself or hating other people. If I was hating other people, I would cut myself, and generally, if I was hating myself, I would throw up.

Kylie associated self-injury with the following concepts: coping, control, pain, and power. In many ways, her self-injury became something in her life that she could control:

I had no control over so many things in my life, and so I took control over the one thing that I knew how...and for me that was food, but when I couldn't do that, because that was taken out of my control, because I was abusing that control...I took control of something else. So, I would cut myself, and then I could heal it and I could control what I cut, when I cut, how deep I cut and how to heal that, and so that basically gave me the ultimate control.

For Kylie, cutting “relieved pain.” She stated, “By focusing on one place that hurts, just kind of focuses me and brings me down.” In Kylie’s mind, this was definitely different from suicidal behavior. She shared, “With most people who engage in self-injurious behavior, they are not at that state [suicidal]. Cause I don’t know, trying to kill yourself by slitting your wrists is very different than cutting yourself because you are trying to relieve pain.”

For Kylie, her self-injury was related to power. In many ways, it gave her energy and empowered her:

So, basically, seeing my own blood was like, a rush for me. Seeing blood like trickle down my leg or something, felt really good to me. It felt empowering, it felt dangerous, I guess and that gave me a rush and a feeling, almost like playing God...that is a little extreme.

Kylie explained what it was like for her to cut herself, including her behaviors, emotions, and physical responses:

I would let it bleed, and I would watch it, and I would be like, wow, this is intense. Yeah, and I could feel like my heart rate speed up. I was very in-tune with my body while this was going on. Not, in really a healthy way but just in like a check out what is going on. And, so basically when it would stop bleeding, I would like Neosporin and bandage it up...it was not only the cause of injury and healing the injury that is power. It is also just the watching the consequences of my behavior play out in a very visual and physical way.”

For Kylie, self-injury was very metaphoric:

It was like I was bleeding out all the crap that I was dealing with. It was just like throwing up. I was throwing up everything that I didn't like. You know, I guess, emotionally it was very metaphorical. And, it calmed me down. So, I guess it was very metaphorical.

In time, counseling helped her with many of her issues related to self-injury.

Kylie related counseling to working out:

Counseling was like a workout session for your coping skills. You work out once a week. You are going to get better at working out. Same with coping. So, I am more confident in my coping skills and my skills to handle situations, myself and others.

Kylie also shared, “Counseling allowed me to get a better grip on control, when I need to take control, when I need to let go. That has helped me enormously.”

My Counselor.

Kylie worked with her third and final counselor, Emily, for approximately 3 years. Kylie began to trust her over time and appreciated the fact that she asked the right questions and served as both an objective point of view and a guide. She also learned to

trust and connect with Emily over time. Eventually, Emily became more of a friend to Kylie than a counselor: Emily enjoyed seeing her each week because she was an “objective point”:

She was just like a second mom. I could tell her that I had sex with someone; whereas, I couldn't tell my mom that. And she would give me objective advice.

It was someone to go to who was completely objective.

Kylie also liked it when Emily asked her questions during sessions. She stated that these questions were “not necessarily, “How do you feel about that?” But like, “What do you think you should have done there?” As Kylie shared, “I would respond, and she would sort of look at me. And, so I was like, ‘Wait, I should think harder about that.’”

Kylie appreciated that fact that Emily would allow her to come up with the answers to questions on her own. “She would ask the right questions. It took me two years to come up with the answer, but it wouldn't have resounded with me if she had just been, ‘Eating disorders are power struggles.’” According to Kylie, “Asking the right questions I think is like a good 40% of counseling,” she stated. She elaborated upon the types of questions counselors need to ask:

You have to know how to phrase things. You know too, it is not necessarily, “What color is that wall?” A lot of people would be like, “pink.” Or, they would say, “Is that wall pink?” But, then you want to say “yes”, but you are like, “Wait maybe it is not”, so you exam it closer you know, so it turns out actually to be like salmon.

For Kylie, she saw the importance in the way a question is phrased. “I think phrasing the questions to allow for an open-minded, deeper examination of things.”

Kylie eventually connected with Emily over time. I am actually like best friends with my counselor. We have weekly e-mails...," she shared. As Kylie stated, "I think a personal connection is really key in any therapist/patient relationship." At first, Kylie didn't talk about her self-injury or eating disorder with her counselor:

We would talk about her, her daughter or maybe school. But, we wouldn't even approach the issue of like me being sick or anything. She would be like, "How are you doing?" And I would be like, you know, "I am ok." And that was it, we would sort of skirt around the issue, we would talk about it, without talking about it, you know...So, but then once we really connected, basically, we were on the same level on a lot of things and I realized that. And, so we finally just started talking about it. It wasn't even a, "Today is the today. We are going to talk about your eating disorder." I just kind of went into it, without even realizing it.

According to Kylie, Emily gave Kylie control of the sessions. "She knew what was going on, she just had to guide me down the path, which can be very frustrating, I am sure." As a counselor, Kylie imagined "you want to tell them that but it's not going to help them. So, you just kind of have to watch them and make sure that they don't give up in the maze."

Counseling.

While in counseling, Kylie responded well to treatment when she was open and ready to the process. On the other hand, when she wasn't ready, she found that she was hostile to her counselors. As she spoke of her counseling experiences, Kylie talked about focusing on the underlying issues, the exploration of alternative behaviors, the issue of confidentiality, and no-harm contracts.

“The one thing that I have really found, through my experiences, through other peoples’ experiences that I have talked to, is basically, you won’t respond well to help or to treatment, unless you are ready,” shared Kylie. With the first two counselors she saw before Emily, Kylie wasn’t ready to stop her self-harming behavior:

I went to a counselor for about a year and then I was like, “I am all better, I swear” and obviously I was lying because I wasn’t ready to be helped...She would ask a question and I would just be like, “I don’t know.” And, I would give her a really big attitude, and usually she would fire back an attitude, and I would get even more angry. And I would just like walk out. We had a really hostile thing.

Kylie’s counseling focused not only on her self-injury, it also focused on her underlying issues, especially with her counselor, Emily. “She would talk to me about the underlying stuff,” stated Kylie. Kylie spoke extensively about the issues the existed beneath her self-injury:

The underlying issues are really the key to the behavior. So, if you can figure out what those are and help them really talk about them and work through them, then that is very helpful, and it helps treatment as well...Instead of just putting a band-aid on the issue, if you could treat the actual thing that is causing it, that is better. Kylie discovered her underlying issues “were my grandfather, I don’t get along with him well. I feel patronized when I talk to him. It makes me really angry.”

Counseling experiences with Emily also focused on developing alternatives to her self-injury. “Those just sort of came along naturally. Like, my counselor and I experimented with a whole bunch of things,” shared Kylie. For Kylie, her alternatives included “breathing relaxation, yoga, running, working out, writing, drawing with

crayons, or whatever.” But, for Kylie, what helped most were just “distractions.” She revealed, “being like, “Stop,” really helped me the most. And a counselor can’t really help you to do that. It just kind of comes with time and with effort and sometimes bad things happening.”

Kylie was glad that her counselor never had her sign a no-harm contract during her time in therapy:

I would have crumpled it up and thrown it at them. I wouldn’t have signed it.

Because, I won’t make a promise unless I can keep it. Or, I try not to...and I need to feel a deep sense of obligation to that person and that cause to make that promise. So, that wouldn’t have worked for me.

For Kylie, her contract with her brother had an entirely different meaning. “The only reason that my verbal contract with my brother worked was because my brother probably made me who I am,” she shared. For Kylie, “it has a different level of permanence to it. I feel a much deeper connection with him, obviously, then I would with someone that I had just met.”

Kylie was definitely aware of the bounds of confidentiality, in that “it can be broken if she thinks that I am causing an inordinate amount of harm to myself or others, et cetera. You know, standard stuff.” During the interviews, Kylie expressed an appreciation for Emily, who did not inform her parents about her self-injury. “It never got to the point where she would tell my parents because I think, to her, that would be so detrimental for our relationship that it would cause more harm than good.” At the same time, Kylie understood the grey line that exists with self-injury:

It is a very grey line. And so basically, it is really up to the patient and the counselor, in terms of what needs to be done. I, personally, think it should be

pushed as far as fully confidential as possible because, just with my background and feeling betrayed, you know, and like being forced into things, that would have been it. I would have never gone back.

Recovery.

Throughout her counseling experiences with Emily, Kylie was “completely part of” the recovery process. “I was an equal member, if not a majority member in my own recovery,” she stated. Kylie appreciated the fact that she could come to her own conclusions in therapy:

In my experience, it is better to ask the person a question and have them come up with their own. You know, so they figured it out for themselves. I think that is the biggest thing. Asking instead of telling. When, I came up with it, it really helped me with my process of recovery.

For Kylie, an additional component to her recovery included medicinal interventions:

We [Emily and herself] decided that medicine might be a good option for me. I started out with a low dosage of Prozac, and then we stepped up, and then I went on something else, and then I went on something else. So, currently, I am on 100mg of Prozac, 10mg of Neurotin, which is actually an anti-seizure medication, but it also has anti-depressant and anti-migraine properties. And then I am also on Zanax for anxiety, as needed.

Kylie believed in the importance of “not only taking a role in your own recovery, but also taking an active role with other people’s recovery.” Kylie started to give presentations to her church group and her high school psychology classes about her experiences with self-injury (which included cutting and eating disorders). When

speaking to her church, she shared, “You feel that sense of community and love and trust. In high school, it is not that much.” However, as Kylie, shared, “That actually ended up helping me a lot because they would ask me questions, you know, like, ‘Why did you do this?’ They were just like really straight up with me because I was really straight up with them.” She also shared that the students in her school began to respect her for giving her presentation. “They respected me for not only going through that, but like for presenting.”

Kylie believed that her presentations impacted other students:

I have had people who came up to me and they were like, you know, “I really connected with your story” and they would like wink, and I would be like, “Got it.” And you know, I would give them a card or something for my psychologist, and I would be like, “I go to her. She is excellent.”

Ego Developmental Level

Kylie scored at the E6, the Conscientious level, on the SCT. An individual scoring at this level is able to internalize rules and develop her own personal list of rules that fit their own needs and experiences. An individual at this stage is able to recognize her own role and significance in making decisions. Morality comes from within, rather than what the group decides. At this level, has an increasing ability to critically reflect, to consider alternative perspectives, and to live up to personally established ideals (Loevinger, 1976).

The ogive rule (see table 4.1) allows for some scores to be below and above the level ultimately assigned. Thus, not all of Kylie’s scores were scored at E6. The automatic ogive criterion requires that she attain no more than 12 ratings at E5 or lower; she had 12 ratings at E5 or lower. The explanation of ogive criterion requires that she

attain 6 or more ratings at E6 or higher; she had 8 ratings at E6 or higher. Kylie's total item sum was 94. The following sentence stems and her responses reveal the E6 level:

Rules are: "necessary but need to be reasonable."

Men are lucky because: "they face less oppression in society and the workplace."

A husband has a right: "to be lived and treated with respect and---same as wife."

A women should always: "be realistic."

Summary

Kylie, an 18-year old freshman in college, first entered counseling as a result of an eating disorder. Her parents were aware of her eating disorder, but she never told them about cutting herself. Kylie shared that she had a close relationship with her brother, who died less than a year before our interview together. Before her brother passed away, she promised him that she would not cut herself, and she had remained true to the promise at the time of the interview. In addition to her family, Kylie also talked about her friends from high school and her newly acquired friends in college. Some of Kylie's friends were "very supportive" while others were really more confrontational and would say things like, "What is wrong with you?" Or "Why are you being so selfish?"

Kylie, categorized both her eating disorder and cutting as forms of self-injury. She first entered counseling as a result of anorexia and bulimia. When her parents took the hinges of the bathroom door to prevent her from purging, Kylie reportedly found a new coping behavior, cutting. As Kylie stated, "if I was hating other people, I would cut myself, and generally, if I was hating myself, I would throw up." As she talked about her self-injury during both interviews, Kylie talked about the role of coping, control, pain, and power.

Kylie worked with her third and final counselor, Emily, for approximately three years. Eventually, she began to trust her, and she appreciated the fact that Emily was an “objective point” and asked the right questions. After all, as Kylie said, “Asking the right questions, I think is like a good 40% of counseling. In counseling, Emily also served as a guide with whom she was able to connect over time. For Kylie, “A personal connection is really key in any therapist/patient relationship.” She definitely had this connection with Emily. It was the collection of these behaviors that allowed her to develop a friendship with Emily. “We are like best friends,” shared Kylie.

When Kylie was ready to get help, she responded well to treatment. In contrast, when she wasn’t ready, she was hostile and would give her counselor a “really big attitude.” Her counselor, Emily, focused on her self-injury as well as the issues that existed beneath her self-injury. As Kylie stated, “The underlying issues are really the key to the behavior.” Counseling sessions with Emily also focused on developing alternatives to her self-injury. These alternatives included “breathing relaxation, yoga, running, working out, writing, drawing with crayons, or whatever.” But, for Kylie, she found that “distractions” worked the best.

Kylie was glad that her counselor never had her sign a no-harm contract. After all, Kylie shared, “I would have crumpled it up and thrown it at them.” She also appreciated the fact that her counselor did not inform her parents about her cutting. For her, that “would be so detrimental for our relationship that it would have caused more harm than good.”

Kylie believed in the importance of being “an equal member if not a majority member in my own recovery.” For Kylie, she appreciated the fact that she could come to her own conclusions in therapy. When this happened, “it really helped me with my

process of recovery.” As a part of her recovery, she and her counselor decided that medicine was a “good option” for her. She was currently taking Prozac, Neurotin, and Zanax, as needed. In addition to taking an active role in her own recovery, she also played an integral role in other people’s recovery, giving presentations about self-injury to her church and her high school psychology classes. These presentations helped her, and she believed that her audiences respected her for giving them.

Kylie was in her first year of college at the time of the interview. For her, college “is a point of change, a place to “get to grow into yourself as a person,” and “a place of guided introspection.” In college, Kylie stated, the “stereotypes are much more exaggerated, and I think that the gender roles are much more exaggerated here than in real life. Also, college is an environment with different pressures, both academic and social.” Kylie shared that there is pressure to get good grades, to maintain the honor code, to drink, to smoke pot, and have sex.

Interpretation

Kylie was involved in counseling for approximately four years; she worked with one counselor for approximately 6 months, another for only a few sessions, and her final counselor for more than three years. It is likely that the length of time in therapy influenced her overall satisfaction with her counselor and the counseling process. Kylie’s connection with her counselor, Emily, was gradual, and over time she began to view her counselor as her friend, rather than her counselor. With the two other counselors, she was not able to form a trusting relationship, and these experiences were consequently not as meaningful to her.

Kylie’s mode of self-injury became very purposeful and satisfied two completely different feelings. Cutting allowed her to visually manifest her anger towards others onto

herself. On the other hand, she purged to void her body of her negative or hateful feelings towards herself.

Kylie scored at the E6, Conscientious Stage, on the SCT. Her relationship with her counselor was critically important to her and contributed significantly to her improvements in therapy. Consistent with the E6 level, she was honest with both herself and her counselor during the course of treatment (Hy & Loevinger, 1996). For Kylie, her relationship with her counselor was more like a friend or peer. Her evaluation of this statement is consistent with a person functioning at the E6 level; ideas such as companionship are important at this stage (Hy & Loevinger).

As indicative of the E6 level, Kylie was able to critically reflect upon her feelings and actions (Hy & Loevinger, 1996). For Kylie, cutting was primarily about control. When she was actively cutting and purging, the issues surrounding control appeared to be excessive, which is common at the E6 level (Hy & Loevinger). However, this was not the case at the time of the interviews; since she stopped cutting and purging, it appeared that her issues surrounding control were mainly resolved.

Kylie thoughtfully expressed a range of feelings related to her cutting, purging, and additional emotional issues. She also spoke critically of gender roles and the exaggeration of stereotypes for women in a college setting. Although discussion of gender roles is common at the E6 level (Hy & Loevinger, 1996), her discussion was more consistent with a person functioning at the E7 level, due to the critical nature of her discussion.

Chapter Summary

This chapter presented the within-case analysis of each participant. Included in each separate case were all findings themes with related sub-themes, in the participants'

own terms. Each analysis was followed with individual ego development levels, as well as my own interpretation of their functioning levels. The following chapter, Chapter 5, will be a presentation of the cross-case analysis, of all participants.

CHAPTER FIVE
CROSS CASE ANALYSIS

Chapter Four represented a within case analysis of each participant and these findings included themes and sub-themes for each participant. Ego developmental scores and a brief interpretation of the findings followed each case presentation. Chapter Five represents a cross-case analysis of the ten participants in the study. Unlike Chapter Four, which relied on indigenous themes, Chapter Five will include interpretive themes. Interpretive themes no longer reflect the participants' voices. Rather, these themes are in the words of the researcher, myself.

At the end of each theme, will be a summary of the ego development analysis. The ego development levels of participants ranged from the E5, Self-aware stage to the E7, the Individualistic stage. The modal level was E7, Individualistic Stage, with a total of 5 of the women functioning at this stage. This section will be divided into three groups--E5, E6 and E7. The following table a list of participants according to stage and grouping profile:

Table 5.1

Ego Development Grouping

EGO DEVELOPMENT LEVEL	PARTICIPANT GROUPING
E5	Claire, Juliana
E6	Kylie, Katie, Juliana
E7	Sam, Ann, Jane, Calliope, Becky

Overview of Analysis

In the next step of analysis, I explored and examined all participants' themes and sub-themes. Then, I found similarities, using my own interpretive language, across all participants. To qualify as a cross-case theme, the theme must be present in at least three within-case analyses. The foregoing analysis procedures resulted in the following six themes; the related sub-themes are included in the parentheses; About Myself (family, friends), Self-Injury (Describing Cutting, How I learned about it, privacy, eating disorder), College Experience (pressures, being a women in college, transitions), A Helpful Counselor (helpful, not helpful), Counseling Techniques (alternatives, questions, talk, contract), Treatment (different methods, college counseling center, focus of treatment), and Experiences In Counseling (feelings in counseling, behaviors in counseling, suggestions for the future). The chapter will proceed in the order of these themes. The following table (5.2) represents an illustration of the cross-case themes:

Table 5.2

Cross-Case Themes

WOMEN	IMPORT. RELATIONSHIPS: Family Friends	SELF-INJURY Describing Cutting, How I Learned About It, Privacy, Eating Disorder	COLLEGE EXPERIENCE Pressures, Being A Woman, Transitions	A HELPFUL COUNSELOR: Helpful, Not Helpful	THE COUNSELING PROCESS: Techniques, Forms of Treatment, Focus on Treatment	EXPERIENCES IN COUNSELING Feelings, Behaviors, Suggestions
Amy	Family, Friends	Describing, Privacy	Pressures, Being a Woman	Helpful, Not Helpful	Techniques, Forms	Feelings, Behaviors, Suggestions
Claire	Family, Friends	Describing, Privacy, How I Learned	Transitions, Pressures	Helpful	Techniques, Focus, Forms	Feelings, Suggestions
Sam	Family, Friends	Describing, Privacy, Eating Disorder	Pressures, Being a woman	Helpful	Techniques	Suggestions
Ann	Family, Friends	Describing, Privacy	Being a woman	Helpful, Not Helpful	Techniques, Forms, Focus	Feelings, Behaviors, Suggestions
Juliana	Family, Friends	Describing, Eating Disorder	Being a woman, Pressures	Helpful	Techniques, Forms	Feelings, Behaviors, Suggestions
Katie	Family, Friends	Describing		Helpful, Not Helpful	Techniques, Forms	Feelings, Suggestions
Calliope	Family, Friends	Describing	Being a Woman, Pressures	Helpful	Techniques, Focus, Forms	Feelings, Behaviors, Suggestions
Jane	Family, Friends	Describing, How I Learned	Being a Woman	Helpful, Not Helpful	Techniques, Forms	Suggestions
Becky	Family	How I Learned, Eating Disorder		Helpful, Not Helpful	Techniques, Forms	Feelings Suggestions
Kylie	Family, Friends	Describing, Eating Disorder	Being a Woman, Pressures	Helpful	Techniques, Forms, Focus	Feelings, Behaviors, Suggestions

Theme One: Important Relationships

Nine of the total ten women talked about their family, and seven women talked about their friends. Upon review of their comments, it seemed as they were actually talking about Important Relationships. This interpretive theme, Important Relationships, includes sub-themes related to the participants' *family* and *friends*. For the sub-theme of *family*, the participants talked about their *parents* and *mother*, and for the sub-theme of *friends*, the participants talked about *finding out* and *friends with problems*.

Family

Parents.

Seven of the interviewed women talked about the role of their parents. Three of the participants talked about their parents' reactions to their self-injury and their involvement in getting them treatment. Four of the women spoke about their decision not to tell their parents about their self-injury.

The interviewed women experienced a diverse range of reactions from their parents. Ann's parents "pretended it didn't exist," or it "didn't happen," failing to address or talk about her self-injury with her. However, her parents did bring her to a doctor once they discovered that she was harming herself. In Ann's mind, her parents got her treatment because they were concerned about how her behavior would reflect upon the family: "My dad is like really big on the image of the family, and that was a bad image so he was trying to take care of that," she stated. Katy's parents also initiated her involvement in counseling. However, Katy felt like her parents didn't take the time to find someone that was "good." She shared the following about her parents' attempt to get her counseling:

They [my mom and dad] were so desperate to locate somebody, and they both are very private people and so they couldn't turn to their friends to say, 'We need help.' So, it was mostly just looking in the phonebook to find somebody whose schedule worked with theirs and mine after school.

Juliana's parents were similar to Katy and Ann's, in that they helped her to get treatment. However, Juliana shared that her parents often complained about how much her counseling cost:

At one point I ended up going to a state school. I will never forget my mother saying, "We wasted all of that money for you to get better, for you to go to a state school"...That is a horrible thing to say to your child...a horrible thing.

Her parents also felt like they knew the cause of her self-injury, and they often chastised her for her behaviors; her family believed that she "lacked self-control" and were frustrated that she was not able to behave in a "normal pattern."

Calliope shared openly that when she was harming herself in high school with safety pins and razors, her parents "didn't know." Amy and Kylie also initially hid their self-injury from their parents. For Amy, she didn't want to "upset" her parents, "hurt them," or "let them down." Kylie echoed similar sentiments and stated, "I didn't want to disappoint them." However, for Kylie, she believed that her parents probably knew about her self-injury, although they never spoke of it. Claire also felt this way; for her, she never talked about her cutting directly with her parents.

Mother.

Six women talked specifically about the role of their mothers. Four of the mothers were concerned or supportive, while two of the participants talked about the lack of support or understanding they received from their mothers.

Becky's mother found out about her self-injury when she was in college, shortly before she passed away. According to Becky, her mother did not "understand" her behavior, and they only talked about it briefly about it on one occasion. Additionally, Ann's mother also didn't "understand" her behavior; she was determined that it was "just a phase."

In contrast to Becky and Ann, Calliope, Amy, Jane and Claire talked about the support their mothers gave them or the concern they expressed during the counseling process.

Jane's mother was very agreeable and helped her immediately to get counseling. Additionally, Calliope's mother, who learned about her self-injury in college (long after she started harming herself), took the news of her self-injury "really well." In fact, her mother shared with her that she had cut herself one time in high school. For Calliope, she preferred to speak to her mother, rather than her father, about her self-injury. In her eyes, "It seemed like a girl issue." Amy's mother was supportive in her reaction to her self-injury and expressed a great deal of concern. In fact, Amy shared, "It was one of the only times I have seen her mother cry. I felt really bad...I obviously got really upset because she was so upset..." Katy's mother reacted in a similar manner. She shared, "For a long time after she couldn't look at my baby pictures because she said, you know, here was this perfect child who was unblemished in some ways, and she wasn't just talking physically but also emotionally and how painful it was to not blame herself..."

Friends

Knowing.

Six of the participants talked about the significance of their friends knowing or not knowing about their self-injury. For Calliope, only a couple of her close friends were

aware of her cutting during high school, although she didn't talk about it often with them. She shared, "I wanted to have fun and I didn't want to be a burden on them."

Claire, Sam, Kylie, and Juliana talked about their self-injury with friends. Sam's friends were upset when they discovered that she was cutting herself. However, they encouraged her to talk to them about their problems, and she found this to be extremely helpful. Kylie experienced encouragement from her friends, as well. Many of her friends were supportive and often let her know they were there for her, but never pushed any of their views upon her. Juliana's friends were also supportive, but in a different manner from Sam and Kylie's friends. Juliana shared that she had one friend who would transport her to a store so she could purchase gauze and alcohol, the necessary supplies which cleansed her wounds after cutting.

In contrast, Kylie had some friends who were angry towards her for harming herself. For example, some friends "were really up in my face about it. They were like, 'Why are you doing this?' 'What is wrong with you?' 'Why are you trying to kill yourself?' 'Why are you being so selfish?'" Like Kylie, Claire had one friend that she told in college, was "really upset," notifying both the school and her parents; this friend was ultimately responsible for her initial experiences in counseling. Claire explained that her friend's approach "was kind of weird. I think it would have been better if it worked out differently."

Friends with Problems.

Four of the ten women interviewed talked about having friends with problems. Ann and Calliope both talked about friends who also engaged in self-injury. Ann shared that many of her friends had problems and were "sketchy." She commented that "one of the worst days" of her life was when she learned that a close friend was also cutting

herself. Calliope also had friends who were engaging in self-injury. She shared, “I guess it seemed normal because a lot of my friends were very smart girls, so I thought it must be kind of normal for smart girls to cut themselves.”

Although Kylie and Katy didn’t talk about their friends specifically cutting themselves, they did share that many of their friends had emotional problems. For Katy, many of her friends had eating disorders, like herself. Additionally, Juliana had a close group of friends in college with a variety of different mental health concerns. She talked about one friend who had attempted suicide “numerous times” and another friend who had “very serious chronic depression.”

Summary Interpretation

Family relationships and friendships were significant to all of the interviewed participants. Six of the ten women talked about their parents’ reactions to their self-injury and their level of involvement during the counseling process. However, what was notable was that more than half of the women talked about the role their mothers played in their lives, how they reacted to their self-injury and how they supported or failed to support the participants during the counseling process. In addition to the family relationships, six out of the ten participants talked about their friendships. A total of seven of the participants talked about their friends knowing or not knowing about their self-injury. Six of these women chose to tell a select group of friends, and this decision resulted in diverse reactions; some friends were concerned and upset, while others were angry. One friend in particular went as far as driving the participant to the store to get cleaning supplies, which aided the participant in the completion of their cutting ritual. This interpretive theme says little about the participants’ actual experiences in counseling. However, these important relationships are integral to understanding who

each of these participants is and how her familial relationships and friendships may or may not have influenced who she ultimately was at the time of the interview.

Application of ego development to Interpretive Theme

This section will demonstrate the application of ego development to the interpretive theme, Important Relationships. The first grouping will examine the participants' responses at the E5 Level (Self-aware Stage), the second grouping will examine participants' responses E6 Level (Conscientious Stage) and the final grouping will examine the participants' responses at the E7 Level (Individualistic Stage).

E5 Level/Self-aware Stage (Claire, Juliana).

Attitudes and beliefs consistent with the Self-aware stage emerged within this interpretive theme.

The attitudes and beliefs of Claire and Juliana appeared consistent with the E5 level. Rather than thinking of the exclusive categories of right and wrong, a person at the E5 level thinks about appropriateness: what is right for the time, place, and situation (Hy & Loevinger, 1996).

This was reflected in both Claire and Juliana's responses. Claire spoke critically about the actions of one of her friends, who found out about her self-injury and notified her parents and school officials. In response to her friend's actions, she shared that this approach was "weird" and she "wished it worked out differently." Although Claire appreciated help from her friend, she believed her friend's approach was not appropriate and almost drastic for that particular situation.

The theme of appropriateness emerged in Juliana's discussions about her parents. For example, she shared the following:

I went to a state school. I will never forget my mother saying, “We wasted all of that money for you to get better, for you to go to a state school”...That is a horrible thing to say to your child...a horrible thing.

Juliana recognized that her mother’s statement was not only insensitive for anyone to say, but it was particularly “awful” for a *mother* to say to *her daughter*.

E6 Level/Conscientious Stage: (Amy, Katie, Kylie).

Attitudes and beliefs consistent with the Conscientious stage emerged within this interpretive theme.

As indicative of the E6 level, guilt arises when one has hurt another person (Hy & Loevinger, 1996). This concept was illuminated with Kylie, Amy, and Katie. For example, Kylie didn’t tell her parents about her self-injury because she didn’t want to “disappoint them.” Amy echoed similar sentiments and shared that she kept her self-injury from her parents because she didn’t want to “upset” them, “hurt them,” or “let them down.” Eventually, Amy’s mother discovered that she was cutting herself, and Amy talked about the impact of her mother’s reaction. She shared, “I felt really bad...I obviously got really upset because she was so upset...”

As indicative of the E6 level, decisions are made for reasons (Hy & Loevinger, 1996). This concept was demonstrated with the women who scored at the E6 level. Amy shared that her parents, who were very “private people” and “didn’t feel comfortable talking to their friends for guidance.” As a result, they looked in the phonebook to find a counselor for Amy. This description clearly demonstrates that Amy recognized that certain decisions are made for reasons. This concept also emerged in Juliana’s dialogue. She shared that she decided to talk her friend about her self-injury for “practical reasons.” These practical reasons involved her friend providing her transportation so she could

attain the necessary tools to harm herself and care for her wounds, such as gauze and rubbing alcohol. Again, Juliana's decision to contact a friend was for a clear-cut reason--to get supplies to clean her wounds.

E7 Level/Individualistic Stage: (Sam, Ann, Calliope, Jane, Becky).

Attitudes and beliefs consistent with the E7, Individualistic stage emerged within this interpretive theme.

At the E7 level, problems of dependence in relationships are considered. This was evidenced in Calliope's responses. She shared that "only a couple of her close friends were aware of her cutting during high school, although she didn't talk about it often with them. She said, "I wanted to have fun, and I didn't want to be a burden on them." Calliope didn't want to become emotionally dependent upon her friends; for her, it was easier to keep her self-injury from her friends and share her feelings only with her counselor.

As indicative of the Individualistic Stage, there is a greater complexity in conception of interpersonal interaction (Hy & Loevinger, 1998). When talking about the sub-theme, *friends with problems*, both Ann and Calliope talked in depth about their friends who were also cutting. Their discussions about the impact of their friends cutting and the reasons behind their self-injury were reflective and demonstrated a keen awareness of their interpersonal interactions. In comparison, Ann and Katy (who scored at the E6 level) also talked about their *friends with problems*; however, their descriptions were far less complex and in depth.

Psychological causality is one trait found within the E7 level (Hy & Loevinger, 1998). Sam evidenced awareness of psychological causality within her interpersonal relationships. For example, her friends were extremely upset about her behavior and

encouraged her to talk to them about their problems. As a result, Sam was thankful for her friends' support and found them to be extremely helpful to her. This demonstrates that Sam was able to make the connection between her friends' behaviors and her own emotions. This was contrary to Kylie (who scored at the E6 level); she only commented about the encouragement her friends gave her; she didn't make the leap to talk about how these behaviors impacted her on an emotional level.

Theme Two: Self-Injury

All ten participants talked about different aspects of their self-injury, in terms of their physical and emotional responses. They also talked about how they learned about the behavior and how they worked hard to keep it from others. Finally, the women spoke about eating disorders as a form of self-injury. Upon review of their comments, it seemed as they were actually talking about self-injury. This interpretive theme, *Self-Injury*, fell into four separate groups: *describing cutting*, *a learned behavior*, *privacy*, and *eating disorders*.

Describing Cutting

Nine out of the ten participants described their cutting behaviors, in terms of suicide, pain, feelings, physical responses, and coping.

Suicide.

Three of the participants talked about their suicide attempts or suicidal ideations and the distinct differences between self-injury and suicide. Ann admitted that she had two previous suicide attempts, yet she saw these attempts as different from the times she was cutting herself; "the cutting was more because I couldn't cry," and "the suicide was just like I couldn't handle it." Jane, on the other hand, shared that she did not attempt suicide; however, she was removed from school for "suicidal gesturing." For Jane, it was

hard to “classify” this injury. On the one hand she admitted, “It wasn’t that, I want to kill myself, but I am just going to go with it and see where it goes. If I die, fine. If not, it will be more of the same.” In contrast to Ann and Claire, Sam did not exhibit suicidal behaviors. However, she did express thoughts of overdosing on pills to a friend in college. In spite of this experience, she shared that cutting was not “terminal,” meaning that the behavior was never an attempt to end her life. Finally, Kylie expanded on the differences between cutting and a suicide attempt, as she stated, “Trying to kill yourself by slitting your wrists is very different than cutting yourself because you are trying to relieve pain.”

Pain.

Four of the participants talked about the physical and emotional pain they were experiencing. Each of the participants shared how the cutting was a physical representation of the emotional pain she was experiencing. Amy shared, “The pain inside was so much, and like I didn’t want to talk about it so it was just easier to cut and feel some sort of physical manifestation of the emotional pain.” Calliope and Becky nearly replicated this explanation as they both talked about how the act of cutting was about taking the pain emotionally and manifesting it in a physical form. Finally, Sam agreed; for her, cutting allowed her not to “have the pain inside by externalizing it.”

Feelings.

Four women, Calliope, Jane, Becky, and Amy, talked about their feelings and how they directly or indirectly influenced them to cut themselves. Calliope talked about the specific feelings that drove her to cut herself. Calliope cut herself when she was feeling upset or mad at herself. For example, she stated, “I would get really mad at myself. I’d be like, ‘You did really bad on your test,’ and I would cut myself when I

would get upset.” On the other hand, Jane struggled with feelings of depression. As Jane stated, “I feel that I like my depressed self because I was always thinking, I was always thoughtful, contemplative, and so, I was always thinking about life, and me.” For Jane, her depression was related to what she referred to as an “existential crisis.” When she was cutting, she asked herself the following question:

If you are here on this earth for no reason and you are happy, that is one thing...But, if you are here on this earth and you are depressed, then why are you here at all? You should just get it over with.

Becky and Amy also talked about their feelings of depression. Becky shared, “It’s not even empty...it’s past empty. It’s worse than empty. It’s like an unidentifiable pain that you have.” Amy shared that her feelings of unhappiness and depression ultimately caused her to cut herself off from other people. As she described, “I got into a very, very bad place in my head.”

Physical Aspects.

Three of the participants talked about the physical aspects of cutting. For Sam, she often cut herself when she was feeling stressed, and her cutting allowed her to have a physical “release” from this stress. On the other hand, Ann believed that her cutting represented a physical expression of her feelings. As she stated, “I was a girl who instead of crying, cuts.” Kylie was the only woman to explain in detail about the physical aspects of cutting. She shared,

Seeing my own blood was like, a rush for me. That sounds so gross...But, seeing blood like trickle down my leg or something, felt really good to me. It felt empowering, it felt dangerous, I guess, and that gave me a rush and a feeling, almost like playing God...that is a little extreme. But, and so then, basically, you

know, I would let it bleed, and I would watch it, and I would be like, wow, this is intense.

Coping.

Three of the women, Juliana, Katy, and Kylie, each talked about how cutting served as a coping behavior for them. For Katy, she first started cutting as a means of control, but it eventually developed into a coping mechanism. She stated, "I didn't have any control in my life, and that [self-injury] was the only way to exercise some kind of command over what was happening to me." For Kylie, she cut because she "didn't know how else to cope." Additionally, Juliana talked extensively about cutting as a coping behavior. She often switched coping behaviors. For example, if she stopped cutting, she started smoking or drinking. She also shared when her eating disorder was at its peak, her cutting was at its lowest point, and conversely, when she "recovered from the eating disorder, the cutting got worse.."

A Learned Behavior

Five of the interviewed women talked about how they learned about cutting; three talked about how they learned about the behavior from television or a book, while two participants talked about how they learned about cutting from other people.

Jane first heard about cutting from a book, while Claire and Becky learned about it from television. Claire shared, "My senior year in English they made us read *Reviving Ophelia*, that talks about like girls with problems, and I was like, "I'm a girl with problems," and it was like, here is what people do when they have problems." Jane and Becky both talked about two different television programs which influenced their initial experiences with cutting. For Jane, she got the idea to cut from an episode of *7th Heaven*. Jane shared, "I had never heard of it before then." Becky first learned about

cutting from a movie, *Secret Cutting*, on the USA Network. Shortly after watching the movie, she shared, “I tried it and it was magic.”

Both Calliope and Juliana learned about self-injury from other women. Calliope shared, “I went to a nerd camp. I loved it. It was such a great time. I was really happy there. But, I remember my friend showed me her arm....it was horrible.” Although she didn’t cut herself immediately after this incident, she believed that it impacted her early experiences with self-injury. Juliana discovered the behavior in an inpatient treatment facility for her eating disorder. Upon reflection, she learned about self-injury from watching a woman in her group session who would scratch her hands and pick her cuticles. “I essentially picked up [this behavior] from watching her,” Juliana shared.

Privacy

Four of the women talked about how self-injury was a private matter, which they often hid from others for a variety of different reasons. For Amy, although she is no longer actively cutting, she still did not want her history of self-injury to be known to others, for fear that she will be looked at “differently.” She admitted that there was “some sort of shame attached to” the behavior and therefore shared, “I don’t want it to come up in somebody’s conversation with someone else. I don’t want it to be spread around.” For Sam, her self-injury was something that she didn’t like to talk about with her family, friends *and* counselors. She shared that her counselor often asked her about her cutting and she “didn’t want to talk about it. It was just my thing.” She continued, “I’m not proud of it at all. But I just mean...it’s not something you want to talk about with other people.”

For Claire and Juliana, they not only kept their self-injury from their family and friends, but they also hid it from their therapists. Claire learned that if she told her

therapist she was no longer cutting, she would no longer have to attend sessions.

Additionally, Juliana learned how to keep it from her therapists through others in the inpatient treatment facility. She stated, “Everyone in the room teaches you. If you have a plan [to hurt yourself] you can’t...don’t say anything.”

Eating Disorder

Four of the interviewed women talked about their experiences with an eating disorder. Throughout the interviews, they each viewed their eating disorder as a type of self-injury, although distinct from their cutting. All four of the women, Juliana, Sam, Becky, and Kylie first entered counseling as a result of their eating disorders. Kylie shared that her cutting overlapped with her eating disorder. For Kylie, she either cut herself or purged, depending upon the surroundings. She shared, “if I was in a place where I couldn’t throw-up being unnoticed, like a public bathroom or crowded something, I would cut.”

Both Juliana and Becky both received inpatient treatment for their self-injury. Becky received inpatient treatment for anorexia and bulimia during two separate periods in college. Juliana was significantly younger during her inpatient treatment experience. At the age of 12, she was admitted to an inpatient center for anorexia and bulimia. Her cutting, which she recognized as a “separate sort of illness,” manifested itself in this center, after she observed other patients engaging in the behavior.

Summary Interpretation

While the majority of the interview questions did not focus on their experiences with self-injury specifically, all ten women interviewed talked about at least one aspect of self-injury. Nine out of the ten women described their cutting in terms of coping, feelings, pain, and physical aspects. Four explained how self-injury was distinct from

suicidal ideation. Privacy emerged as a prominent theme, as four women spoke about the importance of hiding their self-injury from family, friends, or their therapists. I found it compelling that four women with a history of eating disorders viewed their eating disorder as a form of self-injury, distinct from their cutting behaviors. All four of these participants first entered therapy due to their eating disorders. The participants' extensive discussion about cutting indicates that that this behavior is a multi-layered phenomenon, with emotional, psychological, and physical repercussions.

Application of ego development to Interpretive Theme

This section will demonstrate the application of ego development to the interpretive theme, Self Injury. The first grouping will examine the participants' responses at the E5 Level (Self-aware Stage), the second grouping will examine participants' responses E6 Level (Conscientious Stage), and the final grouping will examine the participants' responses at the E7 Level (Individualistic Stage).

E5 Level/Self-Aware Stage: (Claire, Juliana).

Attitudes and beliefs consistent with the E5 level emerged within this interpretive theme.

Claire and Juliana's attitudes and beliefs appeared consistent with the E5 level. They both demonstrated an increased Self-awareness, which is evidenced at the Self-aware stage (Hy & Loevinger, 1996). However, their evaluative statements were rather simplistic and were focused more on their behaviors than their thoughts or emotions. For example, Claire revealed that she started cutting after reading a book in high school. She stated, "In English they made us read *Reviving Ophelia* that talks about like girls with problems and I was like, 'I'm a girl with problems,' and it was like...here's what people do when they have problems." Juliana also talked about how she learned to cut herself.

She shared that she learned the behavior after watching a woman in her inpatient group therapy session. She shared, “I essentially picked up [this behavior] from watching her.” Again, both Juliana and Claire’s responses and reasoning demonstrated an understanding of themselves and their behaviors. However, their explanations were simplistic and cursory, especially when compared to Jane, Becky, and Calliope, who also talked about how they learned about cutting, and scored at the Self-aware stage.

The Self-aware stage is still basically a version of conformity (Hy & Loevinger, 1996). Aspects of conformity emerged in the responses of Claire and Juliana. Juliana conformed to the expectations of the inpatient counseling group; she learned from others what to say and what not to say to therapists. Additionally, Claire conformed to the expectations of her counselor during therapy. In time, she learned that if she told her therapist she was no longer cutting, she no longer had to attend sessions. Furthermore, it communicated to her therapist that she was improving and possibly meeting his/her expectations for recovery.

E6 Level/Conscientious Stage: (Amy, Katie, Kylie).

Attitudes and beliefs consistent with the E6 level emerged within this interpretive theme.

Self-evaluative statements are important and inner states are described in vivid terms at the E6 level. Amy, Kylie, and Katie, each demonstrated one or both of these features of the E6 level. When describing her feelings related to self-injury, Amy shared,

I felt like I was losing my place. I was very unhappy, started cutting and removed myself from all sort of social situations, sort of cut myself off from other people. I got into a very, very bad place in my head.

Through this discourse Amy illustrated a clear picture of her emotional status at the time she started cutting. Kylie also painted a vivid picture as she talked about the physical aspects of cutting. She shared,

Basically, seeing my own blood was like, a rush for me. That sounds so gross...But, seeing blood like trickle down my leg or something, felt really good to me. It felt empowering, it felt dangerous, I guess and that gave me a rush and a feeling...

Finally, Katie talked about how her self-injury served as a coping mechanism. While her dialogue was not exactly a vivid description of her feelings, it was certainly self-evaluative. She shared,

I didn't have any control in my life, and that [self-injury] was the only way to exercise some kind of command over what was happening to me. And, then, as time kind of went on, it became a coping mechanism and more of just an outlet for frustration...

This dialogue demonstrates that Katy was able to critically evaluate her own actions and keenly aware of her inner self.

E7 Level/Individualistic Stage: (Sam, Ann, Calliope, Jane, Becky).

Attitudes and beliefs consistent with the E7 level emerged within this interpretive theme.

An individual functioning at the E7 level is able to demonstrate psychological causality (Hy & Loevinger, 1996). For example, Calliope talked about the specific feelings that drove her to cut herself. "I would get really mad at myself. I'd be like, 'You did really bad on your test,' and I would cut myself when I would get upset." This description demonstrates that Calliope was aware of what specifically drove her to harm

herself-a feature of psychological causality. Ann was also able to make links between her actions and emotions. Ann believed cutting was the only way she expressed her feelings. She stated she was a girl who, “instead of crying, cuts.” This statement also demonstrates psychological causality; Ann understood that her inability to cry contributed or even caused her to cut herself.

At the E7 level, emotions are reported at greater depth (Hy & Loevinger, 1996). Jane and Becky spoke openly about their feelings, and their descriptions were multifaceted and in depth. For example, Jane spoke about her feelings of depression and how she actually liked her depressed self because she was more “contemplative” in this state. Her depressed state was reflective of an existential crisis. She shared,

If you are here on this earth for no reason and you are happy, that is one thing.

Which is kind of how I feel about it now. But, if you are here on this earth, and you are depressed, then why are you here at all? You should just get it over with.

Additionally, Becky used descriptive phrases to paint a picture of what her depression felt like: “It’s worse than empty, it’s like an un-definable pain that you have. It’s something that’s so intangible which makes you even more confused...” This dialogue also demonstrates that Becky had the ability to talk about her emotions at a deep level.

Theme Three: College Experience

Nine of the ten women talked about their college experiences. Their responses were divided into three separate sub-themes: pressures, being a woman, and transitions. Upon review of their comments, it seemed as they were actually talking about the college experience. This interpretive theme, *College Experience*, includes three sub-themes, *pressures, being a college-aged women, and transitions*. The first sub-theme falls into

two separate sections, *academic pressures* and *social pressures*. The second and third sub-theme, being *a college-aged women* and *transitions*, stand on their own.

Pressures

Nine of interviewed women talked about the pressures women face in college. Their comments fell into two separate groups, academic pressures and social pressures.

Social Pressures.

Eight of the women talked about the academic pressures they experienced in college. Three of the women talked about general social pressures, while two of the women talked about social pressures specific to women.

Sam, Ann, Kylie and Claire talked about the challenges of behaving a certain way or “fitting in” the social scene in college. For Sam, the “social pressures” or the “social scene” was one of the “hardest things” for her to negotiate. She realized, “Not a lot of people see it that way. Many people are like, ‘This is the best four years of my life.’ I am like, ‘No, they are not.’ You are like in limbo a lot of times.” Ann also talked about her struggle to fit into the particular social scene in college. As a college student, she was surprised to find that cliques still existed on a college campus. She shared, “It is like high school, but on a bigger level.” Claire also talked about the pressures of acting a certain way or fitting the typical college student mold. She shared, “You are expected to be a certain way, to be interested in certain things. You know, hang out with certain people. For me, it was kind of hard to fit in exactly.” Finally, Kylie talked about some of the specific pressures that college students may encounter, in order to fit in or be accepted. She talked briefly about the pressures to drink socially, to try pot, and to have sex.

Juliana, Calliope, Jane, and Amy each talked about the social pressures related to being a woman in college. More specifically, they talked about the pressure to uphold a specific physical appearance, which, they argued, is often exacerbated on a college campus. Juliana shared, “I think that there is a high expectation for women particularly on this campus to be attractive, which includes being thin and fit at the same time.” Jane agreed: “Being a college girl you are supposed to be attractive and thin and having a great you know, romantic or sexual life in addition to all your studies...” Also, Calliope talked about the specific attire college women must adhere to in order to receive certain social privileges. She shared, “You feel that you have to dress up, and you have to show your cleavage, and you have to wear a short skirt. Because if you’re not, then you aren’t going to get in the party, if you are not pretty enough.” Finally, Amy talked in depth about being a woman in a sorority. She experienced “a lot of pressure to act in a certain way and to associate with certain kinds of people.” She continued, “In a sorority you are definitely expected to associate with a certain type of person, like, the people who ‘go out’ and the people who are ‘fun.’”

Academic Pressures.

Eight of the women also talked about the academic pressures they encountered in college.

Calliope, Ann, Jane, and Claire each talked about the high standards they experienced at this specific college. As Ann shared, “It is like you have to do well. You’re paying to do well.” Calliope felt these high standards from her professors. Additionally, Jane talked about the high caliber of students at this college. She shared, “it is also stressful because everyone who is here got excellent grades in high school and expects to keep getting them and to be on top of their own performance level and usually

on top of everyone else.” Claire shared that these high standards are also applied to expectations about her future. She shared, that in this environment, “You are supposed to get a certain degree and you know, supposed to work on getting a career right after you leave school, or go to grad school and all that.”

Juliana, Amy, and Sam talked about the intense workload they experienced at this college. For Amy, maintaining a standard of academic excellence with her work was difficult:

It has been a definite struggle. I guess academically and trying to stay focused has been extremely difficult. And, there have been times when I haven’t wanted to do my work, where, I just feel like I literally can’t force my body to work anymore.

Sam also talked about feeling overwhelmed with having to do some much work cramped into a short amount of time. Finally, Juliana talked about the overwhelming workload she experienced in graduate school. “It is more competitive than I would imagine an average graduate school experience was going to be. It is overwhelming because the workload is significantly different from an undergraduate workload,” she shared.

Being a College-Aged Woman

Five of the interviewed women talked about the role of college-aged women in society. These women are Amy, Calliope, Kylie, Jane, and Becky. Kylie, Amy, and Calliope talked about the stereotypes and images that college-aged women encounter. For example, Kylie talked about how college-aged women are stereotyped as women who are flamboyant and party excessively. She shared, “There is so much stereotyping and so many generalizations that are made about college aged women, stemming from

things like 'Girls Gone Wild'...When you think of college-aged women, you think of girls taking their tops off."

Both Amy and Calliope talked about the changes that have occurred for women over the years. Amy stated, "It is not so much like you grow up and get married now. It is like you grow up and have to find a career, to support yourself." Calliope echoed the sentiments of Amy. She shared that she was aware of many gender stereotypes and inequalities towards college-aged women. However, at the same time, she shared, "If I lived a hundred years ago, I wouldn't be able to come to college. But, at the same time, I think well now I can, so now, what can make it better."

On the other hand, Juliana and Becky talked about the current societal and cultural influences upon women. Juliana talked energetically about one specific societal trend:

Women from elite colleges are opting to stay home instead and how this is their new mission in life to become mommies. And, because there is sort of this conservative backlash throughout the country, it has sort of permeated all levels of society. Women are thinking that, "Ok, I can go back to doing this, and it is ok now."

Juliana was disgusted with this trend and talked about her decision not to have a family. Becky talked about current cultural influences she experienced as a Black woman. She shared,

Society sees me as an African-American female or Black woman. But, then in the Black Community, I guess because I am educated and I don't come from the same culture, they see me as not Black enough. So, I am kind of in this weird limbo. I have never quite fit in either place.

Transitions

Four of the participants talked about issues related to transitions in college. Three of the women, Calliope, Kylie, and Claire, talked about the significance of the transition from high school to their freshman year, while Juliana talked about her transition from college to her first year in graduate school.

Calliope, Kylie, and Claire each talked about their freshman year in college and what the transition from home to school was like for them. Calliope's freshman year was isolating, and she believed this transition ultimately contributed to her cutting. She also shared that in "college, especially like the first year, everything is so in flux. It is good to have something stable, and I think that loss of stability contributed to my cutting." Both Calliope and Claire noted improvements as they entered their sophomore and junior years in college. For example, when asked what contributed to her improvement Calliope shared, "I guess partly like it was my second year here, and it wasn't that big of a transition from home to college." Unlike Calliope and Claire, Kylie expressed a positive viewpoint about the transition from home to college. She noted that the first year of college was a difficult transition for many. However, she believed that college "is a good intermediary between high school, where you have to ask to use the bathroom, and the real world, where no one cares where you are." She also stated that college "is a really good bridge. You get to grow into yourself as a person, you get to discover yourself, emotionally, and intellectually...it is a place of guided introspection."

Although Juliana completed college, she noted similarities between her freshman year in college and her first year in graduate school. When asked what it was like to be a student she shared, "I imagine that you would get comparable answers from an 18-year

old who is just starting undergraduate. So, I imagine it would be the same thing that a freshman in college might say. It is isolating, it is difficult, it is confusing.”

Summary Interpretation

The college experience for these women was largely influenced by the pressures they experienced, who they were as women, and the transitions they encountered. Nine of the ten women talked about the pressures they experienced as a college student. Five women talked about the social pressures, and five women talked about the academic pressures. (One participant, Calliope talked about both the academic and the social pressures.) Being a college-aged woman also influenced who these women were. Five of the interviewed women talked about their role as women and the stereotypes they encountered on a daily basis. Finally, four of the interviewed women talked about their transition from home to school. All of these women talked about their first year as a student, and the effects this transition had upon them, emotionally.

Application of ego development to Interpretive Theme

This section will demonstrate the application of ego development to the interpretive theme, College Experience. The first grouping will examine the participants' responses at the E5 Level (Self-aware Stage), the second grouping will examine participants' responses E6 Level (Conscientious Stage) and the final grouping will examine the participants' responses at the E7 Level (Individualistic Stage).

E5 Level/Self-aware Stage: (Claire, Juliana).

Attitudes and beliefs consistent within the E5 level emerged within this interpretive theme. For many people at the Self-aware stage, there is an acute sense of the distinction between the self and group or how one makes meaning of themselves in context of the group (Hy & Loevinger, 1996). Claire and Juliana spoke of the difficulty

they experienced transitioning their first year at the college. They both had to negotiate how they fit into this new college environment. Although they were aware of the difficulties that the transition presented, they did not elaborate or expand upon their difficulties, especially when compared to the women who scored at the higher levels. It is difficult to know exactly why Claire and Juliana had difficulties transitioning. However, it is possible that they experienced discomfort in their new social situation or feelings of loneliness - two behaviors common at the E5 level.

E6 Level/Conscientious Stage: (Amy, Katie, Kylie).

Attitudes and beliefs consistent within the E6 level emerged within this interpretive theme.

An individual functioning with the Conscientious stage demonstrates an increasing ability to critically reflect upon her own life, especially as she puts things into a broad social context. This was certainly the case for Amy, Katie, and Kylie as they reflected upon their experiences in college.

Kylie talked about the ease she had transitioning from high school to college and about college in broad terms. In her mind, college was a place where “you grow into yourself as a person; you get to discover yourself, emotionally, intellectually. Additionally, Amy spoke in broad social terms about being a woman in today’s society. She shared, for women, “It is not so much like you grow up and get married now. It is like you grow up and have to find a career, to support yourself.”

E7 Level/Individualistic Stage (Jane, Claire, Becky, Ann, Calliope).

Attitudes and beliefs consistent with the E7 level emerged within this interpretive theme.

The women who scored within the E7 stage spoke in depth and demonstrated a keen ability to critically evaluate themselves in the context of the college environment. Their responses were multi-faceted and demonstrated an advanced ability to view themselves in relationship to those around them.

At the E7 level, individuals begin criticizing stereotyped prescriptions of gender roles (Hy & Loevinger, 1996). The women who scored at the E7 level took it a step further than the women who talked about gender roles and expectations at the E6 level; they spoke more in depth, and they elaborated upon their thoughts and beliefs regarding gender roles. For example, Jane talked critically about the expectations that women face in college. "Being a college girl, you are supposed to be attractive and thin and have a great you know, romantic or sexual life in addition to all your studies," she stated. Additionally, Calliope talked critically about gendered stereotypes and was aware of many inequalities that college-aged women encounter. However, at the same time, she recognized the changes that have occurred over the years and also spoke about her own role in potentially making these changes. She shared, "If I lived a hundred years ago, I wouldn't be able to come to college. But, at the same time, I think well now I can, so now, what can make it better."

Theme Four: Counselor

All ten of the participants talked about different counselors with whom they worked. This interpretive theme, Counselor, includes sub-themes related to *what's helpful* and *what's not helpful*. For the sub-theme of *what's helpful*, the participants talked about the *helpful behaviors of their counselor* and their counselor as *a friend*. For the sub-theme, *what's not helpful*, the participants talked about a counselor who *didn't understand* and a counselor with *unhelpful behaviors*.

What's helpful

All ten of the participants spoke about aspects of their counselors that they found to be helpful to them.

Helpful Behaviors.

Eight of the women interviewed talked about helpful behaviors their counselors utilized during the counseling process. Calliope spoke about one counselor with whom she worked at the counseling center. Her counselor made her feel important, in spite of the fact that she was “seeing so many students” on campus. According to Calliope, this counselor “made me feel like I was a valuable person and that really helped out.” She also stated, “I know one time I was playing a concert, and my name was on the radio and she made sure to mention that. And that made me feel really happy and she remembered everything. And that is impressive.” In addition to Calliope, Jane appreciated the specific actions of her school counselor in high school. With this counselor, she didn’t feel forced into anything. “He didn’t press any counseling philosophies on me. He didn’t try to counsel me. He just tried to let me talk, and I liked having someone else to talk to,” she shared.

Jane worked with a counselor who was confrontational, which she found to be helpful. She shared, “He made me sometimes mad. And, I thought that was good because that was really getting me involved and not just sitting on a couch talking.” In addition to Jane, Katie also liked the fact that her counselor was confrontational. She stated, “She challenged me...and it wasn’t in a way that hurt.” For this counselor, it was, “‘Listen, you need to stop doing this, and this is why,’ and it was that good balance of me coming to those realizations on my own.” Finally, Kylie talked positively about her third and final counselor, Emily, whom she worked for approximately three years. For Kylie,

Emily was an “objective point.” She stated, “I could tell her that I had sex with someone; whereas, I couldn’t tell my mom that.” She continued, “And she would give me objective advice. It was someone to go to who was completely objective.”

In terms of the specific behaviors five participants talked about how their counselors listened to them during sessions. For example, Calliope shared, “She, my counselor, was just a really good listener, and I think that was very beneficial.” Amy talked in detail about a counselor she met only briefly, when she was admitted to the hospital after taking a bottle of Advil. “She was very calming, very um, again not judgmental at all. She definitely seemed to sympathize with me, and sat there with me and let me cry to her and let me get like months of pent up feelings off my chest and sort of was a good listener to me.”

A counselor who demonstrated an understanding of her clients was also found to be helpful. Jane appreciated the fact that her counselor understood her unique needs. She shared the following:

He was a counselor specifically for gifted students, or gifted kids and adults, and he was very intelligent himself, so I always felt like I could talk about...I didn’t have to worry about saying things that smart kids would say... And, I guess he understood more the problems that smarter kids have.

Becky also appreciated the fact that her counselor made an effort on her own, to understand her, specifically her self-injury and her depression:

She asked [about the self-injury and the depression]. She didn’t know and she asked. And she tried to understand, and then she did her own little research to

understand it, and she realized that she wasn't the authority...I was...And I could help educate her. She really showed an effort.

A Friend.

Five of the ten participants talked about the role of their counselor, as a friend. Kylie shared that she considered the last counselor she worked with to be “friends, more than anything.” She went on to say, “I think a personal connection is really key in any therapist/patient relationship.” Katy also referred to one therapist, Dr. Kelly, with whom she worked in high school, to be “more of a friend or an aunt.”

Jane, who worked with several counselors, referred to her second counselor, “as kind of a mentor or friend.” She shared, “The second one I feel like I could stop by his house or something.” Additionally, Sam talked about the counselor with whom she last worked at the College Counseling Center, who was also Columbian. She stated, “It was kind of a mixture of a little friends but not friends...I can talk to her in any tone. I don't have to be very formal.” She also stated, “It was kind of like a partnership. It was like a partnership of the two of us against the cutting.” Finally, Ann talked about the theme of her counselors as friends. She shared, “David and Joanna were like my best friends because it didn't matter what it was, they were always there.”

What's Not Helpful

Four of the ten women talked about different aspects of their counselor that they found to be unhelpful. This section is divided into the following sub-theme; didn't understand and unhelpful behaviors.

Didn't Understand.

Four of the interviewed women talked about how their counselors failed to understand them.

Over the course of four years, Becky worked with several counselors in both inpatient and outpatient settings. One negative theme that emerged for her was the lack of understanding her counselors demonstrated. Her first counselor, “Jesus Lady,” evoked a great deal of negativity:

I was just some 18-year old kid, who said I was going to hurt myself, and she was there to take my money. She didn’t care to understand me. Just shut the fuck up and pay me. That is what I felt with her.

Although Becky liked her second counselor better, this counselor failed to understand her as a unique person. “The second one, I think tried to make me fit a mold so that she could understand me because she only understood the mold.” Sam spoke similarly about the majority of her counselors. She stated, “I don’t know if they understood me, but they understood my situation. It is kind of like, they have seen this a hundred times.”

Katy also remarked how her counselor never understood who she really was. She shared that although they tried to understand her, she believed that they never truly knew who she was. “I feel like they tried to understand me in the past, but that I was mainly a name on their calendar twice a week.” Claire echoed the comments of Katy; she talked about her counselors never really getting to know her as a person. “I don’t know if they understood me as a person, but I think that had some sort of understanding of what was going on. Like, it is their job to understand...Like the theoretical, the broader issues.”

Unhelpful Behaviors.

Six of the women talked about unhelpful behaviors their counselors utilized, which they found to be unhelpful.

Becky, Jane, and Amy spoke critically about how their counselors infused religion into the counseling arena. Becky referred to her first counselor as “Jesus Lady”

because she forced the idea of religion into her sessions. She stated the following about her: “She told me I needed God.” And she told her, “You need to stop.” “She was like that with everything.” Amy also didn’t appreciate her counselor utilizing scriptures as a therapeutic tool:

I felt like she was sort of judgmental and brought religion into the picture too much. I didn’t really appreciate the handing out of the scripture verses to tell me, that I am loved no matter which way I am, and I have to accept myself for who I am. I can’t really remember anything positive about going to see her.

Finally, Jane briefly mentioned one counselor who read the serenity prayer during a counseling session. Jane was turned off by this approach and found it to be extremely unhelpful.

Sam, Ann, and Juliana also talked openly about some of the unhelpful behaviors their counselors demonstrated during therapy. For example, Sam talked critically about one counselor with whom she worked; this counselor failed to normalize her behavior for her, and never told her, “she was not the only one” harming herself:

I think that is the best thing that counselors can say. Because, I never heard that. And, I was, you know, embarrassed. But, I never heard it from her. She never said, “These things happen and you don’t have to be embarrassed about them. And, you are not the only one.” Yes, I mean I know that I am not the only one, but she never said that.

Both Ann and Juliana talked about how their counselors were sometimes too forceful or “pushy” during sessions. For example, Ann shared that her counselor pushed her and failed to consider her emotions during sessions. In sessions, Ann “would get really upset,” and the counselor “would just keep going.” Juliana made similar

statements as she talked about how her counselor would be forceful in sessions, almost putting words in her mouth. She shared, “Sometimes counselors will put words in your mouth so you sort of fit their category in a neater way.” Juliana believed that she was at the point where she could stand up for herself or assert herself in therapy. However, she recognized that many clients would not be able to do this; “If the patient is not as Self-aware they will just sort of go along with it.”

Application of ego development to Interpretive Theme

This section will demonstrate the application of ego development to the interpretive theme, Counselor. The first grouping will examine the participants’ responses at the E5 Level (Self-aware Stage), the second grouping will examine participants’ responses E6 Level (Conscientious Stage), and the final grouping will examine the participants’ responses at the E7 Level (Individualistic Stage).

E5 Level/Self-aware Stage: (Claire, Juliana).

Attitudes and beliefs consistent with the E5 level emerged in this interpretive theme.

The Self-aware stage is still basically a version of conformity. However, at this level, individuals become aware that not everyone, including themselves, conform to a particular stereotype or grouping (Hy & Loevinger, 1996). This concept was reflected in the responses of Claire and Juliana; they spoke about their counselors fitting them into a general category or profile, based on their behaviors. Both Claire and Juliana rejected this belief. As Juliana shared, “Sometimes counselors will put words in your mouth so you sort of fit their category in a neater way.” Juliana didn’t believe that she fit a specific profile and could assert herself if her counselor made statements that didn’t match her views or fit her unique needs.

E6 Level/Conscientious Stage: (Amy, Katy, Kylie).

Attitudes and beliefs consistent with the E6 level emerged in this interpretive theme.

At the E6 level, individuals are increasingly more reflective and begin to think in terms of communication and expression. (Hy & Loevinger, 1996). Both of these elements are manifested in Amy, Katy, and Kylie's responses about their counselors. All three women talked about how they communicated or didn't communicate with their counselor. For example, Katie talked about how her first counselor was confrontational and challenged her to consider the "fundamental inaccuracies" within her own statements. Kylie talked about how she enjoyed communicating with her counselor because she served as an "objective point" and freely gave her advice. Finally, Amy criticized one counselor, who used scripture verses as a therapeutic tool. For Amy, this mode of communication was ineffective, and she didn't appreciate this approach.

Ideas such as companionship are salient at the E6 level (Hy & Loevinger, 1996). Therefore, it should not be surprising that two of the five women who talked about their counselor as a "friend," scored at the E6 level. Kylie and Katie both shared that they considered their counselors to be a "friend," however they did not elaborate upon this statement. This was certainly in contrast to the women who scored at the E7 stage; as I will mention below, the women who scored at the Individualistic Stage not only viewed their counselor as a "friend or partner," but they also expanded upon this statement.

E7 Level/Individualistic Stage: (Ann, Sam, Jane, Calliope, Becky).

Attitudes and beliefs consistent with the E5 level emerged in this interpretive theme.

The theme of friendship between counselor and client continued at the E7 level. Jane, Sam, and Ann not only talked about their counselor as a friend, but they also expanded upon their statements and spoke with greater complexity than the women who scored at the E6 level. At the E7 level, the theme of friendship also had an added component; Sam's relationship with her counselor became more collaborative in nature, and the two developed more of a "partnership," against the cutting.

The counselors' lack of understanding emerged as a theme at the E7 level. For example, both Becky and Sam shared that from the outside it may have appeared that the counselors understood who they were. However, they learned from their experiences that their counselors may have understood their "situation," rather than their unique selves. This mode of reasoning is reflective of the E7 level, where the individual is now able to distinguish appearance from reality (Hy & Loevinger, 1996).

At the E7 level, there was significant variability in what the women found to be helpful or not helpful. However, each of these women demonstrated a keen ability to reflect critically upon their past experiences with their counselors. They each spoke in relative terms; they were able to reflect upon both the negative and positive aspects and behaviors of their counselors. For example, Although Becky liked her second counselor better, the counselor failed to understand her as a unique person. "The second one, I think tried to make me fit a mold so that she could understand me because she only understood the mold," she shared. Their ability to think in relative terms versus absolute terms is certainly a reflection of their functioning level (Hy & Loevinger, 1996).

Theme Five: The Counseling Process

Each of the ten women talked about the wide-range of approaches their counselors used with them, the types of treatment they experienced, and the actual focus

of their treatment experiences. Upon review of their comments, it seemed as they were actually talking about *The Counseling Process*. This interpretive theme is broken down into three major sub-themes: *counseling techniques*, *forms of treatment*, and *focus of treatment*. The first sub-theme, *techniques*, is broken into four sub-groups: *alternatives*, *questions*, *talk*, and *contract*. The second sub-theme, *forms of treatment*, is broken into medical management, alternative forms, and *College Counseling Center*. The third sub-theme stands alone as the *focus of treatment*.

Techniques

All ten of the participants talked about the different techniques their counselors used during the counseling process. This section is divided into four sub-groups; alternatives, questions, talk, and contract.

Alternatives.

Six of the participants talked about alternatives that their counselors suggested. Some believed the alternatives were helpful, while others found them to be unhelpful. Within this section, some of the women expressed competing thoughts about alternative behaviors for self-injury. For example, Juliana found that some aspects of alternative behaviors were helpful while other aspects were not helpful.

For Amy, her counselor suggested that she write down her feelings more. She also learned not to “isolate” herself from others. She found these alternative behaviors to be successful, making it less likely to harm herself. Juliana also found the exploration of alternative behaviors to be helpful; she enjoyed when her counselor encouraged her to think about or make a list of alternative behaviors. For Juliana, this allowed her to be “actively engaged, as opposed to passively engaged in sessions.” Finally, Calliope also found the exploration of alternative behaviors to be helpful:

My counselor really stressed, because she knew that I was really artistic, like to write a poem about what I was feeling...or just do something else. And, that is what I do now. Like, when I get sad, I play my violin, and that is good.

Both Sam and Katy's counselors failed to explore alternative behaviors during their counseling sessions. Sam would have liked to talk about alternative behaviors with her counselor. Additionally, Katy shared that her counseling experiences were not directive, and consequently her counselor never taught her or suggested to her alternative behaviors. As a result, she did her own exploration on the internet and "yahoo-ed something like alternatives to self-injury." This search proved helpful to her as she discovered that holding ice cubes was one way to prevent her from cutting herself. For Katy, this approach worked very "effectively."

Five of the interviewed women shared that alternative behaviors weren't helpful. As stated above, Juliana found the exploration of alternative behaviors to be helpful. At the same time, she also realized that they were only temporary solutions.

There were periods where I managed to sort of assuage the need to self-injure by picking up another healthy or acceptable behavior, at the urging of a counselor...if that makes sense. Um, it didn't really last too long because they were terribly simplistic behaviors that were sort of short-term answers.

For Kylie and Jane, the alternative behaviors their counselors suggested didn't seem to help them. Jane shared that although her counselor and she experimented with several different alternatives (breathing relaxation, yoga, running, working out, drawing, etc.), the only thing that stopped her from cutting was combating her thoughts about harming herself; she would repeatedly tell herself to stop. Jane never believed in the utility of

alternative behaviors. As she firmly stated, “Alternatives are just that. They are alternatives...and nothing that I have heard of this far is really going to substitute.”

Questions.

Three of the women talked about the questions their counselors asked during sessions. Calliope and Sam talked about how their counselors seemed to ask the same questions repeatedly during the counseling process. Calliope shared, “It just felt like the same question just phrased a different way. Like, ‘How often do you cut yourself?’ Or ‘How many times per week?’” For Sam, when her counselor asked the same questions “over and over throughout the sessions,” it made her feel like “the counseling was going nowhere.”

Calliope and Kylie commented upon the types of questions their counselors asked. Calliope shared, “I really liked that she just, she asked me how it made me feel, and she asked me questions about how; she went deeper into the issue, like things that I didn’t think of, that she made me realize.” Kylie echoed these comments, as she also talked about the type of questions her counselor asked. She shared, “I liked it when my counselor would ask me questions, but not necessarily, ‘How do you feel about that?’ But like, ‘What do you think you should have done there’ Or ‘What do you think?’” For Kylie, these questions forced her to “think harder,” and she appreciated when she “would come up with a solution or an answer on my own.” These comments demonstrate that Calliope and Kylie appreciated questions that encouraged them to think on a deeper, more meaningful level.

Talk.

Three participants said that talking during sessions was helpful. Sam shared that counseling was “just time to talk to someone without having the pressures of what they

are going to say or think about you.” Ann agreed and stated it was nice to “just talk” with her school counselor in high school. Finally, Calliope talked about one counselor at the College Counselor Center with whom she enjoyed working. “It was just so nice to have someone who cared and I could talk to about these things,” she shared. “I just need to talk.”

Contract.

Four women talked about the contracts their counselors asked them to sign, or not to sign, during the counseling process. Ann and her counselor, Joanna, made an agreement they referred to as “promise weeks.” According to Ann, “After each session I would have to promise not to harm herself until the next week.” If she wasn’t ok, then Ann would have to call her or write her an e-mail. Upon reflection, Ann believed that this approach helped her and often prevented her from cutting herself.

In contrast to Ann, Katy, Becky, and Kylie believed no-harm contracts were ineffective. Both Katy and Becky thought that they were a “joke.” Although Katy’s counselor never asked her to sign a no-harm contract, she expressed the following:

I mean that would have been just a joke because it would have made me just disrespect the therapist into thinking that this is going to stop me and that they were delusional enough to think that this was somehow going to be beneficial.

For Becky, she didn’t see the value in no-harm contracts with the majority of her counselors. However, with the one counselor with whom she respected and connected, she believed that the contract worked for her. With this counselor, Becky “thought twice” about cutting. Kylie also didn’t have to sign a contract during her counseling experience. “I would have crumpled it up and thrown it at them,” she stated. In her view, she wouldn’t have signed it:

I won't make a promise unless I can keep it. Or, I try not to. Um, and I need to feel a deep sense of obligation to that person and that cause to make that promise.

So, that wouldn't have worked for me.

Forms Of Treatment

All ten of the interviewed women talked about the different forms of treatment they experienced in counseling; this section is divided into the following four sub-groups: medical management, alternative settings, family therapy, and the college counseling center.

Medical Management.

Five of the interviewed women talked about the medical interventions they received while in therapy. While some of the women viewed this approach as favorable, others found it to be a negative experience.

Kylie, in collaboration with her counselor, decided that medication was "a good option" for her. At the time of the interview, she was still taking the following medications; Prozac - an antidepressant, Neurotin, an anti-seizure medication which "has anti-depressant and anti-migraine properties" and Zanax, as needed. Kylie thought favorably about these medications and saw improvements while taking them. This was not the case for Claire. Although she was prescribed medication, she didn't believe it helped, and she stopped taking it after a year. Claire felt powerless in therapy when it came to medical interventions:

After I started, I really didn't have any personal input in like, I wanted to take it or after all, I wanted or I think I need a higher dose or anything. There were a few times when I didn't want to take it anymore, but both my parents and the counselor were like you have to keep taking it, you have no choice.

Juliana, like Claire, did not find the use of medication to be helpful to her. She took various medications for a period of five years and worked with a number of different psychiatrists. She shared, “They put me on the weirdest things. They like kept me on Prozac for like six years. So, I don’t know what the hell was wrong with these guys.” Juliana believed her medication was almost always “mismanaged.” As a result, she learned to manage her own medication over time and would sometimes take “other people’s Zanax” when she was having a difficult time. Kylie echoed many of Juliana’s statements; she also disagreed with the manner in which her medication was managed. One time, she was prescribed an anti-seizure medication. However, Katy did research on her own and discovered that this particular medication had “a history of having a fatal rash, and a lot of side effects that she [her counselor] didn’t tell me about.” Oftentimes, Katy would have to call her aunt, who was a psychologist, before she took any of the medication that was prescribed to her. Although she had a negative view of her medical interventions, she also recognized that this “probably had to do with the fact that I wasn’t seeing them [the psychiatrists] on a regular basis. So, there wasn’t a client-counselor relationship that was ever established.”

Alternative Settings.

All ten of the women interviewed received individual outpatient counseling experiences. In fact, most of the interviews focused on these experiences. This sub-theme includes information from settings beyond the individual outpatient experiences. Four of the women spoke about their diverse experiences. Juliana and Becky received inpatient treatment; Jane was briefly in a day treatment program, and Ann was involved in a group counseling program.

Both Juliana and Becky received inpatient treatment primarily for their eating disorders. At 12- years old, Juliana was placed in a facility to address her anorexia and bulimia. During a group therapy session she observed other women engaging in self-injury and began harming herself. According to Juliana, cutting was a “learned behavior.” After approximately eight weeks, she was moved to an outpatient program. According to Juliana, there was a “fear,” that being around “seasoned anorexics” would only cause her further harm.

Becky also received treatment within an inpatient setting on two separate occasions, primarily for her anorexia. According to Becky, it was “the worst experience of her life.” Becky found her time there to be ineffective:

It didn’t work because they didn’t know anything about anything. I knew more about my problems than they did. And they were upset because I was educating the girls about eating disorders and this, that and the other. They didn’t like me and I didn’t like them!

Jane briefly entered a day program after she was removed from school due to “suicidal gesturing.” She did not find this experience to be particularly helpful. She shared, “Everyone there was there for different problems. So, they were people that weren’t really doing anything with their lives and their psychological problems were all they had, basically.” Therefore, Jane was release from the program after only three days. According to Jane, she wasn’t surprised they let her go so quickly. To her, it was “obvious.” “I answered all the questions right and stuff,” she shared.

Finally, Ann was involved in a counseling group at her high school. According to Ann, her school counselor recommended her to the group “for the sole purpose of getting me out of class and letting me see somebody.” Although she didn’t find the group to be

particularly helpful, she did form strong and long lasting relationships with two of the group leaders, Joanna and David. Both Joanna and David worked at the Mental Health Services Board, and Ann began volunteering with Joanna in the community and eventually started seeing David for individual counseling.

Family Therapy.

Family therapy emerged as a prominent sub-theme. Six of the ten women talked about this mode of treatment; four of the women found it to be unhelpful, while two women found it to be helpful.

Although Juliana experienced “a handful” of family sessions, she realized that they were not only unhelpful, but they were also “impractical” for her parents, who had several young children at home. Upon reflection, Juliana realized that every time her parents were involved in her counseling sessions, it got “disastrous.” Juliana’s parents advocated for her to continue counseling, “but at the same time they realized the impracticality of it seeing that they had a large flock of young children.” Ann also experienced family therapy on a limited basis. Her first counselor involved her mother, which proved to be an awkward situation for Ann. “My Mom was bound and determined that it was just a phase, and she was expecting like a two-week phase, not years.” She also stated, “I would have always had really good excuses for why I cut, and she didn’t really understand the concept so it just kind of hindered the process.

Although Amy did not have an actual family session, she did report that one of her counselors invited her parents to a session. Although she was asked to join her parents, she refused, not wanting to be a part of the session. To this day, Amy still does not know what her parents talked about with the counselor. Therefore, she had no opinion on whether it was helpful or not helpful. Becky had an experience similar to

Amy; her counselor involved her family by calling them on the telephone. For Becky, involving her family, even on this level, was helpful, especially to her sister, who eventually learned to understand her behaviors.

Unlike the above women, Katy's family sessions were more regular. However, she did not find them to be helpful at the time she was in therapy. According to Katy, "I was still very angry at my mom and dad. What was brought out during my sessions was more bringing to the surface things that I had withheld." With this being said, Katy recognized that the sessions were helpful in the long run, and she had a greater appreciation for them now. Like Katie, Kylie also had regular family sessions. Kylie's first counselor briefly involved her family in a session. However, she found this to be unhelpful. She shared, "she didn't even know me. I was like, "How dare you involve my family, you don't know them...you have no idea about them. You don't even know me and that is your connection to my family." Kylie's opinion of family counseling changed when her last counselor involved her family. Kylie enjoyed these sessions, and they were able to talk about a lot of deep-seated familial issues. In some cases, she would "prepare" things to say or way to approach her family, with her counselor. "She was on my team," shared Kylie.

College Counseling Center.

All of the interviewed women sought counseling at one time or another at the College Counseling Center. However, not all of the women talked about their views and experiences directly related to the College Counseling Center. During the interviews, four of the interviewed women talked about the College Counseling Center, in terms of their views and experiences.

Claire and Jane talked about their overall views of the counseling center. Claire was annoyed that she was required to receive counseling services at the College Counseling Center. In fact, attending sessions was contingent for her to remain in college housing:

There is something in the handbook that if you are like causing or could be hurting yourself or causing danger to yourself, then you are not allowed to stay in campus housing or something until you see a counselor.

Claire had an ambivalent view of the counseling center. “They were really overbooked and it was like filing people through. I mean it [the Counseling Center] wasn’t especially helpful or detrimental. It probably didn’t make much difference for me either way.”

Jane also worked with a counselor from the counseling center during her freshman year in college. Working with this counselor, she was required to sign agreements that she would not hurt herself each week. She spoke about her view of these agreements:

I just felt it was all focused on the school’s liability and not focused on me. You know, it wasn’t about me when I was filling those out. It was just so that they could go on record for doing it.

Jane also talked about the political aspects of the counseling center:

You know that you are there for counseling but you also have to have a strategy. Because the college system is you know, political. It’s associated with the Dean’s office, and they all talk. And so, when you go to a college counseling center, you have to figure out what your first priority is.

Three of the interviewed women talked specifically about their experiences at the College Counseling Center. At the time of the interview, Ann had refrained from cutting for over two years. However, when she attended counseling sessions at the College Counseling Center last year, the counselors she worked with her hyper-focused on her self-injury:

I guess it was because it was my first semester here, and they harped on this issue because they wanted to see if I was going to start again. But I was like, “I am asking about a completely different topic.”

This overall experience was frustrating for Ann and painted an overall negative picture for her of the College Counseling Center.

Juliana, who attended counseling services at her undergraduate institution, found the services to be limited. She shared, “The college counseling center was so overwhelmed with the amount of care that they had to provide to all of these people that they couldn’t really provide care to any person at a given time.” She also stated that her problems were possibly too extensive for the counseling center:

They were so unwilling to treat me because I had such a long history of, let’s just say, illness. It is very hard because of their limited resources. They do better with people who, you know, their grandmother just died, and they need like six weeks of therapy to talk about how much they miss their grandmother.

Focus of Treatment

Eight of the interviewed women spoke about the overall focus of their counseling experiences.

Both Claire and Kylie talked about the specific “issues” on which their counselors focused during counseling sessions. For Claire, her counselor “missed the point,” by

focusing mainly on her family issues and failed to “focus on the major issues,” which to her were her anxiety and depression. For Katie, the “issues” on which her counselors focused on were mainly about her family and her feelings about “what was going on in her family.” Lastly, Juliana spoke openly about the overall lack of focus her counselor demonstrated. She revealed, “None of my treatment really focused specifically on any given element at any given point.” For her, it was mainly her talking and saying what was on her mind and her counselors, in turn, “focusing on whatever she brought in” to that particular session.

Amy, Jane, Ann, Calliope, and Kylie talked about how their counselor did or didn’t focus on their self-injury during sessions. Amy stated, “Cutting was the focus of one of our sessions, but after that like I really didn’t want to talk about it, so I sort of didn’t.” Although her counselor asked her specifically about her cutting, Amy “brushed it off” and “avoided it” with her counselor. In contrast to Amy, Jane, Ann, and Calliope’s counselors focused primarily on their self-injury throughout the counseling process. According to Jane, the majority of her counselors focused primarily on her self-injury in sessions and their “first priority was to stop” her from cutting. She stated that one counselor “would just always make it a big issue. She would ask how my last week had gone and acted like the most important indicator about how my week had gone was whether I had cut myself or not.” For Jane, whether or not she reframed from cutting had little or nothing to do with how her week went. Calliope’s counselors also focused primarily on her self-injury during sessions. She shared that a central focus on her counseling was to determine the reasons behind her self-injury or what drove her to this behavior. “Once I knew the reasons, I could try to stop it,” she shared. In contrast to these experiences, Kylie was thankful that her counselor focused on “the underlying

issues,” rather than the cutting. In her mind, focusing only on the cutting was like “putting a band-aid on the issue.”

Summary Interpretation

For the interviewed women, the techniques and approaches that their counselors utilized largely influenced their level of satisfaction with therapy. The techniques that the counselors utilized were significant for nine out of the ten interviewed women. Six of the women talked about the alternatives their counselors suggested. Four women talked about the questions their counselors asked during the counseling process. Three women appreciated that their counselors created an atmosphere where they could sit and talk. Finally, four of the women talked about the no-harm contracts their counselors encouraged them to sign.

Seven of the interviewed women talked about the different approaches their counselors utilized. Five of the interviewed women talked about the medical interventions they received while in therapy. The majority of the women received individual outpatient counseling experiences. However, four of the interviewed women talked about their experiences within an inpatient treatment setting, a day treatment program, and group counseling. Also, during the interviews, five of the interviewed women talked about the College Counseling Center. Additionally, six of the ten women talked about family therapy. Eight of the interviewed women spoke about the overall focus of their counseling experiences. Four of the women talked generally about some of the issues their counselors focused on, or failed to focus on. Additionally, three of the participants talked about how their counselors focused or failed to focus on their self-injury during the counseling process.

Application of ego development to Interpretive Theme

This section will demonstrate the application of ego development to the interpretive theme, The Counseling Process. The first grouping will examine the participants' responses at the E5 Level (Self-aware Stage), the second grouping will examine participants' responses E6 Level (Conscientious Stage), and the final grouping will examine the participants' responses at the E7 Level (Individualistic Stage).

E5 Level/Self-aware Stage: (Claire, Juliana).

Attitudes and beliefs consistent with the E5 level emerged in this interpretive theme.

At the E5 level, one begins to see multiple possibilities and alternatives in situations (Hy & Loevinger, 1996). This theme emerged with Juliana, as she talked about both the positive and negative aspects of alternative behaviors in therapy. On the one hand, Juliana believed that alternatives were helpful, and she enjoyed the active exploration of these alternatives in counseling. On the other hand, she recognized that alternative behaviors were "temporary solutions," "short-term answers," and were "terrible simplistic."

A desire for independence emerges at the E5 level (Hy & Loevinger, 1996). Although Claire and Juliana didn't explicitly mention the term independence, they began either exhibiting independent behaviors or displaying a need for independence during the counseling process. For Claire, she felt powerless when she didn't have any say in taking the medication she was prescribed; she desired to have input in her sessions and her negative experiences in counseling were largely influenced by this experience. Juliana often disagreed with the medication she was prescribed. As a result, she learned to

manage her medication on her own; she researched medications and stood up to her doctor if he/she prescribed something she didn't want to take.

E6 Level/Conscientious Stage: (Amy, Katie, Kylie).

Attitudes and beliefs consistent with the E6 level emerged in this interpretive theme.

At the E6 level, the theme of companionship emerges (Hy & Loevinger, 1996). This theme has direct implications for the counseling relationship. With individuals at this stage, the counselor-client relationship becomes more collaborative in nature. This was seen in Kylie's responses. She shared that she and her counselor *together* came to the conclusion that medication "would be a good option" for her. She also mentioned that her counselor, in the context of family therapy, was "on my team."

Amy, Katy, and Kylie spoke openly about the counseling process. Their responses reflected a keen self-awareness and a strong ability to reflect upon their experiences, which is evidenced at the E6 level (Hy & Loevinger, 1996). For example, Katy and Kylie both shared what they would do if their counselors required them to sign a no-harm contract. Katy shared,

That would have been just a joke because it would have made me just disrespect the therapist into thinking that this is going to stop me and that they were delusional enough to think that this was somehow going to be beneficial.

Additionally, Kylie shared, "I would have crumpled it up and thrown it at them." She also stated, "I won't make a promise unless I can keep it. Or, I try not to. Um, and I need to feel a deep sense of obligation to that person and that cause to make that promise."

Kylie's and Katy's responses demonstrated a strong sense of who they were and how they might act in a given situation.

E7 Level/Individualistic Stage: (Ann, Becky, Calliope, Jane, Sam).

Attitudes and beliefs consistent with the E5 level emerged in this interpretive theme.

Each of the women at the E7 level demonstrated a strong sense of personality and individuality. Additionally, the women at the E7 were critical of their counseling experiences and the methods and approaches their counselors used with them in therapy. Their critical nature is a reflection of their functioning level; individuals at this level recognize and accept that relationships are partly antagonistic (Hy & Loevinger, 1996). This was certainly the case with the women who scored at the E7 level. For example, Jane believed that her counselors focused too heavily on her outward behaviors, her cutting. She stated that one counselor “would just always make it a big issue. She would ask how my last week had gone and acted like the most important indicator about how my week had gone was whether I had cut myself or not.” Also, Sam was critical of her counselor, who would ask the same questions “over and over throughout the sessions.” This made Sam feel like “the counseling was going nowhere.”

At the E6 level, the individual talks about communication and the expression of ideas. At the E7 level, these thoughts become more in depth and complex (Hy & Loevinger, 1996). This theme emerged in the responses of Calliope, Ann, and Sam, as they talked about communication during the counseling process. In fact, they were the only three women who spoke about the sub-theme, “talk.” All three of these women viewed counseling as a vehicle and a safe container for them to talk and express their feelings to their counselor, an objective point. For example, Sam shared that counseling was “just time to talk to someone without having the pressures of what they are going to say or think about you.” Additionally, Calliope stated, “It was just so nice to have

someone who cared and I could talk to about these things,” she shared. “I just need to talk.”

Theme Six: Personal Reflections on Counseling

All ten of the women reflected upon their behaviors and feelings in counseling and provided suggestions for women who self-injure and counselors working with women who self-injure. Upon review of their comments, it seemed as if the women were really talking about their personal reflections on counseling. This interpretive theme, Personal Reflections on Counseling, includes three related sub-themes: *feelings in counseling*, *behaviors in counseling*, and *suggestions for the future*. For the sub-theme *feelings in counseling*, the participants talked about being *ready to change* and *negative feelings*. For the second theme, *behaviors in counseling*, the women talked about *trust*, *manipulation*, and *positive actions*. Finally, for the sub-theme, *suggestions for the future*, the participants made *suggestions for clients* and *suggestions for counselors*.

Feelings in Counseling

All ten of the women talked about their specific feelings in counseling. Three participants spoke about the importance of being ready to change, while seven women talked about negative feelings in counseling.

Ready To Change.

Claire, Juliana, and Kylie spoke about the importance of being ready and willing to change while in counseling. When Claire was in counseling, she didn't really accept that she had a problem and in turn was not open to the counseling process. Upon reflection, Claire realized, “You have to acknowledge it [the cutting] as something that is real to you and to the people who care about you. If you aren't going to acknowledge it, then it is even more difficult to like deal with it.” Juliana agreed with Claire; she shared,

“Counseling can only be of limited help, if you are not willing.” Kylie agreed, and expanded upon the comments of Claire and Juliana. She stated:

I went to a counselor for about a year and then I was like, “I am all better, I swear,” and obviously I was lying because I wasn’t ready to be helped. You can’t really get help until you are ready. Or, that is in my case.

Negative Feelings.

Seven of the ten participants spoke about their negative feelings in counseling. These negative feelings were unique for each of the women, and their descriptions were powerful. Upon reflection, Juliana believed that she “failed at counseling.” She shared, “It is on the laundry list of things that I didn’t do well. Yeah, because my attitude was this is another thing that I did, that I frankly failed.” She continued, “If you can fail at building a relationship with someone that you are paying to have a relationship with, then there is a problem!”

Amy reflected upon her experiences in counseling, she realized that she was never truly happy:

I felt like I fooled myself into a false sense of happiness because I was in counseling. Yeah, maybe I was giving myself a false sense of happiness because I thought that, that was expected of me. Like, a lot of my issues were, “What do people expect of me?” I have to be what people expect of me versus like what do I feel really inside.

Like Amy, Katy was never truly happy in counseling. In fact, she shared that she mostly remembered “being frustrated,” and “going through the motion and feeling like I was pretty alone and having to do work on my own.” She concluded, “The help that I was

getting wasn't really what I needed. It was a name only. In some ways I wish that it was more positive and that I had a therapist that I really could have worked with."

Sam also talked about her feelings during counseling. Sam felt "embarrassed" about her behaviors and didn't enjoy talking about them with the counselor. On the other hand, Ann felt like she "was a kid, a two year old kid." When asked why, she replied, "Because she like just treated me like I knew absolutely nothing about what was going on with me." Becky also used a metaphor to describe her relationship with her counselor. For Becky, her first counselor expected her to know a lot. She shared, "She would expect me to do certain things that I didn't know. I just felt like her child, her failure child at that. So that's what I hated. She was just there to pick up her check."

Behaviors in Counseling

Seven of the ten women reflected upon their behaviors in counseling. This sub-theme is divided into the following three groups: trust, manipulation, and positive actions.

Trust.

Three of the interviewed women, Ann, Calliope, and Kylie, talked and reflected about the role of trust throughout the counseling process. When Ann reflected upon her overall experiences in counseling, she thought about "trying to trust people" and "learning how to trust somebody again." When asked what she would have done differently in counseling, Ann shared, "I wish I could have trusted a tad more in the beginning." Kylie also talked about the importance of building trust, in her relationship with her last counselor. She shared, "I felt like I had to earn her trust and she had to earn my trust. It was a trust issue, I guess." For Kylie, she eventually would show this counselor her scars, after cutting. She shared, "By that time, by the time we starting

doing that, we had gotten to the point where I had trusted her a lot, and that is why I would show her.”

Manipulation.

Three of the women, Amy, Claire, Juliana, talked about how they manipulated their counselors, at one point or another, during the counseling process. Both Claire and Juliana spoke about how they often manipulated their counselor into thinking that they were improving and their cutting had subsided. Amy simply avoided the conversations about self-injury because she “didn’t want to confront it in any way.” Clare, on the other hand, took it a step further. Claire learned if she told the counselor she wasn’t cutting, she didn’t have to attend sessions. Juliana did the same with one of her counselors. She shared, “I had one convinced that I was fine...it was great, except for I was getting worse.” Juliana continued, as she talked about both her eating disorder and cutting behaviors. She shared, “You are talking about two terribly secretive manifestations of illness. It is going to be easy to trick people.”

Positive Actions.

Three women, Kylie, Katie and Calliope, talked about some of the positive actions they took while they were in counseling. For example, towards the end of Kylie’s counseling experiences, she began giving presentations to her church group and her high school psychology classes about self-injury. For Kylie, these presentations helped her: “They really helped me because, I learned that even if you don’t know someone, they still care. That sounds sort of cheesy.” Kylie also talked about how people would come up to her after the presentations and tell her that they “connected with her story.”

Kylie and Calliope also talked about how counseling helped them repair their relationship with their mothers. For example, Calliope eventually transferred some of the

things that she talked about with her counselor to her relationship with her mom. “It was kind of like a weaning process,” she shared. Kylie also shared, that now “I talk to my mom about a lot of things.”

Suggestions

All ten of the women gave suggestions for women who harm themselves and counselors working with women who self-injure.

Suggestions For Clients.

Seven of the ten women suggested that clients get help or seek counseling if they were harming themselves. When asked what she would say to college-aged women who were harming themselves, Juliana replied, “I think that it would depend on the individual. I think that I would say that they should probably seek counseling, especially if this is sort of a recently acquired behavior...Because, I actually think that for most people counseling helps.” Amy agreed; she shared, “I would tell them to definitely explore counseling. I think that it is definitely a really good idea. I don’t think that you should be silent about your insecurities and your pains, and you do need to get that out in some form, and counseling, I would say, would be a good first step, and I don’t know...counseling definitely helped me.”

Calliope also enthusiastically suggested counseling to women who were harming themselves. “I’d say, go to counseling. Completely and totally go to counseling. Because, I mean, they are professionals.” She continued, “It is not your fault. Cause, I mean a lot of people think that there is something wrong with them, that they are a bad person because they do that [cut themselves].” Becky spoke fervently about seeking counseling. She shared, “Go to counseling...crazy. Yes, go to counseling and also you

can't discount counseling just because of the rep that it has. Just like buying a pair of jeans, shop around."

Kylie and Katie also agreed that counseling was important for women who were harming themselves. However, they recognized that it was only helpful for women if they were ready to accept help. Kylie shared,

I would tell them, when they find themselves in that moment, to seriously evaluate what you are doing. And decide whether you want to get help or not. Because, I could tell them, you know, "you need to get help." But that is not going to do anything unless they are ready. And to try and get help because there are better ways to cope there are more effective ways to cope.

Katy echoed the comments of Kylie. She shared, "I also know that in order to hear and process that stuff you have to be ready to start recovery."

Suggestions For Counselors.

Seven of the interviewed women provided suggestions for counselors to follow when working with women who self-injure. This section will talk about one theme that emerged largely with five women: being free of judgment. The final paragraphs will include unique, but powerful suggestions from three of the women.

When asked what they would tell counselors who were working with college-aged women who self-injure, Juliana, Amy, Katy, and Ann each shared that it was important for the counselor to be free of judgment.

Juliana talked about the importance of "not being so quick to categorize." Additionally, Amy shared, "I would definitely say to be sympathetic, and you definitely cannot judge because I think that is one of the hardest things for me...Just feeling that I would be judged if I tell them about this [the cutting]."

Like Juliana and Amy, Ann also talked about the importance of not being judgmental. She argued:

Try not to treat them like they are an anomaly that just happened...

And to treat them like a normal human being who instead of crying, cuts.

Or instead of dealing with something, they just cut. It is just not a way to deal with the inside stuff. So, just treat them like normal human beings and try to address everything around them, not just the cutting. Because, if they focus on the cutting, then nothing is getting fixed.

Katy agreed with Ann. She shared,

I think the bottom line is to just try not to alienate them further. Because there is already the knowledge that what you are doing is very bizarre and not normal, and you need to be careful of inadvertently stigmatizing them further.

When asked what she would tell counselors who were working with women who self-injure, Becky gave a multi-faceted response directed towards counselors. "First, take yourself out of the equations and try to see what purpose it [the cutting] is serving." Second, she suggested that counselors should be "patient" and "consistent." Third, she recommended that counselors work on their clients' "timetable." Finally, she used the following analogy for counselors, suggesting that they need to provide their clients with new improved coping skills, before stripping them of their old coping skills: "You can't strip someone of their old clothes until you have a new set available," she shared.

Claire also made a strong suggestion to counselors. She encouraged them to be aware of the online community or self-injury boards. She explained the following about the online web-boards:

There are like a couple of web-boards, they are mostly like support for stopping self-injury but like, I think they sort of like encourage it anyway even if you are on the one that is supposed to help you stop. Like, I feel like counselors should know about those things and even visit them sometimes. Like, I know there were counselors on some of those boards. And it was probably helpful for them and the people they work with.

She also shared that many women on these websites learn information to help them to feel more in control of their counseling sessions:

By reading what happened to them and there were like people like responding to that, you know, you could pick up generally what happens...what to expect...So, if you want to control the direction things go, it is a little easier.

For Claire, she believed strongly that counselor should be aware of this information.

Summary Interpretation

At the time of the interviews, all ten women had completed counseling related to their self-injury. During the interviews, they spent time reflecting upon their general experiences in counseling. A few of the specific questions prompted them to make these reflections; for example, "When I think of my experiences, in counseling, I think of..." Or "What would you tell college-aged women who were self-harming" Or "What would you tell counselors working with college-aged women who self-injure?"

All of the participants reflected upon their feelings in counseling. Three participants spoke about the importance of being "ready to change," while seven women talked about their negative feelings in counseling. The participants' behaviors were also examined. Seven reflected upon their overall behaviors in counseling, in terms of trust, manipulation, and positive actions. Finally, each woman interviewed provided

suggestions for counselors working with women who self-injure and for women who are self-injuring.

Application of Interpretive Theme to Ego Development

This section will demonstrate the application of ego development to the interpretive theme, Personal Reflections On Counseling. The first grouping will examine the participants' responses at the E5 Level (Self-aware Stage), the second grouping will examine participants' responses E6 Level (Conscientious Stage), and the final grouping will examine the participants' responses at the E7 Level (Individualistic Stage).

E5 Level/Self-aware Stage: (Claire, Juliana).

Attitudes and beliefs consistent with the E5 level emerged in this interpretive theme.

At the E5 level, individuals begin to demonstrate an increased self-awareness (Hy & Loevinger, 1996). This theme emerged in the responses of both Claire and Juliana, who scored at the E5 level. They spoke openly about their feelings in counseling, specifically the necessity for the client to be ready to change in counseling. Both Claire and Juliana believed that counseling could not progress unless they were open to the process and ready to change. These viewpoints illustrate that Claire and Juliana both were able to critically reflect upon their own behaviors and demonstrated a strong awareness of their selves.

At the E5 level, one becomes aware that not everyone, including him/herself conforms to certain expectations (Hy & Loevinger, 1996). This was certainly the case for Juliana and Claire. Although they were aware of their expected behaviors in the context of the client-counselor relationship, they both "manipulated" or "tricked" their counselor into thinking that they were improving and their cutting had subsided. Consequently,

they no longer had to attend sessions and conformed to the specific expectations of their counselors.

E6 Level/Conscientious Stage: (Amy, Katie, Kylie).

Attitudes and beliefs consistent with the E6 level emerged in this interpretive theme.

An increased ability to reflect is demonstrated at the E6 level (Hy & Loevinger, 1996). This was exhibited with Amy, Katie, and Kylie's responses; they were able to reflect upon their overall behaviors and feelings in therapy and demonstrated insight while doing this. For example, Amy and Katie realized that they were never truly happy in counseling. Amy recognized that she "maybe fooled herself into a false sense of happiness, while in counseling." Additionally, Katie talked about "going through the motions in counseling" and "feeling alone." In retrospect, she realized that she wasn't getting the help that she needed. Again, these comments demonstrate a keen self-awareness and a definite ability to reflect back upon their experiences.

Kylie and Katie recognized that counseling was only helpful for clients, if they were ready to make changes in their lives. This way of thinking is reflective of the E6 level; comparisons and contingent statements replace absolute statements and rules (Hy & Loevinger, 1996). An absolute rule would argue that counseling was always beneficial to clients. Kylie and Katie's responses reflected a relative point of view; counseling was only helpful when clients were open to the process of therapy.

E7 Level/Individualistic Stage (Ann, Becky, Calliope, Jane, Sam).

The women functioning at the E7 level demonstrated a strong sense of personality and individuality. Overall, their personal reflections on counseling were complex and

multifaceted. Additionally, their suggestions to counselors and clients were thoughtful and addressed both feelings and behaviors.

At the E7 level, individuals demonstrate greater complexity in the conception of interpersonal interaction (Hy & Loevinger, 1996). This theme was evidenced in the responses of both Becky and Ann. When talking about their feelings in counseling, they not only described their feelings, but they explained them through metaphorical language. For example, Ann shared that one of her counselors made her feel like “a two year old kid” because she treated her like she knew “absolutely nothing.” Becky echoed these comments as she remarked, “I just felt like her child. Her failure child at that.”

Relationships are seen as continuing or changing over time, at the Individualistic Stage (Hy & Loevinger, 1996); the women at the E7 level recognized this. For example, both Ann and Calliope talked about how their level of trust changed throughout the counseling process. For Kylie, it took a significant amount of time for her to trust her counselor. As their relationship developed, she slowly allowed her more privileges in the counseling arena. For example, over time, she showed her counselor her scars after she cut herself.

Chapter Summary

This chapter presented six interpretive themes including related sub-themes and sub-groups. The themes that emerged were Important Relationships, Self-Injury, College Experience, Counselor, The Counseling Process, and Personal Reflections on Counseling. Each theme emerged from the similarities that were discovered during the cross-case analysis. In order to be considered an interpretive theme or sub-theme, I established a criterion of three participants. The next and final chapter will discuss the general conclusions and implications from this study.

CHAPTER SIX

CONCLUSIONS AND IMPLICATIONS

Chapter Four presented the findings from the within-case analysis of each participant including individual ego development levels. Chapter Five presented the findings from the cross-case analysis. Six interpretive themes emerged, followed by an application to ego development for the three groupings of participants; those who scored at the E5 level, the E6 level, and the E7 level. The final chapter, Chapter Six, will present the answers to the grand-tour questions along with the three sub-questions. A discussion of the implications for research, treatment, and counselor education will follow. The latter part of each foregoing section will include a comparison to the literature. The chapter will conclude with a brief statement of personal growth.

Research Questions

The grand tour question for this study was: How do college-aged women with a history of self-injurious behavior experience counseling? The sub-questions are the following:

- 1). From the perspective of the college-aged females, what was the nature of the client-counselor relationship?
- 2). From the perspective of the college-aged females, how was their self-injury addressed in the context of the counseling relationship?
- 3). Using Loevinger's framework for assessing ego development, how did college-aged women make sense of their counseling experience?

Grand Tour Question

The grand tour question was: How do college-aged women with a history of self-injurious behavior experience counseling? This section will be divided into two separate

sub-sections: a phenomenological profile, which will illustrate a description of the participants and a summary of the participants' overall experiences in counseling.

Phenomenological Profile

Before talking about the women's experiences in counseling, it is important to know who they are. All the women interviewed were between the ages of 18 and 23. Eight of the women were undergraduates, while two of the women were graduate students, all at a small southeastern public university. All women were unmarried and without children. Of the ten women, eight were Caucasian, one was African-American, and one was Latina.

All of the interviewed women participated in individual outpatient counseling. In addition to this setting, two women received treatment within an inpatient treatment setting for eating disorders; one briefly spent time in a day treatment program, and one woman was involved in a group-counseling program for anger management. A total of six of the women experienced some level of family involvement, ranging from phone conversations between the counselor and family members to regular family counseling sessions. Finally, eight of the participants received counseling in the College Counseling Center, although only four women talked about the specific positives or negatives of their college counseling center.

Each of the women interviewed were no longer *actively* cutting. However, because the term *actively* was not specifically defined, there was significant variance in their last experience with self-injury. One woman, Amy, last cut herself a few months prior to the interviews, while Ann last cut herself almost four years before the time she was interviewed.

Four of the interviewed women also struggled with eating disorders, in the form of anorexia, bulimia, or both. Each of these women first entered counseling for their eating disorders; their cutting emerged after the eating disorder.

All the women spoke about important relationships in their lives, including friends and family. Many of the women kept their self-injury hidden from family and friends. Additionally, the majority of the participants talked extensively about their relationship with their mothers and how their mothers either supported or failed to support them during the counseling process.

Being a college-aged woman was important for the participants, and many were aware of and criticized the gendered stereotypes that they encountered on the college campus. Many of these same women also talked about the stereotypes and pressures that women face on a larger, societal scale.

All of the ten women participated enthusiastically during their involvement in the study. My main mode of communication with the participants was via e-mail, and each woman was timely in her responses to me. On only one occasion did the participant have to re-schedule our interview together, and that was done without complication. All the women showed up on time to the interviews, and they each thanked me for *her* participation in the study.

The following sub-section will describe the women's experiences in counseling. In no way do they represent what all college-aged women with a history of self-injury experience in counseling.

Experiences in counseling

The participants wanted to share their story about self-injury; they spoke in depth about their history of self-injury and their feelings related to self-injury. The questions

on my interview guide focused mainly on the women's experiences in counseling. However, I found that oftentimes the women had more to say and wanted to talk more about their self-injurious behavior, rather than their experiences in counseling. There are a number of reasons why this occurred: Perhaps it was more meaningful and powerful for the women to talk about their self-injury than their experiences in counseling? Maybe no one had ever asked these women about their self-injury, in spite of their time in counseling? Possibly the women were more open to talking about their self-injury, because of the retrospective nature of this study? Whatever the reason, I found it to be an extremely powerful experience to bear witness to these women's internal struggles and experiences with self-injury. This finding has direct implication for treatment, which I will address in the latter section on *Implications For Treatment*.

After spending a significant amount of time immersed in the interviews, it appeared that the women's overall perceptions of their experiences in counseling were negative. Surprisingly, each of the women talked extensively about her positive experiences in counseling, instead of her negative perceptions of their counseling experience. It is hard to know exactly why this is the case. Perhaps a positive experience or a helpful counselor proved to be extremely meaningful and thus memorable for the participants? On the other hand, it was less memorable and more forgettable when their counselors were unhelpful, or they experienced something negative in counseling.

It did not appear as though the specific techniques the counselors utilized in counseling were particularly important to these women. Of the techniques their counselors utilized, the women only talked about broad techniques like talking, questions, contracts, and alternatives. The use of alternatives appeared to be helpful to some, while not helpful to others. The women who found the exploration of alternatives helpful liked

the fact that it allowed them to be active in sessions. However, these same women and others argued that alternative behaviors are really only short-term solutions, or the “band-aid approach” to dealing with self-injury.

Throughout their experiences in counseling, it became clear that the women wanted to be heard and listened to. Additionally, they wanted to be viewed as unique individuals, rather than being made to fit into a category or a specific profile by their counselors. Many of the women shared that once their counselor learned that they were cutting themselves, he/she automatically made assumptions about who they were and adjusted their treatment based on the client being a “cutter.” The interviewed women clearly resented this approach.

The majority of participants expressed that some of their counselors focused directly on their self-injury, while others dealt more with the “underlying issues,” such as general depression, anxiety, familial issues, self-worth issues, etc. The general consensus was that it was most helpful to focus on the underlying issues, rather than the outer “symptoms,” or the actual act of cutting. In contrast, many of the women didn’t like the fact that their counselors focused primarily on their self-injury. Additionally, some of the participants revealed that their counselors asked them to show them their wounds. While the majority of women didn’t like this approach, Kylie and Ann didn’t mind because they had established a certain level of trust over time with their counselors.

As the women talked about their experiences in counseling and their overall history of self-injury, the language they used to describe their behaviors was compelling; their definition of self-injury appeared to be more broad than my former definition, which was synonymous with cutting. This was not the case for these women, especially the four women with a history of eating disorders; these women included eating disorders

and other self-harming behaviors into their definition of self-injury. As this theme emerged halfway through the interviews with these women, it forced me to reconsider the language I was using.

For the interviewed women, self-injury was an extremely private behavior, often associated with shame and even embarrassment. In fact, their behaviors were often hidden from even their closest relationships with family and friends. This theme of privacy definitely translated into the counseling relationship. Many of the women didn't want to talk about this behavior with their counselor. Consequently, they would avoid it, lie about it, or even "manipulate" their counselor into thinking that they were no longer harming themselves.

Although eight of the women received treatment at the College Counseling Center, only four talked specifically about their general views or experiences in the counseling center, irrespective of the counselor with whom they worked. Many of the women felt like the college counseling center was overbooked and ill equipped to deal with problems like theirs. In fact, two of the women were actually forced to receive services from the counseling center, after the college was alerted that they were harming themselves. Unfortunately, being "forced" into counseling basically turned these women off to the idea of counseling, in general.

All of the interviewed women were no longer actively cutting. Many of them had eventually found strength within themselves to stop or learned more effective ways to communicate their distress. It seemed like the majority of the women were in a better place at the time of the interviews. At the same time, it appeared that a few of the women were still searching for answers or guidance. After the interviews were complete, one woman e-mailed me to ask me if I could recommend a counselor for her. It was obvious

that she still was in need of assistance, even though her outward symptom, the cutting, had stopped.

Comparison To Literature

The findings from this study are in no way generalizable to all women who self-injure. Nonetheless, the phenomenological profile is reflective of the demographic characteristics of the majority of women who self-injure. The study participants were between the ages of 18 and 23. This age range is reflective of the statistics demonstrating that the college student population is the most at risk for self-injury. (White, Trepal-Wollenzier, Nolan, 2002). Also, many researchers have characterized women who self-injure as female, single, usually from middle to upper class families and intelligent (Favazza & Conterio, 1989; Zila & Kiselica, 2004). For this study, the women interviewed were also mainly white and single. Additionally, the college where the interviews took place is extremely competitive and consists of a large majority of middle to upper class students.

It is increasingly common for self-harming women to have co-morbid diagnoses with an eating disorder. Individuals with eating disorders are suggested to be a high risk for self-injurious behavior. An investigation of a study that examined the prevalence rates of eating disorders in the self-injuring population yielded eating disorder rates at 30% (Paul, et. al, 2002). Another study by Favazza and Conterio (1989) indicated that 61% of self-injuring participants in their study also had an eating disorder. The 30% incident rate was almost identical with this study, which yielded a 40% incident rate.

Many of the women disliked when their counselors fit them into a specific category or profile and consequently made assumptions about who they were and adjusted their treatment based on being a “cutter.” Levenkron (1998) argued against this

approach. He shared, “we have to credit her with a more rounded identity. We cannot simply see her as one-dimensional—a person who harms herself. A victim’s illness is not her identity” (p. 63). Rogers and Kegan (1991) agreed, drawing parallels between individuals with psychological issues and individuals with medical/physical issues. They argued, “people are obviously not their dysfunctions any more than they are their broken arms or burst appendices” (p.130).

The participants’ accounts of their counseling experiences provide a unique contribution to the literature. Presently, there is little known about how individuals who self-injure view the treatment they are given (Pierce, 1986). In fact, only a few studies exist which speak to individuals’ perspectives on the care they receive after their acts of self-harm. However, each study occurs within the context of a hospital or inpatient setting. For example, studies by Pierce (1986) and Treloar and Pinfold (2002) reported that patients who viewed their staff to be sympathetic demonstrated a lower rate of subsequent self-injury. Additionally, Croach & Wright (2002) discovered that participants expressed a desire to be understood. In spite of environmental differences, similar findings existed within this study; participants found it to be helpful when their counselors demonstrated understanding and empathy, and they didn’t judge the women for their behaviors.

Sub-Question One

Sub-questions one asks the question: From the perspective of the college-aged females, what is the nature of the client-counselor relationship? This section will include the attitudes and beliefs of the interviewed women in terms of their relationship with their counselors.

In the context of the client-counselor relationship, confidentiality appeared to be extremely important to the majority of the interviewed women. The women's opinions on this matter varied significantly. Some believed that cutting, in and of itself, was not enough to break the confidentiality agreement, especially when they were under-age. Others understood that they had "forfeited their right" when they did cut themselves. The one consensual attitude that shined through was authenticity; when the counselor was upfront with the actions they were going to take or not take from the beginning, they felt at ease. When the counselor made a decision "behind their back" or without telling them, they often felt betrayed and were angry with their counselors.

A collaborative relationship was a successful and helpful relationship for the interviewed women. The women appreciated that they were able to work together with their therapists, provide suggestions during sessions, and collectively make decisions regarding their treatment. Generally speaking, a collaborative relationship took time to develop and required the participant to develop a certain level of trust. Sam's succinct comment summarized her view of a collaborative relationship with her counselor: "It was kind of like a partnership. It was like a partnership of the two of us against the cutting."

Being an important player or an equal partner in her own recovery was important for many of these women. The women who believed they had input in the sessions, appeared to get the most out of treatment. This was certainly the case for Ann, Becky, and Kylie. They all felt like they contributed suggestions and controlled the pace of therapy.

The majority of the women talked openly about the characteristics of a helpful counselor. The participants didn't show preference for the gender, race, or age, of their counselor. Instead, they wanted a counselor who was willing to listen to them, who

didn't judge them, and someone to whom they could relate. As I reflect on the interviews, I remember one particular dialogue I had with Amy. Amy worked with two different counselors for approximately a one-year span. When talking about what she liked about her counselors, she didn't mention either one of them. Instead, she talked about the one counselor with whom she talked when she was admitted to the emergency room after ingesting a bottle of Advil. For *two hours* this counselor simply listened to her story, comforted her, and refrained from judging her. To Amy, this woman's "compassion" went a long way. She felt more connected to her than to the counselors with whom she had worked over the course of several months. Amy's description was extremely meaningful and demonstrated the power that listening and compassion can have for a client.

The participants' statements suggest that the time spent in therapy influenced satisfaction with therapy. For example, both Ann and Kylie worked with their counselors for more than two years. They each spoke highly of their counselors and talked about the meaningful relationship they built with their counselors. In contrast, Amy and Juliana, who appeared most dissatisfied with their treatment experiences, worked with their counselors over a shorter span of time. Amy worked with only one counselor for approximately six months, while Juliana worked with a series of counselors over a span of 6 or more years, but never worked with a counselor for a particularly lengthy amount of time.

The majority of the women viewed their counseling experiences to be positive when their relationship with their counselors was like a friendship. They felt like as if they were on the same level as their counselors. Additionally, they felt as if they could be genuine and honest with their counselor. While the majority of these participants

viewed their relationship to be “like friends,” some viewed their counselor as “their best friend” or a close friend. In fact, Kylie shared, “I am actually like best friends with my counselor...and I still e-mail her back and forth.” For Kylie and others who shared this viewpoint, they believed that their relationship went beyond the boundaries of the typical one-hour counseling session.

As some women felt as if they had met a new friend in their counselor, other women felt like a child within the client-counselor relationship. As a “child,” their counselor was the one who made the decisions and determined the direction in therapy. Feeling like a “child” in therapy was directly related to an unhelpful and negative experience in counseling; none of the women who felt like a child perceived their counseling experiences to be helpful.

Although only a few women talked about “feeling like a child,” many others talked about feeling powerless when working with particular counselors. In these cases, their counselors set the direction of the session, conveyed the idea that they had all the answers, and often talked down to these women. This was especially true with the counselors who quoted scripture or who infused religion into the sessions. The participants who experienced this phenomenon resented this approach; they believed they had no input whatsoever into the counseling relationship.

Feeling powerless had direct implications for the women’s overall perceptions of the counseling process and the client-counselor relationship. One woman in particular, had a particularly negative experience in counseling. Upon reflection, she felt as if it were she, who failed at forming the relationship. When asked about her overall feelings about counseling, she made the following powerful statement:

It makes me think of...it is on the laundry list of things that I didn't do well. My attitude was this is another thing that I did that I frankly failed. If you can fail at building a relationship with someone that you are paying to have a relationship, then there is a problem...I think of myself as sort of a failed project.

For Juliana, she clearly took on the responsibility and ultimately blamed herself for her negative experiences in counseling. Her statement has direct implications for treatment, which I will address within one of the upcoming sections, *Implications For Treatment*.

The client-counselor relationship emerged as a prominent theme. For these women, the single-most important predictor of satisfaction with therapy related directly to the nature of the client-counselor relationship. When the participant formed a strong connection, a formative bond, and an equal partnership with her counselor, she appeared not only to improve, but she also viewed her experiences with this counselor in a positive light.

Comparison To The Literature

The following section will provide literature that supports the findings related to the context of the client-counselor relationship.

The quality of the client counselor relationship is particularly important in the context of self-injury. As Levenkron (1998) stated, "If the therapist can prove to the patient that he is both worthy of her trust and dependable enough to form an attachment, then the patient can take what she has learned outside the office, and build positive attachments with others as well" (p. 99).

This research study both supports and conflicts with previous research on adolescents' experiences in counseling. Research findings suggest that the perceived expertness of the counselor is an important factor in considerations for adolescents

(Tatar, 2001). This was contrary to the findings of this study. The women in this study actually preferred a relationship that was peer-like and collaborative in nature. While the differences have merit, the women in this study were at the upper end of the adolescent age spectrum, which is likely to influence their views about what type of counselor with whom they would desire to work. Additionally, the women in this study valued a supportive relationship with their counselor. Research also supports this; adolescents place significant value on an understanding and supportive clinical relationship (Buston, 2003). Additionally, adolescent clients believed that the trustworthiness of the counselor was the most important factor in whether or not the adolescent will seek counseling (Tatar, 2001). In this study, trust proved to be an important factor. For some of the women, trust was established over time with their counselors. For others, trust was never established and was lost when the counselors broke confidentiality.

The participants' views of confidentiality were addressed in this study. Currently, there is conflicting research on best practices regarding confidentiality. Froeschle and Moyer (2004) talked about the importance of weighing legal responsibilities with ethical decisions when working with individuals who self-injure. They also recognized that a school counselor working with a student may be in legal jeopardy for non-disclosure if a student reveals that she is self-injuring and later seriously injures herself. Finally, they talked about the importance of clarifying stance on confidentiality with clients prior to the onset of counseling sessions. Walsh (2006), on the other hand, argued that when working with minors who self-injure, parents should be notified immediately. With an individual who is not a minor, confidentiality should be forfeited when a client inflicts damage that requires medical intervention and when the behavior shifts from self-injury to suicidal behavior.

Across diverse therapy approaches, the quality of the therapeutic relationship has proven to be a significant determinant of beneficial outcomes for clients (Bachelor & Horvath, 1999). Evidence suggests that relationship factors account for approximately 30% of client improvement (Lambert, 1992). In addition to quantitative studies, several qualitative studies have investigated the power of the therapeutic relationship. For example, therapist empathy, understanding, acceptance, support and care have been shown to be important factors (Maione & Chenail, 1999). Although the therapeutic relationship, or therapeutic alliance, is found to be a powerful determinant of therapy outcomes, there remains to be a unified definition of exactly that this relationship looks like (Bachelor & Horvath). However, there is “general agreement that the working alliance, emphasizing the collaboration of client and therapist in the work of therapy is a crucial ingredient” (p. 137). These findings were each found to be significant to the women in this study.

In this study, the women desired a relationship that was consistent with the major tenets of feminist therapy. For example, the majority of women desired a relationship that resembled a friendship or partnership. This is consistent with feminist theory, which views therapy as a non-hierarchical partnership between equals (Corey, 2001). A few women in the study disliked their counselors, who assumed a position of authority. When this happened, the participants often felt like a child. Feminist thought decries this position; within the context of feminist therapy, the counselor is viewed as another source of information, rather than as the “expert” source. Moreover, the therapist and client assume active and equal roles and work collaboratively in order to determine the direction of therapy (Corey, 2001).

Sub-Question Two

Sub-question two asks the question: From the perspective of the college-aged females, how was their self-injury addressed in the context of the counseling relationship? This section will include information about how the participants' self-injury (specifically their cutting) was addressed through the counseling relationship.

For the majority of women, their counselors were aware of their self-injury prior to their entry into counseling. However, their presenting problem was not necessarily their cutting; some entered counseling for an eating disorder, feelings of depression and/or anxiety, or general unhappiness. Others entered counseling after a suicide attempt or "suicidal gesturing." In contrast, one participant, Jane, shared that she initially started cutting in order to get the help she needed. She candidly stated, "I remember thinking that I wished that I could get raped so that I could go to counseling," and "I think one of the main reasons I started cutting was because I felt I needed counseling."

Self-injury, specifically cutting, was addressed in the context of the counseling relationship for all of the participants. For many, their self-injury was the main focus of their experiences in counseling, at the beginning of their relationship or as soon as their counselor learned about their behaviors. However, in time, these women talked about how the focus shifted, in time, to other issues, like their depression or related familial issues.

The majority of participants disliked a primary focus on their self-injury during counseling sessions. Many of these women did not feel comfortable talking openly with their counselor about their self-injury, due to the privacy and shame associated with this behavior. Thus, when cutting became the ultimate focus of the counseling sessions, some women would hide their behavior from their counselor or "manipulate" them into

thinking that their situation had improved. Others believed their counselors were missing the point by placing such a strong focus on their “outer symptoms.” This was the case with Claire; she remarked, “Once I told them I was stopping they were like, the symptom is gone so the problem must be gone, too.” This response suggests that the issues related to cutting go much deeper than the outer wounds.

For the majority of the interviewed women, addressing the deeper issues, rather than their cutting behaviors, was what they wanted their counselor to focus upon. Many women described these issues as the “reasons” for harming themselves, reasons which were unique for all women. Another appreciated a “balance” between focusing on the cutting and addressing the underlying issues. She stated, “I felt like it was all intertwined so you shouldn’t just have this one goal to stop the outward symptoms when the inward symptoms were just as important.”

During both interviews, the women talked about some of the specific actions their counselors took to address their self-injury. A couple of the women shared that their counselors would check their arms, after they cut themselves. These two women didn’t mind this behavior because they had already established a relationship with their counselors.

Throughout the counseling process, no-harm contracts were sometimes utilized. Many of the participants found them to be unhelpful and ineffective. While the majority of women never had to actually sign a contract, many spoke about how they would never sign a form, if given to them. Some saw the contract as “a joke;” they would never take it seriously, while others wouldn’t sign it because they wouldn’t want “to go back on their word.” Additionally, one participant made the point that the contract gives the power to the therapist, taking away the power from the client. While the majority of

participants didn't see the value in the no-harm contracts, some women talked about their effectiveness if a strong relationship had been established. These particular women felt some sense of indebtedness or responsibility to their counselor to uphold their agreement.

Comparison To The Literature

There is a lack of information regarding how self-injury is addressed in the context of treatment. For this reason, the comparison to the literature in this section is extremely limited.

In this study, participants were asked about their perceptions of no-harm contracts. The overall consensus was that the contracts were ineffective and almost patronizing. These feelings are supported by Walsh (2006), who talked extensively about contracts in the context of self-injury. He maintained that no-harm contracts are utilized within the context of treatment for self-injury in order to prevent the behavior from recurring and to ensure liability for the professional. In spite of this standpoint, he argued that there is little empirical evidence to support the efficacy of no-harm contracts. Thus, Walsh recommended against using no-harm contracts in therapy and argued that the risks outweigh the benefits. "The main risk is that contracting for safety often drives the behavior underground by fostering dishonesty" (p.122). Walsh also contended that without acquiring replacement skills, women who self-injure are unlikely to stop harming themselves. Thus, no-harm contracts are largely ineffective.

Hyman (1999) also talked about the ineffectiveness of no-harm contracts. In her view, no-harm contracts falsely imply that women are able to stop themselves from self-injuring at will. She also stated,

The result of such a contract can be more frequent or more severe self-injury. The client often cannot refrain from self-injury, feels shamed that she has failed to

abide by the contract, and injures herself even more because the feelings of shame-already familiar to her-is intolerable (Hyman, 1999, p. 14).

Some of the interviewed women talked about how their counselor repeatedly checked their arms after their acts of self-injury. A review of the literature located only one resource on the effectiveness of this approach. Levenkron (1999) argued the importance of examining clients' wounds on a regular basis. He shared the following:

This makes the cutter less inclined to commit the act; emotionally, she is less isolated. Also, she feels as if the self-inflicted pain is not going unnoticed. If someone she loves or depends on recognizes that she is hurting herself, this says something to her. It tells her that she is cared for and loved; that she isn't invisible (p. 182).

Sub-Question Three

Sub-question three asks the question: Using Loevinger's framework for assessing ego development, how did college-aged women make sense of their counseling experiences? This section will examine the participants' responses regarding their counseling experiences and will be divided into the ego-development groupings established during Chapter Five: the E5 Level/Self-Aware Stage, the E6 Level/Conscientious Stage, and the E7 Level/Individualistic Group.

E5 Level/Self-Aware Stage: (Claire, Juliana)

Two of the women, Claire and Juliana, both scored at the E5 level. As stated previously, Juliana exhibited behaviors consistent with clinical depression. For example, her responses on the SCT were self-deprecating and extremely critical of herself. Research findings suggest that internalizing problems, such as depression, are more prominent at the conformist stage, E4 level or self-aware stage, E5 level. If this is the

case, and my prediction about Juliana's mental health is accurate, then it is not surprising that Juliana scored at the E5 level (Krettenaauer, et. al, 2003).

As indicative of the E5 level, Claire and Juliana each demonstrated an increased self-awareness and a newfound ability to conceptualize inner life experiences. As they spoke about their experiences in counseling, however, their reflections were rather simplistic, especially when compared to the multifaceted and elaborate responses found at the E6 and E7 levels.

The Self-aware stage is still basically a version of conformity (Hy & Loevinger, 1996). In the context of treatment, both Juliana and Claire conformed, at some level, during the counseling process. For example, while in an inpatient treatment facility, Juliana eventually conformed to the expectations of the inpatient-counseling group. Upon reflection, she revealed that she learned from others what to say and what not to say about revealing her self-injury. Additionally, Claire conformed to the expectations of her therapist in treatment. Although she was not getting better, and she continued to cut herself, she told her counselor that she was no longer harming herself. This way, she fulfilled the expectations of her counselor and satisfied her own desire to terminate counseling.

At the E5 level, individuals begin to see multiple possibilities and alternatives in situations. Both Claire and Juliana demonstrated this way of thinking within the context of their counseling experiences. This particular theme emerged with Juliana, as she talked about both the positive and negative aspects of alternative behaviors in therapy. On the one hand, Juliana believed that alternatives were helpful, and she enjoyed the active exploration of these alternatives in counseling. However, at the same time, Juliana

recognized that alternative behaviors were “temporary solutions,” “short-term answers,” and “terribly simplistic.”

E6 Level/Conscientious Stage: (Amy, Katie, Kylie)

Three of the women, Amy, Katie, and Kylie, scored at the E6 level, or Conscientious Stage. Beliefs and attitudes reflective of the E6 level emerged. Each of these women demonstrated an increased ability to reflect upon her experiences and critically evaluate her own actions during the course of treatment.

At this level, guilt emerges when one has hurt another person. This concept was illuminated in each of the women’s responses; all of them refrained from telling a loved one about their self-injury because of fear of hurting them or letting them down. Additionally, at the E6 level, the theme of companionship emerges (Hy & Loevinger, 1996). With individuals at this stage, the counselor-client relationship became more collaborative in nature. Kylie’s counselor became a friend to her, and within the context of family therapy, was a member of her team. This viewpoint was also reflected at the E7 level, although the women at this level were able to expand upon their responses, and their dialogue was more complex.

E7 Level/Individualistic Stage (Ann, Becky, Calliope, Jane, Sam):

As indicative of the Individualistic Stage, there is a greater complexity in conception of interpersonal interaction (Hy & Loevinger, 1998). Additionally, the women at the E7 level demonstrated a strong sense of personality and individuality, and were able to reflect upon their experiences and their relationships through a critical lens.

Psychological causality, a prominent theme within the E7 level, emerged within the responses of the women at the E7 level (Hy & Loevinger, 1996). For example, Sam evidenced the awareness of psychological causality within her interpersonal relationships.

For example, her friends were extremely upset when they discovered that she was cutting herself. Sam's, friends encouraged her to talk to them about her problems, and she found this to be extremely helpful to her. Sam was able to make the connection between her friends' behaviors and her own emotions.

At the E7 level, individuals begin criticizing stereotyped prescriptions of gender roles (Hy & Loevinger, 1996). The women who scored at the E7 level took it a step further than the women who talked about gender roles and expectations at the E6 level; the women at the Individualistic stage spoke in a more in depth manner, and they elaborated upon their thoughts and beliefs regarding gender roles. Jane talked critically about the expectations that women face in college. "Being a college girl you are supposed to be attractive and thin and having a great, you know, romantic or sexual life, in addition to all your studies."

The theme of friendship between counselor and client continued at E7. Jane, Sam, and Ann not only talked about their counselor as a friend, but they also expanded upon these statements, and spoke with greater complexity than the women who scored at the E6 level. The theme of friendship also had an added component; Sam's relationship with her counselor became more collaborative in nature, and the two developed more of a "partnership," against the cutting.

Relationships are seen as continuing or changing over time at the Individualistic Stage, and the women at the E7 level recognized that. For example, both Ann and Calliope talked about how their levels of trust changed throughout the counseling process. For Kylie, it took a significant amount of time for her to trust her counselor. As their relationship developed, she slowly allowed her counselor more privileges. For example, over time, she began to show her counselor her scars, after she cut herself.

Comparison To The Literature

Unlike other cognitive developmental theories, ego development has been studied in clinical populations, including psychiatric patients and hospitalized adolescents. Hauser, Jacobson, Borman, Noam, Bowlds, Knoebber, and Powers (1991) argued that the investigation of ego development and psychopathology is ideal since ego development is directly related to clinically relevant dimensions such as impulse control, social judgment, and anticipation. Additionally, Swenson (1980) stated that ego development, when compared to all of the developmental theories, seems best applicable to counseling. It is possible that college-aged females at various levels of ego development may reflect upon their experiences in counseling differently.

Research suggests that the modal level of the general adult population in the United States is the E5 level, or Self-Aware Stage. For adolescents, the modal level is the E4, or Conformist Stage (Hy & Loevinger, 1996). Interestingly, findings of this study locate the modal level of participants at the E7 level, the Individualistic Stage. This Individualistic Stage is significantly higher than expected for the age range (18-23) of this study. Additionally, even the two women who scored at the E5 level and the three women who scored at the E6 level are above the modal level for adolescents and young adults. Upon closer examination, the Individualistic Stage appears well matched for the population of interest - college-aged women with a history of self-injury. Several factors appear to contribute to this high ego level. These factors are not necessarily additive, but they do each contribute in some way to the elevated score.

Self-injury is an internalizing psychological phenomenon; the act is directed towards the self. Research suggests that externalizing behaviors are associated with lower levels of ego development, while internalizing behaviors are associated with higher

levels of ego development (Noam, 1999). Evidence suggests that internalizing behaviors are more salient at the conformist or self-aware levels. Additionally, Hauser and Safyer (1999) contended that emotional conflict is linked to higher levels of ego development. If self-injury is a manifestation of emotional conflict, as this study suggests, these high ego scores are consistent with theory and research.

While many developmental psychologists maintain that higher levels of ego development are synonymous with adaptability and maturity, Noam (1999) disagreed. He argued,

It is this conceptual problem – that complexity and maturity are built in to one stage model – that is exposed when we study the relationship between ego development and psychopathology. In our own reformulation of ego development and self development, each developmental advance in ego complexity produces the possibility for more complex and internalized, self-destructive behavior... (p. 48).

This is certainly the case for the interviewed women. At high levels of ego development, their conceptualization of their interpersonal world was complex and integrated.

However, their recent histories of cutting demonstrated a particular lack of maturity or adaptability.

Noam (1999) also maintained that the attainment of higher levels of ego development may be synonymous with “the opportunity to transform vulnerabilities to create more mature adaptations (p. 84).” At the time of the interview, the participants were no longer cutting. Further, the majority of them did not display other less adaptive coping behaviors; such as substance abuse or sexually acting out. Instead, many of the women seemed to have developed adaptive mechanisms for coping, including seeking

counseling, focusing on education, and establishing communication with family and friends regarding their issues and personal concerns.

Additionally, research demonstrates that resiliency is associated with higher levels of ego development. Resilient individuals appear to be well adjusted and well functioning cognitively, emotionally, and interpersonally; these individuals are most strongly correlated with the profiles of the higher, conscientious, individualistic, and autonomous ego-levels (Krettanauer, Ullrich, Hofmann, & Edelstein, 2003). I argue that the women at the E7 level, in fact, were resilient; each of them was no longer harming herself, appeared to be thriving in school, and demonstrated a strong sense of personality and individuality.

Aside from the research of developmental psychopathology, additional findings may also contribute to the high ego levels. For example, the retrospective nature of the study may have influenced the scoring on the SCT. All women were no longer actively cutting; their absence from self-injury ranged from three months to four years. Therefore, they moved beyond their problematic behaviors, which likely contributed to their elevated scores. The interviewed women might have scored at lower levels of development if the interviews had occurred while the women were actively cutting themselves.

Another contributing factor relates to specific characteristics associated with higher levels of ego development. Research indicates that females from higher socioeconomic status with higher intelligence scored higher on ego level (Krettanauer et al., 2003). If this is true, these scores are consistent with such findings. The specific location of the study, a small southeastern public college, is known for its high academic

standards for acceptance and its large percentage of the study body who are middle to upper class.

Finally, while the participants' commitment to the study was, in totality, less than five hours, it is possible that their involvement may have been a growth producing experience. For many of the women, the interviews served as the first opportunity to share and reflect upon their experiences with self-injury and their experiences in counseling.

Study Implications

This section includes implications for treatment, research and Counselor Education. Contrary to the other sections of this chapter, the comparison of the literature will be infused throughout each section, when applicable. This section is in no way an attempt to apply these findings and conclusions to the larger population of women who self-injure. This would be antithetical to qualitative research and unethical on my part.

There were definite limitations to my study. First, there was no racial or cultural diversity; eight of the participants were Caucasian while one was African-American and another was Latina. This is partly due to the location of my study. I recruited all participants from a small public college in the Southeast United States. The majority of students who attend this campus are middle class and Caucasian.

The population from which I recruited is likely to be skewed. The modal ego development level of the participants was E7, which is much higher than the modal level for adolescents (E4, the Conformist Stage) and the modal level for the general adult population (E5, the Self-Aware Stage). It is possible that the participants' willingness to participate in this study is indicative of a higher level of ego development. Additionally,

evidence suggests that volunteers for research studies tend to be better educated and are more intelligent than non-volunteers (Gall, Gall & Borg, 2003).

I used a shortened version of SCT, consisting of 18 items rather than the long form of the SCT, which consists of 36 items. I made this decision because I believed that the benefits of using the short form outweighed the drawbacks; although a small amount of reliability and validity was lost, it took considerably less time for the women to complete. Rather than using the typical short-form of the SCT, I chose to utilize the odd numbers of the long form, because it seemed to ask more questions that were applicable to women's issues (Krumpe, 2002). This form, which is not standardized, may also contribute to the limitations of the study.

Treatment Implications

Self-injury is an emerging phenomenon for college-aged women. In spite of this increasing trend, the behavior is commonly misunderstood and mismanaged by mental health professionals. The time is now for counselors to take the time to learn about this behavior so they can better meet the needs of women who self-injure and are in treatment. The findings from this study have direct implications for treatment. With this being said, these suggestions in no way represent treatment implications for all college-aged women with a history of self-injury. The results of this study, after all, are only logically generalizable (Rossman & Rallis, 2003).

There is no doubt in my mind that the women in this study wanted to share their story. Although the majority of my questions were focused on the counseling experiences, the women talked most extensively about their history of self-injury and their feelings associated with self-injury. Upon reflection, I remember one woman who asked me, "Don't you want to know why I cut myself?" Initially, I was caught off guard

by this statement. Although I agreed to listen to her explanation, I didn't think that her response would have any bearing on the study. I now believe differently; the women wanted to tell their story and wanted to be heard, which has direct implications for treatment. The cognitive-behavioral approaches that many counselors rely on may not be the best fit for this population. Rather, I believe that narrative therapy or a postmodern approach may be most appropriate.

For example, forming a combined feminist/narrative perspective may be particularly powerful for these women. Both frameworks share the viewpoint that human beings are all active in giving meaning to our experiences (Mize, 2003). Additionally, both narrative and feminist approaches support the idea that sharing one's story in an egalitarian fashion creates the possibility of reshaping and redefining the client's lives (Corey, 2001).

Family therapy is an additional therapeutic approach that may be effective for women who self-injure. Many of them talked about contentious relationships with family members. Thus, family therapy could serve as a forum to explore these relationships. The counselor could also utilize family therapy to educate family members about the phenomena of self-injury. However, because of the secrecy and shame attached with self-injury, it would behoove counselors to use family therapy in conjunction with individual therapy. It would be helpful for the individual counselor to collaborate with the family counselor about treatment goals. Additionally, individual therapy could assist the client with strategies to communicate with family members about their self-injury and their feelings associated with self-injury.

Self-injury is often associated with shame and embarrassment. The behavior itself is a very personal and private matter. Many of the participants in the study did not want

to talk about their behavior with others, especially their counselor. Others went so far as hiding it from their counselors, or manipulating their counselors into thinking that they were no longer cutting themselves. This reality has direct implications for treatment: establishing rapport and forming a connection with women who self-injure are critical. Without a trusting relationship, it is likely that women will keep their self-injury hidden, making them less likely to communicate about their behaviors in the future with their counselors (Walsh, 2006). Counselors must take their time in establishing rapport and refrain from pushing women to talk about their self-injury. In this study, it appeared that once a connection was established, the women became open to the counseling process. Additionally, they were emotionally invested in their relationship with their counselors and this relationship often served as a vehicle for growth and change. As stated before, in the context of self-injury, the therapeutic relationship is critically important and can have long-lasting implications for improvement (Levenkron, 1999). Therefore, therapists should closely monitor the relationship with their clients on a regular basis (Bachelor & Horvath, 1999).

For the interviewed women, their length of time in therapy largely influenced their satisfaction with therapy. Both Juliana and Ann worked with the same counselor for over two years. In this time, they were able to develop a formative bond with their counselor, and the therapeutic relationship served as a catalyst for growth and change. While it would be ideal for therapists to engage clients in long-term treatment, this is unrealistic for many counselors. In our present day, managed care and insurance companies dictate the length of treatment or number of sessions for the majority of clients.

When the cutting stops, the problem is fixed. This is the frame of mind under which many counselors operate. I also adopted this viewpoint, as a beginning counselor working with women who self-injure. The women's responses within this study indicate that this is not the case. The absence of self-injury could mean the following: the women are hiding their self-injury from their counselors, in order to fulfill expectations for improvement or to get a ticket out of counseling. For others, it could mean that the behavior indeed did stop but the underlying issues still exist. To many of the women, the underlying issues, were what they wanted to focus on in therapy. In fact, it seemed as if the most helpful therapy was the therapy that did address these issues. This reality has direct implications for counselors: While the self-injury is important to address in the context of the counseling relationship, it is also important to focus on what drives this behavior—the underlying issues. Many women expressed that the cutting was only a “symptom” of the problem. Helping women to consider these underlying issues could be an effective approach to treatment.

Counselors, therefore, should never rely on the absence of cutting or reductions in the rate of self-injury as the only indicator of progress in counseling. Presently, there is a lack of empirical research on the value of focusing on the underlying issues with individuals who self-injure. However, Walsh (2006) talked about the underlying issues, or in his words, the core problems with suicidal persons. He argued, “Finding the specific source of the unendurable, inescapable pain is the primary focus in working with suicidal persons” (p.16). I suggest that this should also be the primary focus when working with women who self-injure.

As stated previously, early approaches to self-injury called for the use of no-harm contracts in treatment. Both Walsh (2006) and Hyman (1999) denounced the use of

contracts with individuals who self-injure. The participants from this study mostly agreed with the most current viewpoint; the majority of women did not take the contracts seriously and found them to be ineffective. With this being said, two women shared that they were more effective with counselors with whom they formed a strong connection. This finding has direct implications for treatment. Counselors should be aware that no-harm contracts are unhelpful in most circumstances. However, once a strong relationship has developed over time, the contracts may carry more weight for the clients. It seems like they are more likely to “keep their word” to someone in whom they are invested and with whom they feel a connection.

The majority of the women in this study preferred to have a partnership or “friend like” relationship with their counselor, while they dislike the counselors who assumed more of an expert status. This should not be surprising; the modal level of ego development for the women is at the Individualistic Stage. The women at this level desired a more collaborative relationship with their counselors. This finding has direct implications for treatment: It would behoove counselors to adopt a theoretical framework that is more collaborative in nature. I suggest that a feminist approach may be ideal for this population. Within the context of feminist therapy, women’s experiences are honored and considered central in understanding their distress. The feminist counselor aims to empower the client through a non-judgmental, non-expert, stance. Moreover, an egalitarian relationship exists, and a collaborative relationship ensues (Corey, 1998). Feminist theory, then, appears to be an ideal approach for women who self-injure.

In my viewpoint, self-injury is a developmental phenomenon. If this is true, it is imperative that counselors adopt a developmental framework for addressing this

behavior. It is important that counselors do not define these women by their dysfunction.

Rather, Rogers and Kegan (1991) argued that we should,

Address our patients as people first of all, struggling to understand and organize their own experience - even their painful and anomalous experience - we would direct ourselves to the meaning-regulative rules or principles by which they *do* that understanding and organizing (p. 130).

This statement indicates that as professionals, it would behoove us to examine the way that our clients make sense of their world and organize their experiences internally, rather than focusing on the outward pathology or dysfunction, which may initially bring them to therapy.

Implications For Future Research

There is an increasing amount of research on different aspects of self-injury: the behavior, contributing factors, demographic information, characteristics of individuals who self-injure, etc. In spite of this, there remains a dearth of information regarding treatment approaches for working with individuals who self-injure, and there is even less research about the experiences of women in counseling. This section will describe implications for future research, garnered from this study's findings.

For this study, I interviewed ten college-aged women, eight of whom were Caucasian. This lack of diversity certainly poses added limitations to the logical generalizability of the study. Future research, both qualitative and quantitative, is needed with diverse populations; self-injury needs to be examined in the context of different races, cultures, gender, and ages.

This study examined the clients' perceptions regarding their experiences in counseling. Future research should continue to examine the clients' views of counseling.

Additional perspectives should also be examined; counselor and family perceptions of self-injury would add to the research and, I believe, will provide clinicians with a broader understanding of this phenomenon.

I was genuinely surprised by the emergence of certain themes or sub-themes in this study. For example, I didn't expect the sub-theme of the College Counseling Center. However, with eight of the women receiving services in this environment, it was not surprising that the women had opinions about the College Counseling Center. I believe it would be powerful for researchers to further investigate self-injury in the context of the College Counseling Center, as well as interview counselors who work at a College Counseling Center to determine their perceptions and experiences with this phenomenon. An investigation into different colleges' or universities' policies on self-harm would also be worthy to examine. While there is no empirical research regarding the effectiveness of treatment for self-injury on college campuses, research was found on the status of mental health care on college campuses. Chisholm (1998) criticized the quality of care at college counseling centers, questioning their ability to provide well-trained and experienced staff who are current with the disorders most prevalent among college-aged students. In a response to this article, Stone, Vespia, and Kanz (2000), found a general lack of support for Chisholm's challenges. Nonetheless, an investigation into the context within the College Counseling Center would be useful.

In addition to the investigation of care in the context of the College Counseling Center, I also see the value in investigating the phenomenon of self-injury on college-campuses. While contagion episodes have been studied in the context of inpatient treatment settings, jails, and juvenile detention facilities, it remains to be investigated in the college or university setting (Walsh, 2006).

As a family counselor, I found it compelling that six of the ten women talked about the involvement of their family in counseling sessions. For these women, some viewed the involvement of their family members as helpful, while others found it to be detrimental. Future research examining the effectiveness of involving or not involving family members could be useful. Additionally, family counselors' perceptions of self-injury and experiences of working with self-injury in the context of the family would also be interesting to examine. At the present time, there appears to be a lack of empirical evidence regarding the usefulness of family therapy. Additionally, much of the research is conflicting. Levenkron (1998) argued, "The more significant people in her life who are involved in changing the patient's expectations, the more effective the treatment" (page 155). Additionally, Froeschle and Moyer (2004) maintained that involving the family in treatment for self-injury reflects best practices for under-aged individuals. Contrary to these findings, family therapy has been cited as an example of an ineffective treatment strategy (Zila & Kiselica, 2001; Favazza, 1996).

Many of the interviewed women, especially those with a history of an eating disorder, used the term "self-injury" to describe a range of self-harming behaviors; anorexia and cutting were both distinct forms of self-injury. With this in mind, I believe that it would be worthwhile for researchers to compare and contrast different forms of self-injury, in terms of both client and counselor conceptualizations and counselor approaches to these distinct behaviors. For example, do counselors approach cutting in the same manner as an eating disorder? Are their treatment plans similar?

The social construction of women's roles and images within both a historical and contemporary sexist culture creates a complex and potentially hazardous milieu, impacting young women in ways that are typically explained as individual intra-psychic

dysfunction. I believe further research is needed to create a comprehensive feminist understanding of self-injury and a correspondingly feminist treatment model.

Implications For Counselor Education And Training

Self-injury is a pervasive issue and emerging phenomenon affecting women. It need not be ignored in the context of a counselor education program. Pre-service instruction on working with this population is imperative.

Information and knowledge about self-injury should be infused into the practicum or internship experience as well as group supervision classes. A workshop on self-injury could be helpful to counselors who are likely to work with this population in their future career as counselors.

Clinical training must focus on collaborative models; introduction to post-modern and feminist theory is essential. Although didactic instruction is important and valuable, modeling and role-playing will also be important.

Findings from this study indicate that the therapeutic relationship is of utmost importance. It is critical for counselor training programs to focus on relationship building skills, through lectures, modeling, and role-plays; the application and importance of the therapeutic relationship should not be minimized. As stated previously, the quality of the therapeutic relationship has proven to be a significant determinant of beneficial outcomes for clients, across diverse theoretical approaches (Bachelor & Horvath, 1999).

Personal Statement

Last year, I remember contemplating my dissertation topic in Dr. Sharon Krumpe's office, one of my future committee members. I distinctly remember a conversation we had about qualitative research. Dr. Krumpe had completed her qualitative dissertation about four years prior. I asked her what her experience was like,

and she responded, “It is a life altering experience.” At the time, I didn’t understand what she meant by this. Further, I couldn’t comprehend how the research process could be that powerful. However, as I sit and reflect upon my experiences over the past year, I now know exactly what Dr. Krumpe meant. This experience has indeed been life altering and life affirming, and I am so thankful that I decided to pursue this journey.

More than anything, I am so very thankful to the women who volunteered to participate in this study. I am still in awe that these women took the many steps to get in contact with me in the first place. They not only had to see a flyer on campus, but they had to write down my contact information and then phone or e-mail me. For a behavior that is associated with shame and secrecy, contacting me was truly an act of courage. What I was most impressed with was their willingness to let me sit with them and bear witness to their stories. I remember one woman shared that she was in a sorority here on campus, and none of her “sisters” knew of her history of self-injury. Yet, she sat before me, a complete stranger, and spoke candidly about her experiences. Today, I am still blown away by this.

There is no doubt that the knowledge that I received from this study will frame my future work with women who self-injure. In fact, it already has! I now worry less about stopping the behavior and have begun to view self-injury as a symptom of issues that exist beneath the wounds. I focus less on what I do now and focus more on being present to, honoring, and respecting my client’s story. It is certainly a humbling experience to know that my approach in the past was not as effective as I thought.

At the start of this endeavor, I thought that there was so much to learn about self-injury and the counseling experiences of women who self-injure. I was aware that my knowledge base was only a small percentage of what I needed to know in order to work

effectively with this population. A year later, I feel like I know less, which is both scary and exciting; there is so much to learn about self-injury, and I hope that this is only the beginning for me!

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APPENDIX A

INFORMED CONSENT

I understand that I am volunteering to participate in a research project for the purpose of investigating the counseling experiences of female college students with a history of self-injury.

The research project is conducted by Laurie Craigen as part of the requirements for a doctoral degree in Counselor Education at the College of William and Mary. The study will begin in the fall of 2005 with a 60-minute semi-structured interview that will be audio-taped for the purpose of transcribing the data for analysis. A second 60-90 minute session consisting of a final interview and a short writing exercise will be held approximately 2 weeks following the first. At the end of both interviews an e-mail will be sent asking two follow up questions for the participant to comment on.

It is expected that the participation in this research will be a positive experience for those involved and the resulting report will provide valuable information and understanding about the counseling experiences of college-aged women with a history of self-injury. There is no anticipation of any foreseeable risks or discomfort from participation in the study; however, if the study causes distress, referrals to the college counseling center will be provided, and additional resources for counseling will be provided by contacting the researcher and Dr. Victoria Foster.

My participation is completely voluntary, and my refusal to participate will not result in any penalty. I may decline to answer any question or withdraw from the project at any time. My identity will remain anonymous, and all information received by the researcher as a result of my participation in this study will remain confidential.

If I have any questions at any time during my study, I may contact Laurie Craigen via e-mail at lmcrai@wm.edu or at the following office number: 757-221-2363

Signature & Date

APPENDIX B

INTRODUCTORY LETTER TO PARTICIPANTS

August 29, 2005

Dear _____,

I am a doctoral candidate in the Counselor Education Program at the College of William & Mary. As part of the requirements for my degree, I am undertaking a research study to investigate the counseling experiences of college females aged 18-23, with a history of self-injury.

To gather information from this study, I plan to interview 12 college-aged women with a history of self-injury who have been involved in counseling within the last three years. If you decide to participate, I will need your commitment to meet me twice at a location convenient for you for interviews and a short written exercise. I estimate that each meeting, scheduled at your convenience, will last approximately one hour. I will have refreshments for us during this time. After both interviews, I will e-mail you two brief follow up questions to answer.

During this process, your identity will remain anonymous; your name will never be used to identify your responses. At the beginning of the first interview, you will choose a pseudonym and you will be referred to by this pseudonym throughout the study. Your participation will remain confidential, and I will give you copies of your interviews so you can check them for accuracy and make corrections or additions, if you like. At the conclusion of the study, I will send you a summary of my findings.

I understand that your time is precious, but please consider that research in this area is extremely limited, and your participation in this area will help clinicians to provide valuable counseling services to individuals who self-injure. I also hope that participating in this study will prove to be a positive experience for you. In any event, your participation is completely voluntary, and you may withdraw from this study at any time without a penalty. For your participation in this study, you will also receive a \$25.00 gift certificate. If you think you might be interested, or if you have further questions before deciding, please contact me via email at lmcrai@wm.edu, or via phone at 757-221-2363.

Sincerely,

Laurie Craigen

APPENDIX C

BRIEF DEMOGRAPHICS QUESTIONNAIRE

Please circle the appropriate response:

1. Age
 - a. 18
 - b. 19
 - c. 20
 - d. 21
 - e. 22
 - f. 23

2. Race
 - a. African-American
 - b. Caucasian
 - c. Latina
 - d. Asian Pacific Islander
 - e. American Indian
 - f. Multiracial
 - g. Other: _____

3. In what form of self-injury do you engage?
 - a. Cutting
 - b. Burning
 - c. Both Cutting and Burning

5. How long were you involved in counseling?
 - a. 0-6 months
 - b. 6-12 months
 - c. Two years
 - d. More than two years

APPENDIX D

QUESTIONS FOR FIRST INTERVIEW

1. Did you enter counseling as a result of your self-injurious behavior?
2. Did your counselor ever attempt to involve your family members in counseling?
3. If yes, do you think that was helpful?
4. At age did you have your first counseling experience?
5. Did you refer yourself to counseling?
6. If not, who suggested you attend counseling?
7. What did you think counseling was going to be like before you started?
8. Tell me about your history of self injury.
9. Before counseling began, did you talk to anyone about your self-injury?
10. Tell me about your counselors' reactions to your self-injury.
11. Tell me about your families' reactions to your self-injury.
12. Give some examples of what you liked the best about how your counselor worked with you.
13. Give some examples of what you liked least about how you counselor worked with you.
14. On the whole, would you say that your counselor focused primarily on your self-injury during your counseling sessions?
15. Did you think that this approach was helpful?
16. Tell me about your relationship with your counselor.

APPENDIX E

QUESTIONS FOR SECOND INTERVIEW

1. Respond to the following question: When I think of my experiences in counseling, I think of....
2. How did it feel to be in counseling?
3. Do you feel that your counselor understood you?
4. If yes, how did your counselor demonstrate this to you?
5. If not, how did your counselor fail to demonstrate this to you?
6. What is it like to be a college student today?
7. Talk about some of the pressures about being a college student and female in today's society.
8. What would you tell other college students who are harming themselves and are involved in counseling?
9. What would you say to counselors who are working with female college students who self-injure?
10. Has counseling changed the way that you think about yourself?
11. Has counseling helped you to understand the issues related to your self-injury?
12. Has counseling helped you to develop alternatives to harming yourself?
13. Was counseling what you expected?

APPENDIX F

SENTENCE COMPLETION TEST FOR WOMEN (Form 81)
Abbreviated Form

Date: _____

Instructions: Complete the following sentences.

1. Raising a family

2. A man's job

3. The thing I like about myself is

4. What gets me into trouble is

5. When people are helpless

6. A good father

7. When they talked about sex, I

8. I feel sorry

9. Rules are

10. Men are lucky because

SCT, p.2

11. At times she worried about

12. A woman feels good when

13. A husband has a right

14. A good mother

15. Sometimes she wished that

16. If I can't get what I want

17. For a women a career is

18. A woman should always

Laurie M. Craigen
 130-A Indian Springs Road
 Williamsburg, VA 23195
 Email: lmcrai@wm.edu
 Tel: 757-876-3655

EDUCATION

Ph.D. Candidate

Counselor Education

The College of William and Mary (CACREP accredited)
 Department of School Psychology and Counselor Education

Cognate: Marriage and Family Therapy-
 Family/School Collaboration

Dissertation Title: “A Qualitative Investigation of the Counseling
 Experiences of College Aged Women with a
 history of self-injurious behavior”.

Doctoral Candidate: Expected date of graduation, May 2006

Ed.S.

School Psychology

The College of William and Mary (NASP accredited)
 Department of School Psychology and Counselor Education
 August 2002

M.Ed.

School Psychology

The College of William and Mary (NASP accredited)
 Department of School Psychology and Counselor Education
 August 2002

B.A.

Psychology

The College of the Holy Cross
 Department of Psychology
 All-Academic Team
 Dean’s List
 May 1999

CERTIFICATION, AND LICENSURE

Licensed School Psychologist, Commonwealth of Virginia
 Licensed Professional Counselor, Expected date of licensure, June 2006

ADDITIONAL TRAINING**Assessment in Family Counseling**

Assessing Depression: The CAD for Counselors (Clinical Assessment of Depression)
 [Presented by Bruce Bracken, Ph.D., Instrument Developer], 2005
 Utilizing the Global Assessment of Relational Functioning (GARF) in Treatment
 Planning, 2004
 Incorporating Family Process Diagrams and Structural Mapping in Treatment,
 2004
 The CAB (Clinical Assessment of Behavior): A Collaborative Tool for Family
 Therapists [Presented by Bruce Bracken, Ph.D., Instrument Developer], 2004

COURSES TAUGHT, *The College of William and Mary***Instructor**

ED C33 Techniques of Counseling, Fall 2005

Teaching Assistant

ED 762 Marriage and Family Counseling, Spring 2006
 ED 646 Family Practicum, Summer 2005
 ED C42 Practicum in Counseling, Spring 2005.
 ED C42 Practicum in Counseling, Spring 2004
 ED C33 Techniques of Counseling, Fall 2004
 ED C31 Career Development, Spring 2003

Additional Teaching Experience

Broaching Issues of Difference, College of William and Mary, 4/05
 Self-Injurious Behavior and Eating Disorders, College of William and Mary, 2/05
 Self-Injurious Behavior: Knowledge, Awareness, and Intervention, College of William and
 Mary, 3/04
 Techniques in Counseling: Reflecting Feelings, Old Dominion University, 12/04
 Harvard/Mind Body: Relaxation Training and Awareness, Old Dominion University, 4/00

PROFESSIONAL EXPERIENCE***May 2005-Present: Student Director of the New Horizons Family Counseling Center, College of William and Mary***

New Horizons Family Counseling Center (NHFCC) is a project funded through a consortium of six local school divisions to enhance school and family relationships and student success through the provision of free year-round family counseling services within the school systems. Counseling services are provided at the William & Mary campus and in four regional schools. Research and training projects are central to the mission of the Center. Families referred: approx. 300 families/year from six local school districts. Families served: approx. 200-230 per year. Responsibilities of the Director include grant renewal and program administration, coordination of NHFCC in concordance with the Family Counseling internship and Doctoral Cognate; development and update of Policy and Procedure Manual; writing the Annual Report to the Board of Directors, School Superintendents and

Dean of the School of Education; administer face-to-face individual and group supervision; provision of staff development workshops and specialized training modules in family counseling; development and supervision of research projects; supervise and direct data collection; and maintain HIPAA requirements. Students currently enrolled – 7 Masters Level Interns, 6 Doctoral Interns, 2 Post Graduate Interns.

September 2004- May 2005: Director, Project Empower, College of William and Mary

Project Empower is a program funded by the School of Education. The project enlists the efforts of professionals and students from various school-related disciplines to conduct prevention curricula in local schools. Responsibilities of the director include planning and providing a comprehensive data driven bullying prevention program for a local school, collaborating and consulting with school professionals, supervising graduate student participants in the program, and conducting classroom guidance lessons weekly.

September 2003-May 2004: Coordinator, America Reads, College of William and Mary

America Reads is a grant-funded prevention program committed to decrease rates of literacy and instruct Elementary School aged children to read. The program at William and Mary selects approximately 25 students to participate in the program. Responsibilities of the coordinator include processing applications, organizing and participating in a committee that selects applicants, organizing meetings with students selected to the program, communicating with reading specialists, organizing schedules, and monitoring all students' progress in the program.

May 2004-August 2004: Coordinator, Eastern Virginia Writing Project, College of William and Mary

The Eastern Virginia Writing Project is a summer program that offers k-12 teachers the expertise necessary to strengthen and evolve their own writing programs. Responsibilities of the coordinator include planning, scheduling, coordinating speakers, and additional administrative duties.

December 2001 to May 2002: Graduate Assistant for HTSAC (Historic Triangle Substance Abuse Coalition), College of William and Mary

The Historic Triangle Substance Abuse Coalition is a grant funded collaboration and partnership of organizations and individuals committed to reducing substance abuse through treatment, training, and prevention. Responsibilities of a Graduate Assistant include presenting research findings at monthly coalition meetings, serving of several subcommittees, creating comprehensive evaluations for several prevention program, and participation in community substance abuse prevention activities, specifically for families and adolescents.

August 2000 to May 2002: Graduate Assistant for C.O.P.E.S. (Community, Outreach, Prevention, and Educational Services), College of William and Mary

COPES was a project funded by the School of Education at the College of William and Mary. Responsibilities include presenting Harvard/Mind Body Relaxation Training to secondary education professionals, college faculty, and college students, facilitating anger management groups in local schools, creating and implementing a substance abuse prevention group at Merrimac Youth Detention Center, volunteering for

“America Reads” within local Elementary Schools, presenting drug and alcohol awareness curriculum to Freshman dorms at the College of William and Mary, and presenting trainings, sponsored the American Lung Association to teach tobacco prevention in the schools.

September 2000-June 2001: Research Assistant for the Center for Health Quality, Outcomes and Economic Research, Boston University

The Center for Health Quality, Outcomes and Economic Research (CHQOER) is one of 11 Centers of Excellence within the Veterans Administration Health Services. Responsibilities of research assistant include interviewing physicians across the New England area, attending meetings with the staff physicians on the study, as well as other administrative duties.

RESEARCH AND PRESENTATIONS

Refereed Publications

Craigen, L. & Foster, V. (2005). Self-injurious behavior: An emerging phenomenon. *VISTAS 2005: New Directions in Counseling*, 303-307. American Counseling Association Special Monograph. Alexandria, VA: ACA.

Craigen, Laurie (2006). Group Proposal: A Group For Parents Living With a Depressed Child. In Corey, M. & Corey, G. (2006). *Groups: Process and Practice*, 7th Edition. Thomson Brooks/Cole, United States.

Day-Vines, N., Wood, S., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., & Douglass, M.* (2005). Broaching the subject of race, ethnicity, and culture during the counseling process. *Journal of Counseling and Development*. Manuscript in press.

*After the first author, authors are sequenced randomly and contributed equally.

Publications

Craigen, Laurie (2003). Self-Harm: An Epidemic On The Rise. In *The Virginia Association for School Psychologists Newsletter*. Williamsburg, Va.

Craigen, Laurie (2004). Self-Harm: An Epidemic On The Rise. In *the Tennessee Association for School Psychologists Newsletter*.

Manuscripts in Progress

Dotson-Blake, K. & Craigen, L. (2005). Self-injury as a force in school counseling: A model for conceptualization and practice.

Craigen, L. & Foster, V. (2005). *A Systems Approach To Working With Self-Injury*.

Craigien, L (2005). A Treatment Model for Working With Self-Injury.

Research In Progress

Foster, V., McAdams, C., Craigien, L., Dotson-Blake, K. (2005). Factors influencing the process of family counseling: Data from a university-based clinic serving families referred by schools.

Reports

New Horizons Family Counseling Center Annual Report. (2004-2005). Submitted to New Horizons Regional Education Center Board of Directors, Peninsula School Superintendents, and to the Dean, School of Education.

Refereed Professional Presentations

Day-Vines, N, Wood, S., Craigien, L., Douglas, M., Holman, A., Dotson-Blake, K. (April 2005): Broaching The Subject of Race, Ethnicity During The Counseling Process. Presented at the American Counseling ACES, Pittsburgh,PA.

Day-Vines, N, Wood, S., Craigien, L., Douglas, M., Holman, A., Dotson-Blake, K. (April 2005): Broaching The Subject of Race, Ethnicity During The Counseling Process. Presented at the American Counseling Association Annual Convention, Atlanta, GA.

Craigien, L. (April 2005). Adolescents: A Systems Approach. Presented at the VACES Graduate Research Conference, College of William and Mary.

Craigien, L. (January 2005). Self-Injury: A Systems Approach. Accepted at IAMFC Conference in New Orleans, LA.

Craigien, L., Dotson-Blake, K. (September 2004): Home-School Partnerships; What Counselor Educators Can Do. Presented at the SACES Conference, Athens, GA.

Craigien, L. (September 2004) Self-Injury: An Emerging Phenomenon. Presented at SACES Conference, Athens, GA.

Craigien, Laurie, Dotson-Blake, K., Keener, H., Wood, S. (September 2004): Masters' Students' Experiences in Supervision: Implications for Counselor Educators. Presented at the SACES Conference, Athens, GA.

Craigien, L. (April 2004). Self-Harm: An Epidemic On The Rise. Presented at the American Counseling Association Annual Convention, Atlanta, GA.

Craigien, L. (October 2002). Living with Mental Illness: A Combined Psychoeducational/Support Group for Parents Living with A Depressed Child. Presented at the ACES Conferences, Park City, Utah.

Craigien, L., Milliken, T., Muldner, J. (November 2001). Harvard/Mind Body Relaxation Techniques. Presented at the VACES Conference, Charlottesville, VA.

Craigien, L., Milliken, T., Muldner, J. (October 2001). Harvard/Mind Body Relaxation Techniques: Knowledge and Training. Presented at the SACES Conference, Athens, GA.

Craigien, L., Long, C., Muldner, J., Schmidt, C. (April 2001). Harvard/Mind Body Relaxation Techniques. Presented at VCA Conference, Richmond, VA.

Rokutani, L., Craigien, L., & Muldner, J. (April 2001) Collaboration: A Systemic Approach. Presented at VCA Conference, Richmond, VA.

Minor Research Grants

The Parent Institute - \$5000.00. Secured funding for research examining barriers to family School collaboration (May 2004-Current)

Other Assignments

Certified Trainer, Harvard Mind Body Relaxation Training. (Training conducted at College of William and Mary.

Editorial Assistant (2005), Virginia Counselors Journal.

Awards Committee (2004), Virginia Counselors Association

Co-Chair, Graduate Student Interest Network (2004), Southern Association of Counselors Educators and Supervisors (SACES).

HONORS, PRIZES AND AWARDS

Galfo Research Fellowship Award, College of William and Mary, 2005

Margaret, The Lady Thatcher Medallion (awarded to a graduate student at the College of William and Mary on the merits of character, scholarship, service and excellence), 2003

Kappa Delta Pi, College of William and Mary, 2002

Member, Kappa Delta Pi Honor Society 2002-Present

Purple Key Society, College of the Holy Cross, inducted fall of 1998

PROFESSIONAL MEMBERSHIPS

American Association for Marriage and Family Therapy (AAMFT)

American Counseling Association (ACA)

Association for Counselor Education and Supervision (ACES)

Virginia Counselors Association (VCA)

Virginia Association of Counselor Education and Supervision (VACES)

Southern Association for Counselor Education and Supervision (SACES)