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Stained Glass at the Cutter's Edge

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STAINED GLASS AT THE CUTTER'S EDGE

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By

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TABLE OF CONTENTS

ABSTRACT

This thesis explored the personal experience of creating a stained glass window with five adolescents who had previously been identified as causing self-harm to themselves. The narratives of these five adolescents between the ages of thirteen to seventeen were collected in qualitative interviews. This study emphasized the importance of; self-object and transitional object, destructive and creative process, power and self-esteem. The literature illuminates; the history of self-mutilation, the current issues with self-mutilation, including the internet and cultures outside of the United States, the combination of narrative therapy with art therapy, the use of stained glass as an intervention, and the ethical considerations involved in the creation of a stained glass window. Furthermore, this study confirmed that creating a stained glass window had a positive effect on self-mutilating adolescents.

INTRODUCTION

"The truth about childhood is stored up in our body and lives in the depth of our soul. Our intellect can be deceived, our feelings can be numbed and manipulated, our perception shamed and confused, our bodies tricked with medication. But our soul never forgets. And because we are one, one whole soul in one body, someday our body will present its bill. "

-Alice Miller

When I first learned about art therapy I completely understood why it worked. I understood without words, how powerful the art process could be. My body had known the depths of great sadness in adolescence. In the pages of my journals I could draw, scribble, and splash dabs of colors onto the blank sheets, only there would I find my balance.

Equilibrium seemed lost in adolescence, I remember saying to myself, "When will this ride end? When will the bad days not seem so terrible?" Now looking back knowing what I know now, I see all the value in having felt just so much intensity. These difficult years helped me to understand the teens that I now see in my office. I respect the anger, the sadness, and the quiet resentfulness that seems all around them.

With all these defense mechanisms holding strong, the only place that we could go was into the world of art. I often hear myself saying to these teens that doubt themselves, "Don't think about what you're doing. Let your body take over. Let symbols and color come onto the paper. Ignore your voice of judgment, this isn't about what you produce, this is about your experience, your process."

The first time I heard about the mixture of creating a stained glass window with teens that were cutting I literally got the chills. This I felt in my bones, was it. This was the piece that brought light onto what art therapy was all about. Self-mutilation is extreme; in turn an extreme intervention was needed.

PROBLEM STATEMENT

"The skin becomes a battlefield as a demonstration of internal chaos. The place where the self meets the world is a canvas or tabula rasa *on which is displayed exactly how bad one feels inside."*

-Psychologist Scott Lines

Self-Mutilation

Self-mutilating refers to the direct and deliberate damaging of one's own body tissue, without the intent of committing suicide (Favazza & Conterio, 1989). This harmful behavior can include such things as cutting, scratching, picking at scabs or interfering with wound healing, burning, punching self or objects, bruising or breaking bones, as well as other forms of bodily harm (Favazza,1998).

Percentage of Population Who Self-Mutilate

Millions of teens around the world regularly participate in the act of self-mutilation. Many experts are estimating the incident of self-mutilation occurs in 1% of the population (Strong, 1999). They have found that the typical onset begins at puberty and lasts between five to ten years, but can persist much longer without treatment. Self-mutilators are notoriously difficult clients, being at times suspicious, frigid, untruthful, un- communicative and determined to hold onto their symptoms at all costs (Conterio & Lader, 1998). In the past medical practitioners and therapist have largely relied on hospitalizing these adolescents hoping to restore their emotional health.

Nearly 50% report having experienced physical and/or sexual abuse during childhood. As high as 90% have reported that they were discouraged from expressing emotions, particularly, anger and sadness (Conterio & Lader, 1998).

Why do so many adolescents choose self-mutilation?

Self-mutilation provides relief by turning emotional pain into physical pain. Also for many who have been abused over an extended period of time, the body becomes numb from feelings, by seeing the blood, and feeling the pain, many are reminded that they are alive and in control (Favazza. 1998).

Many of these teens report feelings of emptiness, feeling under or over stimulated, unable to express their feelings, not understood by others and fearful of intimate relationships. Self-mutilation acts as a coping mechanism used to relieve painful feelings and is generally not an attempt to commit suicide. This form of temporary relief can become a very addictive and destructive cycle (Conterio & Lader, 1998).

Within most of the books and articles written on self-mutilation, it seems each person has a different story, a different motivation, and a different feeling before, during, and after they harm themselves, yet they are all working toward the same goal of self soothing. Many who self mutilate feel empty and numb while hurting themselves. After the act has been completed many will report that the pain can be extremely intense yet the aftermath will be oddly calming, soothing and alive.

What type of treatment is currently being used to treat self-mutilation?

According to Nock and Prinstein's article, *Contextual Features and Behavioral Functions ofSe(f-Mutilation Among Adolescent's,* this phenomenon has received relatively little research attention causing slow progress in the increasing need for alternative methods of help (2005). Some of the difficulties in research progress have been in the recruitment of participants, the collection of reliable data, and the ethical and legal deterrents involved when working within this population. Most of the studies that

have been done with adolescents who self-injure have included a correlation with a wide range of clinical constructs. Although this identification may help to predict who is at risk for becoming a self-mutilator, it does little to figure out how to help stop the current problem. This maladaptive coping strategy must be replaced by using healthier strategies to communicate unspoken pain. A self-injurer has not learned to express pain with words, and so expresses it by acting it out onto his or her body.

Treatment thus far has included a combination of medication, psychotherapy, and cognitive-behavioral techniques, staged and individualized to each client's need (Strong, 1999). Many times, clients will be medicated in a hospital unit without a doctor looking at the symptoms and realizing that there is a reason all this is happening (Conterio & Lader, 1998). Many times psychiatrists will label self-mutilators as psychotic and put them in restraints. If a therapist were to look at the symptoms as a window, eventually the reasons this is happening would become clear and the individual would no longer be doomed to replay the trauma.

Nock and Prinstein found that medications have been an important part of treatment for some individuals. Antidepressants such as Prozac have been successful in reducing chronic, repetitive cutting (2005). Naltrexone, a drug used to block the release of the body's natural opiates, and the euphoric high that cutting produces, has shown some success in trials. The body naturally produces its own opiate-like substances and uses them as neurotransmitters (The Brain from Top to Bottom, 2007). Other drugs that can be used to block the body's natural release of adrenaline have been found helpful in reducing side effects from past trauma. The majority of research on these drugs has been conducted on war veterans (Nock & Prinstein, 2005).

In 1986 at the National Institute of Mental Health Rex Cowdry and David Gardner conducted a double-blind study of four medications to treat self-mutilation and other impulse control problems. Each patient took in succession, an antipsychotic drug, an anti-anxiety drug, one of the older generation antidepressants, and an anticonvulsant. One of the most significant improvements was seen while patients where taking carbamazepine, the anti-seizure medicine known by the commercial name Tegretol. They found that no serious acts of self-mutilation occurred during the Tegretol trail. Yet even Cowdry stated that this is not the magic treatment, "Drugs need to be used in conjunction with psychotherapy, because self-injury is often a long-established pattern tied up with significant difficulties in relationships and other behaviors that have developed," (Cowry & Gardener, 1986, p. 164).

Little research has been done on the effects of traumatic stress and its specific impacts on self-injury. Using a trauma-based approach will help patients stop the terror that haunts them from the past. Stress management and relaxation education help clients develop skills to manage anxiety so that they can control emotions and feel less overwhelmed. An approach called eye movement desensitization and reprocessing (EMDR) is reported to help defuse the emotional impact of traumatic memories through systematic exposure to imagined scenarios while in a relaxed state (Shapiro, 1989). However using EMDR can be a risky intervention and should not be used during times of crisis. Using EMDR relies on the cooperation of the patient for the procedure, so it is essential that the therapist can access that the environment be secured for complete safety in the days leading up to the procedure (Paulson, 1995).

Cognitive-behavioral therapy (CBT) views cutting as a learned behavior, driven by self-destructive thoughts and beliefs. The behavior is maintained by positive reinforcement (attention, nurturance) and negative reinforcement (relief from distress) (Linehan, MM, 1993). CBT believes that the behavior can be "unlearned" by changing negative thought patterns, teaching clients healthier coping skills, and withdrawing rewards. Strong (1999) provides the basis for research in her book *The Bright Red Scream* by laying out the importance of dealing with high-risk emotions, feelings, and situations.

Some of the most positive results have been seen while using a treatment called dialectical behavioral therapy (DBT), created by University of Washington psychologist Marsha Linehan (Strong, 1999). DBT consists of individual therapy for one-hour session a week, plus two and a half hours of group therapy weekly for one year. DBT was created to treat clients who engage in chronic "para-suicial" behavior, which includes both self-mutilation without suicidal intent and true suicidal acts (Linehan, MM, 1993).

The research shows that one of the primary obstacles with the greatest benefit to psychotherapy with self-mutilators is the development of a safe and trusting relationship between the therapist and the client. For most of these individuals, the people who should have been protecting them have been the ones abusing them. Much of the trauma that brought on the self-mutilating will be played out in the office of the therapist (Conterio &Lader, 1998).

A therapist is a 'key component' in working with these individuals to assist in taking the maladaptive coping strategies and replacing them with healthier ones (Levenkron, 1998). For a self-mutilator to communicate the pain that they are feeling

they often rely upon metaphor to express internal and intangible experiences. Self-mutilation represents fragments of a wounded soul in a graphic pictorial fashion (Hitchcock, 1999).

Art therapy is unique in its use of materials to facilitate self-expression using symbols rather than words. Diana Milia explains the process of creation and destruction in her book titled *Self-Mutilation and Art Therapy,* as the contexts where the healing begins. This book gives light to the view of creation and destruction, working as a neutral force to help effect transformation, making morbidity a potentially meaningful part of the process of change. An art-based perceptive on self-mutilation hopes to change the ritualistic act of violence, transforming it into an aesthetic form of expression. By using art, a slow change can occur to transform ritual acts to formed and liberated symbols (2000).

A look at what still needs to be done.

There is an existing need to create an art therapy based intervention, to help adolescents who self mutilate. This thesis will demonstrate the hypothesis that self-mutilators can discover a healthier narrative voice through creating a stained glass window. This will be replicating what Jenny Warren (2002) a former marriage and family therapist and art therapy student at Notre Dame de Namur started in her thesis title *Understanding the Mystery of Cutting.* Warren's work was well received by the students she worked with, yet the population size was small, only two individuals who were able to complete the project. Recreating her initial ideas with a larger population size will help to validate the brilliance of this art directive. She bravely took on the use of glass as

a therapeutic means, and used a material that many would consider risky for both the client and the therapist.

With art therapy, the use of metaphor and imagery is a non-threatening means to working with a population that is unable to verbally articulate their problems. This research will provide an arena in which these often '-voiceless' adolescents can express thoughts and feeling in a safe contained environment.

It is understandable that many would respond with concern to the idea of using glass with adolescents who self-harm. Therefore, it is imperative to determine guidelines for the work to be conducted in a safe manner. The environment will be contained and skillfully observed and each tool and piece of glass accounted for at the beginning and ending of each session. A preparatory training phase will be used to deepen the sense of care and nurturing in the patient-therapist relationship. If the therapist is confident about his or her mastery of working with glass, there is little difference between the use of glass in therapy and the use of a pair of scissors (Somer & Somer, 2000). The early phase will also be used to enhance the therapist's faith in the client's capacity to master the glass, as well as build trust in the patient's commitment to the safety contract.

Many of the clients describe their scars as telling their life's history. Some will even say that each scar represents a particularly important life event that the patient will always remember. "I've got physical scars... It shows that my life isn't easy. I can look at different scars and think, 'Yeah, I know what happened,' so it tells a story. I'm afraid of them fading (Conterio & Lader, 1998, pg. 11)."

The Use of Narrative Therapy

This thesis will use a narrative theory, thus giving prominence to the stories that the clients recount. Story telling or 'narrativising' (Riessman, 1993) is not only an effective and accurate first-hand transmission of information, but it also acts as an empowering experience. This therapeutic process effectively establishes a rapport between author and listener.

Narrative therapy lends itself to working well within this population, with the recreating of the stories in collaboration with the therapist and the self-injurer. It is extremely important to hear the story behind all the pain, to figure out what the individual is feeling before, during, and after each incident. It is not important for the individual to discuss with the therapist the actual destructive behavior, such as the actual act of cutting or burning that lead them to the therapy setting.

Narrative therapy involves an exploration of the shaping moments in a person's life, and the important turning points that often go ignored. These stories guide people in how they think, act, feel, and make sense of life experiences. Narrative therapy can help to focus in on these pivotal events and help to rewrite old stories. Narrative therapy proposes that identity is co-created in relationship with other people as well as by one's history and culture. People come to see themselves by looking in the mirrors that other people hold up. Narrative therapy states that our identity is socially constructed, that an unearthing of these stories, understanding them and retelling them is essential to the therapeutic process. A person's life in crisis is crossed by an invisible story line, which can have enormous power in shaping one's life (Sween, 1998).

The goal in using narrative therapy is to explore these shaping moments in peoples lives that create who they are and what they are doing to their bodies. Within

this thesis clients will also be invited to become their own authors, to make them aware of the reoccurring themes found throughout their lives and help them to decide if they want to keep these dominant themes in their revised stories (Shovlin, 1999).

LITERATURE REVIEW

"How will you know I'm hurting
If you cannot see my pain?
To wear it on my body
Tells what words cannot explain."
-C. Blout

HISTORICAL OVERVIEW OF SELF-MUTILATION

Self-mutilation/body modification has been an integral component to cultural rituals, which spans generations. They reflect a society's traditions, symbols, beliefs, and are interwoven into the fabric of social life. Rituals in which the body's tissue are altered or destroyed often serve the purpose of correcting or preventing conditions that threaten the stability of a community. These rituals are being used to promote healing, spirituality, and social order. In many religions, mutilation/modification rituals are thought to be offerings to the gods and help to achieve a state of holiness, ecstasy, and insight (Favazza, 1998).

Olmecas, and Mayans placed the blood from their genitals on stone idols as a symbol of devotion. Aztec priests pierced their cheeks and lips, slashed their tongues, spilled their blood and sometimes castrated themselves to honor their gods (Favazza, 1998). In many cultures mutilation and modification takes place during initiation rituals in which the child becomes an adult. Teeth are knocked loose or filed to points and inlaid with precious stones, the penis sliced open, and areas of the skin are cut off. This is the price that they believe must be paid to take part in adult communal life (Strong, 1998).

For many years the Catholic Church canonized persons who zealously mortified their flesh as saints. The first publication on cutting was in the New Testament Gospel of Mark, in which a man living in a graveyard, who was believed to be possessed, is

described as cutting himself with a rock (Conterio & Lader, 1998). This statement has been widely ignored for decades. Even Jesus allowed his body to be mutilated in order to save mankind. Yet armed with all this rich history in present day we are faced with tackling the clinical problem that exists in our society.

In the late 1960's psychiatrists and psychologists started reporting that young, attractive and often intellectual women were engaging in habitual non-lethal wrist cutting (Favazza, 1998). "Delicate self-cutters," were the words used to describe these women who used cutting not as an attempt to commit suicide but as an obsessive way to reduce tension (Milia, 1969).

THE CURRENT PROBLEM OF SELF-MUTILATION

Currently self-mutilation has become a pervasive public health problem occurring at a rate of 4% in the general adult population, and 21 % in adult clinical population, yet the population of adolescents causes the most concern (Turkheimer, 2003).

In 1998 Armando Favazza a professor of psychiatry at the University of Missouri, Columbia and the leading expert on self-mutilation, found that based on the prevalence of cutting in various mental disorders, an estimated 2 million Americans deliberately cut or burn themselves every year. This is nearly 30 times the rate of suicide attempts and nearly 140 times the rate of "successful" suicides (Favazza, 1998). He also conducted a survey of 500 university students taking a mandatory undergraduate psychology class which showed that 12 percent-] in 8, had at least once in their lives intentionally cut, burned or harmed themselves (Strong, 1998). The most common forms of self-mutilation are cutting, hitting, scratching, burning or banging parts of the body against walls or other objects (Milia, 1996).

Princess Dianna was one of the first celebrities to shine light on what had been happening for many years when she publicly admitted to cutting her arms and legs for years. She reported in a BBC interview, "You·have so much pain inside yourself that you try and hurt yourself on the outside because you want help (Levenkron, 1998)." Even one of the founding authors of our Oxford English Dictionary used self-mutilation as a form of relief from his insanity, by castrating himself in the mid 1800's (Winchester, 2005).

Pattison and Kahan reported that 63% of self-cutters had used various other methods for self-mutilation, such as burning the skin, penetrating the skin with needles, hitting themselves, and banging their heads against walls. Favazza also extended the concept of self-mutilation to include body customizations such as body piercing and tattooing. All these studies show that 'wrist cutting' is only a very small part of self-mutilating behaviors.

With each new school of thought on the topic comes a new name, such as: de! ibcrate self harm syndrome, auto-aggression, self inflicted violence, repetitive self-harm syndrome, or multiple personality/dissociate identity disorder and the deceptively innocent sounding "delicate self-cutting." Most commonly we hear the behavior called "cutting" where others refer to the actual act: self-mutilation (Razor, 2001). The definition of a self-mutilation is someone who deliberately damages one's own body tissue without trying to commit suicide. The harm is usually deliberate, repetitive, and impulsive (Why Does, 2001). Yet the cohesive understanding of self-mutilation has only really developed throughout the past ten years (Strong, 1999).

THE INDIVIDUAL

Armando Favazza and Karen Conterio, confounded S.A.F.E. (Self Abuse Finally Ends), the nation's only in-patient program specifically designed for the treatment of self-injury. Together they coauthored the largest study ever conducted on cutting, with 240 chronic self-mutilators. They found that the most "typical" self-injurer was a white woman in her late twenties who began hurting herself at age 14. They also found that these women had usually done this at least 50 times, and that the most common form of injury was cutting. More than half the subjects in Favazza and Conterio's study chose the word "miserable" to describe their childhoods (Favazza and Conterio, 1989).

Many self-mutilating individuals report that by inflicting physical harm onto themselves they can feel a sense of relief. The distressing symptoms that commonly are experienced before an individual will cause self-harm range from, anxiety, to depersonalization, to racing thoughts. The effects after the inflicted pain are tension release, ending of depression- euphoria, decreased troublesome or enhanced positive sexual feelings, release of anger, satisfaction from self-punishment, a sense of security, control, a unique way of manipulating others, relief from feelings of depression, loneliness, loss and alienation (Favazza, 1989). In other words many of these individuals are people who use self-mutilation as a vehicle to change their moods, to achieve a state of psychological awareness through self-inflicted pain (Strong, 1999).

The dissociated state that happens after cutting serves to distract the patient from problems, while the cutting and wounding may be looked at as a painful memory, which remains repressed. Mastering pain can also be looked at as power, through directing pain

onto oneself (Milia, 1996). "Self-inflicted pain and wounding is not an end in itself, but an attempt to promote healing and the achievement of a healthier and more autonomous state of functioning" (Milia, 1996 p.60).

TREATMENTS

Medication is something being used with cutters, but there is no single pill that is regularly effective. There are many ineffective treatments out there such as; physical restraints, hypnosis, chemotherapy, no cutting contracts, faith healing, group-psychotherapy, relaxation therapy, electroconvulsive therapy, family therapy, educational therapy, and chiropractic care (Favazza, 1996). These self-mutilators should not have this coping mechanism taken away without helping them realize what triggers' these incidents and learn new, healthier coping mechanisms that can replace the old maladaptive ones (Razor, 2001).

REASONS BEHIND SELF-MUTILATION

There seems to be both an individual and an environmental risk, as to why so many teenagers are acting out in this way. One of the major areas of concern is the environmental risk factor associated with childhood maltreatment. Most research has focused on the role of childhood sexual abuse and self-harm having a great effect on the adolescent years and adulthood (Zorogula, 2003). Literature also suggests that the role of pathological family relationships, parent-child discord, and disrupted bonding can have an impact on the risk for later self-harm (Ogawa, Soroufe, Weinfield, Carlson, & Egeland, 1997). The scope of environmental risk factors for self-harm include forms of childhood maltreatment other than direct abuse, such as emotional neglect and disrupted bonding (Gatz, 2006).

Another important characteristic that plays a role in the development of self-harm is that of emotional dissociation. Using dissociation as a defense mechanism is very common in children who are abused (Strong, 1999). Research has found that self-harm is associated with alexithymia, an inability to express feelings verbally (Zlotnick, 1996). Moreover, they found that self-harming prisoners were more withdrawn and uncommunicative in general, suggesting that they may have been unable or unwilling to express their thoughts, feelings, and other internal experiences verbally (Virkkunen, 1976). When self-harming individuals learn to express their feelings verbally, their self-harm behavior decreases (Mclane, 1996). This idea also goes along with the idea that self-harm is an act of expression and communication by individuals who cannot otherwise express their feelings (Mclane, 1996).

There may be a connection between early childhood trauma and self-mutilation, based on the theory that some trauma victims compulsively seek painful or abusive experiences in attempts to master the trauma. Many of the people using self-mutilation have been abused in their childhood (Why Does, 200 I). Self-mutilators use their body as a theater to reenact the trauma of abuse, simultaneously identifying with the abuser and the victim at the same time (Milia, 1996). Many are acting out the familiar roles from childhood the abandoned child, the physically damaged patient, the abused victim, the (dissociated) witness to violence, self-destructiveness, and finally the aggressive attacker. Thus with a few strokes of the razor the self-mutilator may unleash a symbolic process in which the sickness within is removed and the stage is set for healing as evidence by a scar. Both episodic and repetitive self-injurers hurt themselves for the same reasons, to relieve tension, release anger, regain a sense of self-control, and terminate states of

emotional deadness (Strong, 1998). "The whole idea of cutting yourself is ironic,' says a teenage girl from The Bright Red Scream, 'fingering the Happy Face scar. "Making you hurt to feel better is a really wicked and deranged thing. But to me, it's normal" (Strong, 1998).

A WORLD VIEW OF SELF-MUTILATION

In 1979 a few studies done in Japan found that 'wrist cutting' was taking place by many young females with borderline personality disorder. Up to this point no studies had described self-mutilating behaviors other than 'wrist cutting.' In February 2003 a study was conducted at a juvenile detention center in Yokohama City, Japan with 201 adolescents. The study was designed to identify clinical differences between four different groups; a control group where no self-harm had occurred, a self-cutting group, a self-burning group, and a group that was doing both self-cutting/self-burning (Matsumoto, Yamaguchi, Chiba, Asami, Iseki, Hirayasu, 2005).

They found that in Japan a typical behavior was to bum the skin with a lit cigarette, 'self-burning to prove one self a man with guts.' This appears as a ritual for social binding within delinquent circles. Japanese psychiatrists and psychologist have rarely been interested in this behavior so it has remained unclear if this behavior is the same as self-mutilation. Subjects which were self-cutting and burning were mostly male, while many of those with only self-cutting were female. Many of the self-mutilation practices had to do with a rite of passage, such as the cigarette burning and even the more extreme ritual of finger amputation carried out in the Japanese gangs called Yukuza (Matsumoto, et al. 2005).

Turning to another side of the world and looking at the Turkish culture we see that in the article *Suicide attempt and self-mutilating among Turkish high school students in relation with abuse, neglect and dissociation* (2003) again that child maltreatment and its effects on psychopathology demonstrated that childhood abuse and neglect is highly correlated with suicidal and self-mutilation behavior in children, adolescents and adults. Research has found that self-mutilation is a common reaction to social isolation and fear in both humans and in non-human primates. For example, isolated young rhesus monkeys engaged in self-biting, head banging and head slapping. Self-mutilation behaviors were not primarily related to conflict, guilt and superego pressure but much more to primitive behavior patterns originating in painful encounters with hostile caretakers during the first years of life (Zoroglu, Tuzun, Sar, & Tutkun, 2003).

Out of 862 Turkish high school students 21.4% were found to use self-mutilation behavior, the rate of girls was 21.5% to boys 21.3%. The most frequent behaviors were banging of the head and hitting of the fist to the wall at 11.3%. The rate of cutting was 8.4%, it is important to keep in mind that this survey was done in a public high school conducted in the classroom (Zoroglu, et. al. 2003). In the United States out of 245 college students 14% reported to using self-mutilation and 14% in a community sample of 440 adolescents, with self cutting being the most common. Even higher percentage rates where found among psychiatric inpatients at 61 % (Brown, 2005).

In a study titled *Contextual Features and Behavioral Functions of Self-Mutilation Among Adolescents* (1992) they found different and very interesting reasons why self-mutilation behavior (SMB) is occurring. Some of the more common reasons self-mutilation was happening were; boundary definition, mastery over death, other sexual

impulses, and reduction of tension or to communicate with others. They also found that most SMB did not occur with the use of alcohol or drugs. During the incidents of SMB most adolescents reported experiencing little or no pain. This may make this problem more difficult to treat. Peer influence played a part with 82.1 % reported that at least one of their friends in the previous 12 months had participated in some form of SMB. This suggests that some form of social modeling may play an important role in why this is happening (Nock, & Prinstein, 2005).

In addition to self-cutting, other forms of risk taking are common among adolescents, particularly sexual risky behaviors, such as having sex without a condom. Psychiatric disorders have been linked to higher levels of HIV, along with self-cutting. Out of 76 psychiatric inpatients they found 27% of self-cutters shared cutting instruments, putting them at risk via blood-to-blood contact (Nock, & Prinstein, 2005). That same study found that adolescents who reported not using condoms during sex were 1.9 times more likely to have engaged in self-cutting (Brown, 2005).

THE INTERNET'S ROLE IN SELF-MUTILATION

In today's world of Internet savvy adolescents more and more message boards are spreading information about self-injurious practices. A team at Cornell University identified more that 400 self-injury message boards, mainly populated by females who describe themselves between the ages of 12 to 20. They found that online interactions clearly provide essential support for otherwise isolated adolescents, hut they may also normalize and encourage self-mutilation and add potentially lethal behaviors to the repertoire of established self-injurers and many just exploring identity options. The Internet has become a virtual meeting place where isolated teens can meet with their

peers to hang out. There are three healthy steps to take during adolescences: (a) to establish caring, meaningful relationships, (b) to find acceptance and belonging in social groups (c) to establish interpersonal intimacy (Whitlock, Powers, and Eckenrode, 2006).

THE ROLE OF THERAPY

Through the distortion of a topic that is very difficult to express, fragments of self-abusive behaviors, and painful silences come forth in the narrative of incoherence, confusing both the therapist and the client. The acts of self-mutilation may represent a literal metaphor, sometimes a remarkably accurate metaphor, for an internal experience that is hard to embrace. One of the task of this thesis is to understand the experience of a behavior of the event, the sensations and perceptions, associated with the behavior, as well as related thoughts, emotions, motivations, urges and triggers.

The cause and effect of deliberate self-harm is a behavior associated with a wide range of negative outcomes, both interpersonal and intrapersonal. Because this behavior often arouses intense negative reactions in others the potential exists for it to disrupt relationships in and out of therapy. Despite the alarming prevalence of self-harm, research on the risk factors have been limited and it remains a poorly understood behavioral phenomenon (Conterio & Lader, 1998).

Within our vast language system few words can adequately express what deep pain feels like. Self-mutilation can act as an unspoken word of an intense internal experience. This act can make the unseen experience concrete. Self-mutilation represents fragmentation and wounded-ness in a graphic and pictorial manner. The painful action is a reflection of the emotional and physical internal world of the

individual. How then can self-mutilation be understood when pain is difficult to communicate in a meaningful language?

Breaking free from a life of self-harm may not have one simple solution, but there are people who are getting help and getting healthy. Some people may simply grow out of the behavior that served a need during a crisis in their live, or symptoms may disappear once they begin to explore in therapy why they feel depressed or angry or anxious and what is driving their need to dissociate from those feelings. A successful treatment plan generally involves a mixture of medication, psychotherapy, cognitive-behavioral and narrative therapy techniques individualized to each patient's particular needs. Unfortunately a few years ago, a cost-cutting decision was made to have nurses, not psychologists, run the hospital psych units, and treatment programs were drastically cut back (Favazza, 1998).

It is extremely important not to just medicate the problem, but to find out why the patient is acting out in this way, there is always an important story behind the pain. If you look at the symptoms as a window you will eventually be able to find out what happened in the past to this person and eventually be able to help them relieve these painful symptoms. As soon as the client is able to talk about the story and able to reprocess the traumatic events they will no longer need to replay the uncomfortable drama onto their skin (Strong, 1999).

ART THERAPY

Many who self-mutilate are feeling overburdened and preoccupied within their very stressful state-of-mind. Creating a visual method of art therapy can make ideas become more organized and can help to find answers to difficult problems. Self-

mutilation is an escape from emotional trauma transferred onto the body. By using art therapy the work may become a source not only of immediate release, but also a record of experiences. Guided by a therapist into the intentional world one can truly see how the art can open new possibilities (Milia, 2000).

For many, talking may be too intense or vulnerable to do, especially in the early stages of treatment, hence art therapy will play an important role in the recovery process. This creative means of expression can be used to help people communicate what they cannot put into words. This can be a healthy outlet for their pain and anger, to give them their need for physical release and to eventually become more comfortable within their own bodies.

One way that self-mutilators have been helped with the tools of art therapy is to discover a sense of safety in their bodies and helping them to resolve the unfinished past. Even just the physical act of creating art is seen as being cathartic and can help to release tension and frustration. Art therapy provides an opportunity to exercise the same destructive and integrative urges that underlie their self-abuse. Visual art is a suitable alternative language for nonverbal acting-out. "The art surface may metaphorically provide a healing function similar to that provided by self-mutilation in that it creates a protective layer, a skin, for the self, as in the formation of scar tissue (Milia, 1996 p. 1)." Art therapists arc in an excellent position to nurture the creative energies that drive self-mutilating clients, and to assist them in focusing their energies in a more metaphorical integration of the authentic healthy self.

The material that the art therapist uses must be considered carefully. Rubin (1978) suggested that materials should be synchronized, in terms of their properties, with what the client needs at the current moment. The material that will be used in the therapy process creates a partnership and dialogue with the client. The relationship between the client and the material being used will require an ongoing negotiation (Robbins, 1994).

NARRATIVE THERAPY

This thesis will use a narrative approach, thus giving prominence to the stories the participants recount. One may wonder why telling your life story would be important? It is not only an effective and accurate first-hand transmission of information, but the process of telling ones story is in itself an empowering experience (Reissman, 1993).

How individuals recount their histories-what they emphasize and omit, their stance as protagonists or victims, helps to create a relationship between the teller and the audience. All this information shapes what individuals can claim as their own lives. Personal stories are not merely a way of telling someone about one's life; they are the means by which identities may be created (Roenwald & Ochberg, 1992,). Using narrative therapy as a mean of research, the individuals ideas must be preserved, not fractured, by investigators, who must respect respondents' ways of constructing meaning and analyze how it is accomplished (Reissman, 1993).

One's lived experience is always much richer than can be explained. Using narrative therapy one can hope to give structure and meaning to experiences, yet there are always lived experiences that cannot fully be encompassed in ones story. The organizing of a narrative story takes on a selective process in which we prune and shape our

experiences, finding out what does not fit with the dominant evolving story that others believe to be true about us (White & Epston, 1990).

ART THERAPY AND NARRATIVE THERAPY

In combining narrative and art therapy, a therapist can help to inspire adolescents to find their voices by providing a visual representation in art and to give them the opportunity to revise their stories (Shovlin, 1999). Some experiences are so complicated and intricate that we simply do not understand what we are experiencing. Some of these experiences do not seem possible to retell, and sometimes we do not have the vocabulary necessary to recreate what happened. The narrative story will allow the self-destructive urges to surface in the art therapy process, in both the content of the art and the appearance of the art pieces. For many who have a difficult time verbally communicating, art therapy works well as a nonverbal alternative in treatment (Milia, 2000).

STAINED GLASS AS AN INTERVENTION

The use of glass in therapy has many unique characteristics and may trigger a wide variety of reactions. The process of creating a stained glass window forces one to cut, sand, brake and even sometimes shatter pieces of glass. Taking the fragmented glass and forming them into new shapes can evoke different sensations, feelings, and memories. These pieces of glass can be seen as symbols of a painful life story (Somer & Somer, 2000). Using the glass to tell their story metaphorically can aid in the discovery of a healthier narrative voice.

The display of broken glass fragments has been described by patients as a chaotic, useless collection of debris, lacking a cohesive shape, emitting an alienated, cold

> feeling, and seen as potentially lethal, before soldering the pieces in the stained glass tape. This procedure is necessary for bonding the glass pieces together, but it is also a protective procedure that reduces the risk of being cut. In the patient-material identification process, we noticed that this technique could also be seen as bandaging rough and broken representations of the self, and, therefore, experienced as fairly soothing activity. Considerable physical and thermal energy is required for joining the glass fragments into a self-standing piece of art. For some of our patients, this has not only been a metaphor for their healing process, but also a statement about the potential effects of warmth and protection. Therapists can reflect on the process, discussing with their patient how wrapping, heating, and bonding are necessary steps toward achieving an integrated new entity (Somer &Somer, 2000, p. 10).

Clearly by sublimating their emotions through the stained glass window process many past memories will be released and possibly re-experienced. A certain amount of discomfort is usually necessary for change to occur. Warren discussed in her thesis (2002) a comparison to the process of giving cutters glass to the treatment of homeopathy. When a practitioner gives medicine out to a patient, it is a dose of a substance that produces similar effects to those of the illness. This principle comes from the Latin phrase: *Similia Similibus Curentur,* which means: "Let likes cure likes," This has been a principle that has been known for centuries (What is Homeopathy, 2007).

Using art therapy and the creation of a stained glass window we are in a position to nurture the individual into his or her own unique creative environment. Using metaphors, symbols and colors we can see the process of healing begin.

While working with glass with this population, safety needs to come first. The therapist needs to collect information and evaluate if the client will be able to resist self-destructive impulses during the art process. A contained and controlled environment will help to aide the client to feel safe to disclose past stories. The signing of a contract at each session will be mandatory, along with the freedom for the client to notify the therapist if they are feeling unsafe (Appendix B) (Somer & Somer, 2000). Having a two-week training phase will help to build trust between the patient and the therapist. This period of time will also support the therapist in accessing if the client is ready to begin working with the glass. With the building of this therapeutic relationship, together they will be able to explore the potential opportunities of self-discovery.

METHODOLOGY

Jenny Warren wrote *Understanding The Mystery of Cutting* in 2002 at an adolescent day treatment in Northern California. This research hopes to replicate what Warren did and to bring validity to this process by helping adolescents who are involved in self-mutilation to build a healthier outlet for impulsive behavior. Through creating a stained glass window this research will provide an opportunity to decrease impulsive behavior and build a healthy self-esteem.

RESEARCH DESIGN

1. Externalize the Problem: the stained glass pieces will represent the individuals' problems Uust as the body shows the scars). The glass is then used as a medium to sublimate the act of cutting something outside of them and separate from their body. The study is designed to assess the adolescent's perceptions regarding the impact of the act of scoring a piece of glass (cutting the skin).

2. Story Telling: the stained glass pieces metaphorically represent the past memories. This is where an unearthing of their stories begins, understanding the pain, and re-telling of the story key to the healing process. It will be essential for the therapist to look for unique outcomes during this process in order to build on internal strengths (White & Epston, 1990).

3.Protection: each piece of stained glass is then wrapped in foil for the second to last phase. This wrapping serves as a metaphor for a protective cover. The foil serves as a means of holding each piece (and hence experience), and keeping it from being able to

cut (and/or harm) the client (Somer & Somer, 2000). The glass edges are wrapped in foil to create the binding that will hold the pieces together. By creating this safe space a feeling of attachment to other parts of the self can start to heal. This wrapping of the glass gives each piece or experience a protective wall in which to talk about the pain.

4. Cohesion and Transformation: finally the client will arrange and solder all the selected pieces of glass together. This final step to the art process creates a warm and nurturing space in which the painful past can be joined together with a healthy beautiful future, in the pulling together of all the past pieces. The last step focuses on bringing all the pieces together to help create a healthy new narrative and to reflect on the clients' accomplishments (Sween, 1998). The connection here is joining the edges of the stained glass creating one sculpture, something beautiful out of something that was seen once as a problem. The final step of the art is to show an understanding and sense of control over their cutting. If the client feels comfortable, the art will be displayed and the school community will be invited to view the work. Mirroring a positive side of self can be held by others.

THE PARTICIPANTS

The participants of this study consisted of five self-mutilating adolescents who are attending a treatment center in Northern California. Subject population consists of 4 males; one age 13, one 14, and two 15, and one female age 16. These adolescents have been identified by their willingness to discuss their self-mutilation in individual or group therapy sessions. The sample was based on their interest in participating in the confidential research. The families were sent a letter outlining the study and the safety

rules. All participants have signed letters with full consent and there will be no cost to the students (See Appendix A Consent Form).

RISKS

It was understandable that many would respond with concern at the idea of using glass with adolescents who self-harm. Therefore it was imperative to determine guidelines for the work to be conducted in a safe manner. The environment was contained and skillfully observed and each tool and piece of glass was accounted for at the beginning and ending of each session (See Appendix B Session Contract). A preparatory training phase was used to deepen the sense of care and nurturing in the patient-therapist relationship. There was little difference between the use of glass in therapy and the use of a pair of scissors if the therapist is confident about his or her mastery of working with the glass (Somer & Somer, 2000). The early phase was also used to enhance the relationship between the therapist and the client, and to create faith in the client's capacity to master the glass and to build trust in the client's commitment to the safety contract. The American Psychological Association and the American Art Therapy Association guidelines for the use of Human Subjects in research were adhered to, as were the guidelines of Notre Dame de Namur University. The site where the research was conducted gave consent for their students to take part in this research project.

PROCEDURES

The procedure took approximately eight sessions. There was some flexibility with this time frame depending on the individual's ability to progress. One individual took much longer to complete the process. During these eight weeks the themes of importance were: a) containment and protection; b) self-object and transitional object; c) destructive and creative process; d) symbolic expression, e) power, and f) self-esteem.

The participants were given a semi-structured qualitative interview using open-ended questions for gathering data. This allowed for each individual to tel\ his or her own story. Each interview took approximately 35 minutes, but depended on the participant's responses. The interview occurred on the last session when there was also a celebration of the completed piece.

HOW THE SESSIONS ARE ORGANIZED

1. Creating Your Safe Place: (See appendix D)The first art directive used during the initial session was to visualize and draw your safe place. This was a time for \earning about the history of the client and establishing basic trust. This was displayed in the office for each of their individual session. Using this piece of art as a visual reminder and a tool to focus on if the work got too emotionally intense.

2. Signing the Safety Contract: (See appendix B) the contract was discussed and signed. The signing of the contract happened at the beginning and ending of each session. There was a discussion of the safety of the work, making sure that the client felt safe was of

utmost importance. It was made clear that each piece of glass and the tools used were counted at the end of the session and that if a client purposely hurts him or herself the process would stop. If this happened they were not at a place where they could continue working with this type of material. We would again discuss and explore the issues around being safe.

3. An Introduction to the Art of Creating a Stained Glass Window: The third session was focused on building trust, creating rapport, establishing a relationship, and a discussion of what a stained glass window was. Here the therapist would discuss the tools being used and the process behind each one, the therapist would demonstrate how each tool was used. During this session they would be shown the colored glass in order to get ideas for their window.

4. Scoring of the Glass: It was important to review the previous week, to access the impact and any insight that the client might have experienced. This was the first day that the client would begin scoring the glass. This was a time when past stories could be told to the therapist. Each piece of glass should metaphorically relate to the clients life story. It was also important that during this process the therapist reminded the clients that this would be an art piece that would represent their self-harm by using colors and shapes. The client decided on colors and styles of glass that would be used to make the collective piece. The glass was looked at for the effects of transparence, translucence, and reflectance, in order to truly appreciate each unique piece (Somer & Somer, 2000). This stage was related to the narrative story telling and the unique outcomes that were used to

strengthen the individual self-esteem (White & Epston, 1990). The tools that were used were eye- goggles, latex gloves, a grid and a scoring knife. During this session the fragility of glass was discussed in terms of physical expression and anger withheld. Special attention was noted on the present moment and the sound that each piece made as the client broke the glass.

5.The Grinding: The edges of all the glass pieces were smoothed with an electric grinder. This step was important for the adhesive on the back of the copper foil to adhere to the glass. The therapist acted as a silent witness to the process of smoothing out the edges, holding the bowl of water and with a wet sponge every so often wetting the grinder for the client. This stage was very loud, making it difficult to talk; focusing on the present moment was emphasized. The grinder was one of the most difficult stages for many and being a centered container of support was of utmost importance.

6. Copper Foil: The foiling began this day. The therapist helped the client wrap each individual piece of glass with the foil, covering each side and edge. This was a time for joining with the client, and, in using that metaphor, that the therapist showed the client how the pieces were actively being wrapped for protection.

7. Soldering: This process started with this therapist having previously prepared glass pieces with copper foil wrapped around then to demonstrate for each client. The clients were then able to practice with the therapist's art pieces without fear of making a mistake on their own project. When the client was ready he or she took their pieces of glass

organized them in their positions and then uses a few drops of metal to tack down the pieces. After making sure all the pieces were firmly in place the entire surface was slowly soldered together. This was where the discussion turned to self-esteem and empowerment being discussed. In the end they were able to integrate, contain, and organize all the pieces of glass just as they had done with their individual stories.

8. Celebration: The eighth session was the celebration of the finished piece of art. The therapist cleaned the window and it was hanging with light shining through it. Here the client had time to reflect on the piece and the story they shared with the color. This was where the set of 20 qualitative questions were used to explore the participant's sense of containment and protection; self-object and transitional object; destructive and creative process/ symbolic expression; and power and self-esteem as related to the glass art they created.

RESULTS

Within the qualitative questionnaire there were five main areas that the interviews were designed to address. The interviews were transcribed and then examined for recurring themes and elements that related to each of the categories; containment and protection, self-object and transitional object, destructive and creative process, symbolic expression, and power and self-esteem. This study was designed to assess the self-mutilators experiences and perceptions regarding the impact of creating a stained glass window. The results are presented below in a description of the data from the interview process structured into the five categories.

CONTAINMENT AND PROTECTION

For the theme of containment and protection two main themes emerged out of the qualitative questions, they were feelings of trust and a sense of self-control. These themes came up not only in the artwork, but also in the interactions between the therapist and the client around the art.

It was first noticed with Kathy who seemed upset by the fact that each session began with her signing of the contract, "Do I have to sign this again? Don't you trust me?" Yet later stated that she liked the consistency. During our last session when we were done working with the glass she noticed that the contract hadn't been placed on the table, she asked, "Aren't we going to sign that safety thing today?" Tim also took great pleasure counting all the pieces of glass that he would take out of his box each day. This indicated that having a contained structured environment was of the utmost importance when working with sharp objects.

Another aspect of containment and protection came up in the data focused on

the feelings of trust. Matt described how important it was that, "Finally someone around here trusts me with these tools. That was so cool that you let me work with liquid metal. Not only did it let me know that you trusted me, it was cool to know that I was trustworthy. We can't even use scissors in the classroom."

SELF-OBJECT AND TRANSITIONAL OBJECT

The theme of self-awareness became evident in examining the data related to issues around self-object and transitional object. Kathy was able to clearly identify every color in her stained glass window to represent the emotions that she struggles with. She noticed how anger and sadness were the two main colors that would reappear again and again in her four windows. She explained, "I know that anger is the easiest emotion for me to get to. It's all that I've been raised with; it's all that I know. Even though my piece is filled with my angry color, it still seems really soft to me. I guess that inside I'm really soft. I just wish my parents could see that. All they've ever done is caused me pain. I really like how my windows are a little family." In an ideal world Kathy would have a family that was as harmonious and beautiful as her art piece. Through out this project Kathy treated me as a central mother figure, even checking in with me on days we weren't scheduled to work together. Creating a safe holding environment was essential to helping her work through her past story. Using the art she was able to talk metaphorically about what she wanted and was unable to get from her parents.

DESTRUCTIVE AND CREATIVE PROCESS

In studying the data related to the issue of destructive and creative process there

was one theme that continued to emerge: displacement of aggression. Jason who was the most actively involved in his cutting found that breaking the glass was the most satisfying part of the project. He was able to create a sound that felt extremely satisfying. Holding the small smooth piece he became fascinated with the textural sensation. Even though he was unable to finish the project he stated that, "I haven't cut myself since the second week into this project. l even have my favorite razor blades hidden in my room. Using the art materials has helped me to have some control over myself."

SYMBOLIC EXPRESSION

The term metaphor emerged from participant's responses of the data collected. Tim and Kathy both stated that they were able to look at their art in a different way now. Tim said after finishing his piece, "Its funny how everyone sees something completely different in my window than I do. People will say it looks like a space ship or a sword. But to me it represents a stingray, something that used to cause me pain, but now I can see as something beautiful that's floating up to the surface. Do you see all those bubbles?" Kathy was able to explain her art piece as well using metaphors, "Do you notice how the biggest piece is white, which represents happy and sad. For me both of these feelings go together. I guess for now I'm okay with the happy and sadness living inside me."

POWER AND SELF-ESTEEM

Within the data the most prevalent theme was the theme of power and self-esteem. All five of the participants shared a sense of accomplishment in their art pieces. They

each shared how some of the components seemed hard and scary at the beginning, but that in the end they felt really proud for being able to overcome their fears. Matt stated, "I really liked pushing myself to do something that I'd never done before. I was really surprised that I was able to finish and make something so beautiful." Kathy also shared similar feelings, "Every step I felt really scared. I really didn't think I'd be able to do this project. The hardest part was burning the metal, but since I've been working with the glass I haven't been burning my ankles. Its kind of funny but I haven't really realized it until just now. I don't have any desire to do. I really like having a new set of coping skills."

ANSWERS TO THE QUALITATIVE QUESTION

Four out of five participants gave answers to the qualitative questions. Matt and Kathy were able to article their feelings in written answers and gave very positive reports to the experience. Tim and Jason who both presented as depressed gave feedback that was neutral. Overall none of them gave any indication that the experience was completely negative. All answered that they did not feel in danger of hurting themselves while creating the stained glass window. Four out of five answered that they did not feel any risk in creating a stained glass window. Tim was the only one who answered that he would, "not really," want to work with glass again, yet he also ended the interview saying, "It hasn·l been negative or positive, its interesting."

Kathy and Matt both shared that they learned new things about themselves that were interesting and helpful. Kathy described her experience as, "It made me feel good about myself and know that its one of my new coping skills." Kathy also described that

her first feelings within the project were feelings of fear, but then felt very satisfied when she overcame her fears and eventually got used to all the steps. With the questions that asked what were the benefits of creating a stained glass window she explained that she felt proud of herself. I asked what else she was proud of in her life, she stated, "nothing."

Matt answered many of the questions with playful creative responses, when asked what his first feelings were around cutting the glass he explained, "Hell of sick. I cut glass and I've never done that before. I always wanted to be a spy. I'd cut holes in windows, and stick a telescope out of them." Matt was honest on some questions, for example on the question of what came up while working with the glass he was able to articulate that he still gets depressed. He also explained that the pain was better if it wasn't "influenced" by him, meaning that he would fall off his skateboard instead of cutting.

Tim gave neutral answers to almost all the questions, not willing to say if it was a positive or negative experience. When asked about his feeling around participating in creating a stained glass window and how its affected the way he sees himself he answered, "Not any differently, and I don't see myself very bad either." Yet in the beginning stages of the project he had stated that all of his artwork was indeed bad and he could never say anything good about himself This statement indicated a small amount of improvement overall in his self-esteem. He also stated that he would like to work with glass again because, "You never know what can happen. You might find something good."

Jason answered many of the qualitative questions with, "I don't know," or ·I don't care." Yet I saw great benefit in his participation even thought the qualitative questions

didn't show that. He would arrive to each session with little energy and motivation, yet he would always show up. I noticed how his attendance was very limited but he would always attend on the days we met. He also requested specific colors (black and smoky black) that he needed me to get for his project. This indicated he was more emotionally involved that what appeared on the surface. During the qualitative questionnaire he answered, "I felt normal," to the question "How would you describe your experience in creating a stained glass window?" After further investigation I found that he normally felt abnormal and very uncomfortable at school and at home. I took this as a positive response considering that most of his life he felt 'abnormal.'

The questions overall were not as telling as I had originally hoped for. Not a single client was able to think of a question that they would ask in the future if they were running the research project. In the future I would have fewer questions and ask for more details in the answers.

CASE EXAMPLES

These case examples are included to add further descriptions of the different clients that worked on this project and their individual experiences. The five cases that follow will represent how each individual had a unique outcome. These cases will attempt to show how the motivations for self-mutilation can be multifaceted and layered. Many of these clients have issues associated with separation and individuation stemming from their relationships with their primary object or mother. Self-inflicted punishment may be a means to resolving guilt for sexual urges that are arising in adolescences. At another level conflicts over aggressive urges related to a deep need to preserve the relationship with the mother, would surface in the therapeutic relationship.

The five cases that were a part of this eight-week process all had very different stories around their self- harm and were at very different places in their recovery. The first case is of an adolescent boy who had reported to have stopped cutting several years prior, yet would often show up to session with scratch marks up and down his arms. The second was a girl who would burn her legs and arms using the tip of a pencil eraser. The third was a thirteen-year-old boy who would poke sharp objects into his skin to distract himself from his internal pain. The fourth a seventeen year old boy who had recently been released from a psychiatric hospital where he stated that he had started cutting himself. The fifth boy was not ready to stop his cutting. For him cutting was his only friend and an addiction that he loved. For each client I will outline a brief history and then their reaction to creating stained glass window. All the names of the participants have been changed to protect their confidentiality.

MATT

The first client I will refer to as Matt. He started out his life within a violent and traumatic environment with a father who reportedly physically abused his mother on a regular basis. The mother even reported that this occurred while she was breastfceding him. He was sent to live with his maternal grandmother in Northern California when he was a young child. This detachment from his mother happened during a crucial developmental stage. Both emotional and physical safety where absent from the early years of his life. I le has been estranged from his father since he was a young child.

At IO Matt experienced extreme trauma when a truck struck him as he was crossing the pacific coast highway. He was unconscious in the intensive care for two

weeks and suffered from brain damage and a shattered leg. After the accident he regressed back to an early stage of development with his mother and accounts doing whatever he could to get attention from her. After the accident, he began cutting with razors and was hospitalized after one cut went too deep. After spending many months in the hospital, he became depressed and suicidal. He reportedly tried several times to jump out of a moving car and out of a building window.

Matt was sent to the program for the following: He was caught stealing a bike; he got into a fight with a student, stabbing him with a metal object; and he took an overall defiant stance in the public school setting. He self-soothes by smoking marijuana and was caught in a sting operation buying marijuana a year ago.

The first meeting was spent 'creating a space place' where Matt could visualize if the work became too intense or emotional. Matt's safe place was drawn with paint pens on white paper; he created a black hole in which he placed himself in the very back. This dark place was filled with fantasy, which could represent his subconscious intent in going back to the womb. During that first session we discussed the rules around safety and what it would mean to sign a contract. He clearly explained that he had no intention of hurting himself at the present time.

The second session started with the signing of the contact and an open discussion of what he might like his window to look like (please note that each session started and ended with the signing of the contract). Matt was given a lesson on how to cut glass, which he quickly caught onto. Matt worked hard when picking out the right colored glass pieces. He talked about making a round face then changed his mind and wanted to

make it into a devil. He was able to cut the pieces in curves and circles using a complicated method. At the end he talked about making a pot leaf for the office.

During the third session, he was given an overview of the grinding process. Grinding is the process of smoothing out the edges of the glass. During the grinding he became very interested in poking holes in each piece. He was more interested in seeing what challenges he could complete with the grinding tool, than actually finishing the assigned task for the day. After poking several holes, he was directed to focus on the smoothing out the pieces that he had. With this additional information he took a piece and carved my initials and his onto the glass.

For the fourth and fifth sessions, he was able to focus on grinding only part of the time. He would spend the other portion of time talking about his past and the painful memories he had around the period in his life when he was cutting. During our sessions he would contradict himself from one day to the next making me wonder if he truly had stopped cutting. It was during our fifth session that he showed up with slash marks up his left arm. Explaining that the cuts on his arm were from a skate boarding accident and saying that, "It's okay if you hurt yourself and it's an accident." This day I decided we would take a break from the grinding process to access if he would be safe to continue.

During our sixth session he began to foil the pieces of glass. This day we discussed ways in which he could protect himself from emotional and physical pain. He was very articulate with his feeling of how much he enjoyed feeling the physical pain, yet he also expressed guilt and shame around his behavior. He seemed focused on the issue that he needed to be punished, 'for being bad.' Here he discussed how he wished he could have a father that would punish him. Often times he asked me if I would get mad

at him for the things he did at home. Within this session, he worked to externalize the problems within the family home using art. He would move the foiled pieces of glass around on the board to create the face of a monster.

For the seventh session we soldered the pieces together. This day he discussed his need to feel control in his life. Again he went back and forth with wanting to have his freedom from his mom and wanting to have someone take care of him. Matt stated, "I want to be able to sleep in, to be able to wake up when I want. But I want my mom to carry me to the car in the morning."

The eighth session we celebrated the completion of the piece. He loved the way the piece looked similar to a tattoo gun. We discussed the transition of the art along with the progress he had made. He stated that, "It made me feel happy that my therapist would trust me to have self control and discipline over myself. I also really liked how conscious I was of my hands in what they were doing." In closing he talked about how safe the piece made him feel and how he wanted to show the whole school.

KATHY

Kathy is a sixteen-year-old girl who has a long history of violence and neglect. She has a father who is currently in prison for armed robbery and a mother who is addicted to methamphetamines. She describes her mother as a woman who sleeps all day then drinks and does drugs all night. Recently sharing, "My mom shaved off all her hair because she thinks there's all sorts of bugs on her." Kathy has one brother and three half brothers that all have different fathers. She currently lives with her grandmother in a community trailer park.

She came into our first session stating, 'T m a big old talker!" Filling up the small office with her loud voice and nervous laughter, I was concerned about her ability to focus with dangerous materials. I explained the project and the ideas behind the artwork we would be creating. After hearing that this work would focus around self-harm, she began describing her history of violence. She pulled down the neck of her shirt to display a long scar on her collarbone, explaining that this was caused by her mother throwing her against a wall when she was three. Her mood shifted to real sadness when she recalled that during her two-week hospital stay the only person that came to visit was her grandmother. "My mom didn't even come see me. That's messed up."

At eleven she went from living on the street and smoking methamphetamines, to living in several group homes; it was at this time when she began to burn herself. She created her burns by rubbing an eraser against her skin until the skin was raw. Altogether she showed me eight scars on her legs and arms.

Looking for some relieve from stress, she found burning to be her preferred answer. Even now living with her grandmother she finds it difficult to stop the cycle of self-inflicted pain. With a great amount of guilt she explained how she was still hiding one scar on her ankle from her grandmother. Fearing that the moment her grandma found out she would be sent back to a group home.

For our first session I asked if she could create a drawing of a 'safe place.' She stated that she didn't have a safe place, but that she had an idea of something that made her feel better when she would feel sad. I explained that her safe place could just be an idea, a moment, or an image and directed her to draw what she could. She created a clown with two balloons and hearts floating around the paper. This would represent the

only memory she had of both parents together. For one of her birthdays, her father had bought her two balloons that read, 'I love you,' and her mother had drawn her a picture of a clown that she had cherished.

Our second session, she talked about her self-mutilation and how difficult this project would be for her to complete. When I went over all the tools and what they would be used for she could clearly explain all her fears around working with the tools. I explained how she was in charge of how much she could do and that we could stop and take breaks at any time during the project. Over time, I demonstrated how to use each tool, along with the safety contract and all the rules. This was an important part in keeping the space safe and creating clear boundaries.

For our third session, she started out by signing the safety contract and then discussing how the previous week had been. We discussed the relationship she was involved in with her boyfriend and the intense feelings that went along with it. This day we also discussed how colors and shapes could mean different things to her. Carefully she picked out her collection of glass to be used for her window. Each color had a feeling that went along with it. Red was mad, pink was happy, a swirled purple was sad, pink with white was hopeful, light purple was angry, dark purple was scared, white was sad and happy at the same time, purple with texture was sad and angry.

Session four was spent cutting the glass. Each piece she would cut with a funny sound effect and each time she broke the glass with a pop she would giggle nervously. This session she talked more openly about her sexual abuse and the anger she felt, explaining how the abuse had happened twice by two different men. Both times her mother had known about this and done nothing to stop the events from happening.

During the fifth session, we began grinding the edges of the glass. Kathy was very nervous about his part of the project, again giggling nervously as she began to place her glass on the grinder. About halfway through the session she asked to stop the grinding of the glass. She stated that she needed to talk and that she couldn't hear over the grinding of the glass. She shared stories about her relationship with her boyfriend and how he was the only man in her life who had not abused her. I asked if she was practicing safe sex and she answered that she was not. She also explained how she hadn't had her period for several months. The following session was spent at Planned Parenthood, where they discovered that she was not pregnant.

The sixth session was spent wrapping the glass pieces with copper foil. During this session we discussed how she was able to emotionally protect herself. She surprised me by sharing all the coping skills that she had learned at her last group home, taking deep breaths, drawing, and writing letters. This session she shared all the anger that surrounded her within her family. She discussed what it was like growing up without a mother or father that protect her. She recognized that even though all her parent's had done was hurt her, she still needed their love. She explained her attempts to build a relationship with her mother, "I wrote my mom a three page letter telling her everything I felt, I even said that I wanted to forgive her, and you know what she did? She didn't even read it. She read the first two lines and then threw it away. I know because my grandma was there and she told me." We discussed the value in expressing feelings even if they were met with resistance. She was able to recognize her strength in the letter writing process even though her mother was incapable to receiving the news. It was during this portion of the project that she asked for my help in wrapping the pieces.

Perhaps this was an indication that she needed a mother figure protect her during the rocky stage of adolescences.

The seventh session was focused on fluxing and soldering. Again she started out the session very anxious and worried about working with hot metal. This session was the biggest success in overcoming her fears and building self-confidence. She pointed out that,". It's really scary to think about burning myself with the hot soldering gun, but I used to burn myself all the time with erasers. I guess I'm starting to grow up." Once she got the hang of soldering, she began to relax and have fun with the process. She quickly discovered how to make little metal balls, making four that she called her family. Each ball had a name and a roll that she developed to help her externalize the feelings she had around her own family.

Kathy completed four stained glass windows. She said they were her family. Each one had a home where she wanted them to live. One of the windows would stay in my office, one to her classroom, one to her boyfriend, and the smallest window would go home with her. Her creation- The Family of Four- danced in movement, with shades of soft pinks and purples. The art was fragile and fragmented and I even worried about the lack of support. The windows created a self-portrait into her life. They represented a family she did not have yet wanted more than anything.

For our final meeting she completed the qualitative questionnaire and celebrated her successful completion of the project. We made tea and sat back to enjoy the beauty of what she had created. I discussed how each part of the project brought up fear and took courage to complete. She shared that, "1fl ever think I can't do something I'll just think about my little windows." She was able to express pride in the work she had made

and wanted all the staff to see what she had done. One by one we brought in all the therapy staff, her teacher, and the principal. Out of all the reactions the principal's reaction brought the most joy to Kathy she said, "Oh my gosh, they are so beautiful. You made those? Really they are so beautiful they make me want to cry."

TIM

Tim is a highly depressed thirteen-year-old teenager with a previous history of hospitalization for a suicide attempt. He lives with his mother and older sister in a communal living situation. His mother and father were never married and separated when he was four years old. He stated that his father is a very depressed alcoholic. He has many issues with his older sister and stated that she "makes my life hell." During my first session, Tim would not make eye contact with me or complete a sentence with more than three words. He answered my questions with a loud sigh and most often saying, "I don't know."

Tim appears to have very little patience in dealing with himself and with others. He is very withdrawn from social interactions, extremely sensitive, and suffering from anxiety. These psychological issues will often have somatic problems that come in the form of headaches and stomach aches that he will try to self-soothe by self-harming.

After a few meetings, he began to open up, slowly sharing some insight into what was going on with him. He stated after several sessions that, "The pain I feel in my stomach is so intense that I will poke myself as hard as I can with a sharp object to take the pain away from my stomach and put it onto the outside of my body." The session he talked in great depth about his internal pain and how he had never cut himself but that he

would continuously poke himself with sharp objects. He declared that this act was being done to reduce the internal pain he was suffering from. The fact that he could so openly share these feeling and a desire to stop hurting himself made me feel that he would be able to do the research project.

The first session began by going over the issues involving safety. The first piece of art would be an important component to creating comfort in times of distress. Tim was asked to draw a place where he felt safe from the stress of everyday life. His first response was, "Outside of here? No place is any more or any less safe. My home is not safe. But most houses are safe. So that picture that I did of a house and a tree that will be my safe place." During a previous session, he was given the assignment to draw a house, a tree, and a person, but he refused to draw a person, stating that it was impossible for him to even try.

This session served as a time to establish thoughts and guidelines around being safe. Some of his thought process seemed flooded with anxiety. He seems to live in a state of agony. Tim will hold his breath for several seconds and then all of a sudden let out a deep sigh. He ended the session by asking me, "Do you think religion is real? I don't. It's just a thing to make death easier." This statement seemed to be indicative of the level of depression Tim was experiencing.

The second session started with discussing the previous week and exploring if he would be ready to start picking out glass for his window. He seemed eager to start the project, "I really only like to do work where I can use my hands." As he went through the box of glass, he talked about fun ideas he had about making a disco ball. This was the first time I had experienced Tim's sense of humor and realized he was able to get in

touch with it by using the art materials. With each piece of glass that he would select, he would hold it up to the sunlight coming in through the window and then point it in my direction to see how a person would look behind the sheet of glass.

The third session he had decided on three pieces of glass but then had stated that he would only be using two. He was interested in making his window look like a pair of sunglasses. I decided to go with his idea and see where it would lead us. He also shared with me that his didn't think that his mother would be around much longer. He feared that because she was a smoker and despite all his attempts to help her quit she was unwilling to stop. We discussed feeling of helplessness along with ways that he could help himself to feel more empowered.

The fourth session was all about grinding the edges of the glass. After a quick demonstration, Tim felt confident that he would be able to work the machine. He focused on two small green pieces of glass carving intricate semi-circle designs in each comer. The whole session was spent carving one piece of glass, as I patiently watched without saying a word. I felt this session was important in that I was a silent witness to his work. This session I asked when his birthday was; he replied that he didn't know. Tim later stated, "I don't know my birthday because it doesn't matter. I was born a fat, blind baby." At the very end of the session, Tim was able to refocus himself and began to describe his unique outcome, "You know people who have disabilities are usually really nice. Like me since I'm blind I have really good reflexes."

The fifth session again was spent on the grinding wheel, only this time he was able to complete several pieces without the details. As he finished grinding each piece he would hand the glass to me, asking me to feel the edges making sure that they had been

smoothed. He was beginning to trust the therapeutic relationship and was gradually letting me into his life.

For the sixth session, he began to foil the edges of the glass. He quickly realized how difficult it would be to tape the edges of his two intricate pieces of glass. I felt it was important for him to sit with the project and encouraged him to be patient. He was able to finish all the foiling within the session and stated that he was glad to be done with that component of the project.

The seventh session was organized around fluxing and soldering. When I took out the tools to give a demonstration I joked around saying, "What the flux." He smiled at my silly joke and in the session that followed asked if I was going to make my flux joke again that day. Tim seemed very relaxed around the hot soldering gun; exploring all the ways he could properly use it.

Deciding that he would not be using the two small green shapes that he had originally spent so much time on, he focused on his collection of clear pieces. He told me how his favorite color was clear! Playing with the reflection on the wall, I asked if I could take a photo of this shape. He shared with me that day how he felt invisible and how even the bus forgot about him. Yet, even though he felt invisible he was beginning to show a deeper part of himself. He seemed empowered by the process of soldering and when it was time to go back to class asked if he could stay five minutes longer.

During the eighth session he completed the qualitative questionnaire and we cleaned the glass to sit back and enjoy the window. The window was completely different than what he had originally thought of creating. He had me guess what the shape was, at which point I said a rocket ship. Tim explained how it was actually a

manta ray with bubbles going up out of his tail. We invited other staff in to see his final art piece; he had them each guess what they thought the image represented. He created a very modem shape, playing with negative space mainly using the clear glass. His overall mood and affect changed drastically from the first session to the last. He was able to express feelings and trust that this therapist could hold the information in a safe environment.

JAMES

James is a seventeen year old who has been in and out of the hospital for the last two years. He was found with a rope tied so tightly around his neck that his mother had to cut it off. James currently lives with his mother, older brother and uncle in a small apartment. He has never met his father who is a Vietnam veteran who was injured in the front line of battle and lost an arm. As a child, he was very angry and reports feeling very guilty for abusing his beloved dog. He also slept in his mother's bed until he was eleven years old, explaining that it was easier to snuggle that way.

During our first session, James explained how he began his history of cutting when he was hospitalized the first time for depression. He explained that he used self-harm to feel relief from emotional stress and frustration. Currently he claims to have stopped cutting.

James has a wildly funny sense of humor, keeping me on my toes with his quick wit. The first thing he stated in my office was, "I'm going to make a window out of my blood!!! Is it okay if I cut myself in here?" This may sound horrible, but in reality he said it with so much exaggerated emotion that we both laughed. James is histrionic to

say the least. He is always highly emotive and rapidly moves from one idea to the next. The first thing he does each time he comes into my office is ask if he can have a candy out of the candy jar while reaching in to take a handful. Each time he tries this attention-seeking maneuver, I redirect with you can have a piece. James is constantly seeking attention from adults.

Our first session, I introduced the rules around what we were about to be creating. The safety contract was signed and the directive of creating a 'safe space' was introduced. He began to complain about the directive being too hard but finally decided that a drawing of his bunk bed would depict his ideal of safe.

James came into the second session singing, "I love my glass and my glass loves me." During the second session he began looking through all the different colors of glass. After he picked out all his pieces he began to arrange them onto the board in a beautiful abstract design. After he had removed his gloves and was cleaning up his the space he managed to get a tiny cut from one of the shards of glass. The cut looked similar to a paper cut, painful but without any blood. I asked if he wanted to go wash off his hands and as I was asking he pulled apart the small cut to produce blood. He then began saying, "I'm going to sue you! I'm going to sue this school!" With this I strongly stated that we were going to wash his hand and put a bandage onto it. At this point I also explained my concerns over his reaction and wondered if he was ready to complete the project.

The third session we spoke about his theatrical performance and how there was a time and a place for that, but that this behavior could not continue during this project. I explained further that it was my job to keep him safe and that my main concern had been

with his pulling apart the small cut to see the blood. He apologized for his behavior and explained that he was not going to sue me that he was only joking. I was impressed with the turn around in James's performance after this episode. He began working extremely hard and was the first client to finish his piece. He explained that this was the first piece of art he had ever made. Before the stained glass window he had always resisted doing art of any sort. Unfortunately we were unable to have a celebration because of a medical problem that kept James out of school.

JASON

Jason came from a family with a long line of mental disorders. He explained how his mother was extremely emotional and depressed. He described her as sleeping most of the day and only talking to him when he needed to be searched for cuts. Jason's father is obese and suffers from sleep apnea, requiring him to be connected to a breathing machine while he sleep's; thus his parents sleep in separate rooms.

Jason explained to me that the reason he was sent to this school was because some of the boys at his school said that he was going to pull a knife on them and as it turned out later that day he was caught with a knife in his backpack. Jason was hospitalized for his cutting previous to entering this program. Out of this group of individuals he was the most involved in his cutting. He clearly stated that he was not willing to give up cutting for this project. I explained that he wouldn't have to give up his self-mutilation, but that he would have to sign a contract in order to participate and was not allowed to take any glass. He agreed to all the rules around the project. After the first week of the project, he came to session and reported that he was no longer cutting. The reason he had stopped

cutting was because he was being forced to take Prozac. He discussed how much he missed having the desire to cut, how he missed that feeling more than the feeling of cutting itself. Along with being forced by his parents to take medication, he also lost the privilege to have a bedroom door. This lack of privacy left James feeling extremely frustrated and depressed.

During our first session James sat in my office wearing tight black clothes with blond hair hanging down in his face and his head touching the table. James would only answer yes or no to questions barely loud enough for me to hear, all other questions were acknowledged with a shrug. When asked to create his safe place, he sat and thought for a long time. Finally he remembered a place that he used to go when he was growing up, it was his best friend's bedroom. He was able to draw the room to scale, from a bird's eye view perspective.

The second session was spent going over the safety issues and picking out glass pieces. He was upset that he couldn't find any black glass and searched for colors that were very dark. I reassured him that I could get black glass for the next session. He found a few pieces that he decided he could practice cutting.

The third through the eight sessions have all been about cutting the glass. Unfortunately he has not been able to move past this stage of the project. I felt it was important to let him have control in this one area of his life, since the majority of his life is out of control. In regards to this project, having my client work with stained glass has acted as an assessment tool, but Jason's lack of confidence has stopped him from moving forward with this particular therapy. Jason fears commitment. In regards to this project he couldn't commit to any piece, constantly second-guessing himself. At this time he has

managed to cut many different shapes of glass. He has a small collection of red squares, which he will hold in his hands and shake making soft music. We discussed how hard it has been for him to commit to any color or shape of glass and the possibilities for what could be holding him back.

The project seems to reflect where he is at in the process of his own recovery from self-mutilation. It seems clear that he is not ready or willing to give up cutting but that his parents have taken almost all independence and control away from him. His psychologist has stated that the first time he was hospitalized was because of a fight over him having long hair. The lack of motivation for him to move forward with the project may indicate that he's not ready to continue with the work.

OVERVIEW:

DISCUSSION

This research focused on five self-harming adolescents; each result consisted of a very unique outcome. Each client came in at a different clinical place than the others. All used self-mutilation very differently and each had his or her narrative to share. The overall theme that emerged was within the family's destructive system, either with neglect or abuse.

The goal of this study was to validate what Jenny Warren's research had already established, that creating a stained glass window with adolescent self-mutilators would show therapeutic benefits. It was very important to understand how the therapeutic intervention would play out in the process of the project. This study looked at the impact of creating a stained glass window on each individual's sense of containment and protection, self-object and transitional object, destructive and creative process, symbolic expression, and one's sense of power and self-esteem. This research also wanted to find more ways of understanding the benefits and risks each individual felt was important for future work with this type of project.

COMPAIRING THE RESEARCH WITH THE LITERATURE REVIEW

Several interesting comparisons can be made, between the sited research in the literature review and the findings in this study. The first issue is that self-mutilation has historically been a disorder related to the female population. The second issue is around treatment, or lack there of for many of these clients. Thirdly, a deeper look at the role the Internet has played with the clients who were involved in this research, in comparison to

what the literature discovered. It is interesting to note, however, that the majority of research was done in the late 1990's, proving that there is a need for updated research.

In stark contrast to the majority of literature that proposed that the "typical" self-injurer was a white female who began cutting at around age fourteen (see above p.19), the narratives of these five clients would suggest that this is not always correct. The narratives that were collected for this research showed that out of a school of 33 adolescents, there were at least seven males who had been involved in self- mutilation, and four that were able to participate in this research. Within this research each participant stated that they had started their self-harm well before the average age of fourteen. Even in the book *Bodily Harm* the authors stated that out of the hundreds of women and girls they only had in 1999 seen twenty-five men or boys (Conterio & Lader, 1999). This research shows an increasing need for information on the many males who suffer silently, fearing that the stigma of self-injury is devoted to the female population.

One factor that all the male participants had in common was that each of them at one point in their lives had been in a psychiatric hospital. Within the hospital walls they all learned to self-sooth by harming themselves. While there were specific advantages to being hospitalized and medicated for self-harm, many disadvantages were illuminated by the participants. As stated in the literature there are many different forms of treatment being used in the psychiatric hospitals (see above, p.20). Many stated that the hospital was not only the place where they learned to self-harm, but that it also acted as a "band aid" for what was really going on within their home lives. The literature did indicate that, "self-mutilators should not have this coping mechanism taken away without helping them realize what triggers' these incidents and learn new, healthier coping mechanisms (see

above, p.20)." The research presented embodies this sentiment, of creating treatment that gives individuals a means to coping without causing self-harm.

The literature proposed that there are over 400 sites devoted to self-injury, places where teens could go to get support and not feel isolated (see above, p.24). Each participant was asked whether they would use the Internet either to gather factual information on their disorder, or to receive support from other individuals, and each stated that they would not. It seemed that while the Internet was a good source for information on self-injury, it was not a place that these teens would use to get help. One participant stated that he would only use the Internet to find new ways to self-injure and specific techniques to hide scars from his parents. More research is needed on the negative effects that the Internet can have on adolescents who self-harm.

The sample size started out with three females to four males. One of the three girls dropped out before she began, she returned the consent form and then dropped out of the program. The other female who was unable to continue could not give a reason for her decision. This second female was a selective mute and the task of returning the consent form seemed in and of itself an accomplishment. After the two females dropped out of the research I was left with four males to one female, a very surprising result. All the literature points to a majority of the self-mutilating population as being female.

Working with the female seemed very different than working with the males. Kathy showed more fear in each stage of the developmental process. She seemed to need more from me as far as a caring supportive mother figure. She was much more transparent in her affect and mood concerning her feelings. We took more breaks that prolonged the research, which seemed an attempt to continue the therapeutic relationship

as long as possible. Her issues around attachment were clearly presented in the fonn of learned helplessness. It was important for me to continuously encourage and support her and the projects development. The hours sent working with her were in some ways easier, she was more willing to share her stories and her feelings.

The males that participated in this research were very different than the female. I found with the males more games were played, jokes were made, and periods of silence were expanded. Getting a clear picture of their life story was not as neatly tied up and presents as I had experienced with Kathy. Two of the boys presented with some erotic transference, wanting to make metal balls for me to take home. The boys were fearless in their use of the dangerous materials. The one boy who was unable to finish, Jason seemed the most cautious with every decision that he made, even more so than Kathy. llis sexual orientation is unclear, he presents himself with long blond hair and his gestures could represent a feminine tendency. His uncertainty around his sexuality could also be reflected in his art and his unwillingness to commit.

Overall the findings suggest that the participation in the study of creating a stained glass window to be beneficial. My clinical opinion is that what most of the clients benefited from this therapeutic approach, regaining a sense of independent control over their Iives. At the end of the eighth session each I asked each client to discuss their perceived risks of this therapeutic approach; they all had different answers. Some expressed that working with the hot soldering iron was very intense; one stated that he didn't feel like he had enough time to work on his project; others stated that they didn't believe that there was any risk at all. However, four out of the five said that they would like to continue participating in the creation of a stained glass window despite the

potential risks.

Each client was at a different stage in their relationship with their own issues of self-harm. I saw the creation of a stained glass window to be very therapeutic for four out of the five participants. I believe that the clients who view their past or current relations with self-mutilating as negative and want to change will have the greatest value from this intervention. Creating a stained glass window gave these five adolescents a chance to transfer their destructive feelings onto an external object, something contained and protected that would be safe to explore. This was a time for each of them to share and discover their unique stories, and to reframe and reshape their ideas of themselves just as they had done with the glass pieces.

SUMMARY OF RESULTS

The research and intervention were designed so that the clients would benefit from disclosing and discussing their secret isolating acts of self-harm by engaging in the individual therapy session setting. The research produced a safe setting where the clients felt a sense of structure, trust, and self-control.

One of the greatest commonalities that this research found was that for each participant the experience of self-mutilation is different not only for each person but for each episode. This idea that holds each individual to his or her unique story contributes to the complexity of the disorder and our track record in understanding. With all the complexities of this, the therapist and client can become blind-sided of what therapeutic direction to take. Hence the use of art therapy plays a key role in following the

subconscious direction of the core issue. Keeping these memories/actions suppressed reinforces the fragmentation and dissociation of a difficult life.

The intensity of this research was extremely rewarding and difficult. Often challenging me to the core, emotionally, spiritually, and even physically. There were times when I wondered if this that I had taken on was too great. Ultimately the challenge pushed not only me, but also each participant to go deeper within them. This final quote sums up nicely what society needs to hear, "Like the very blades they hold against their skin, the experience of self-mutilation cuts deep into their psyche. It tears their soul apart in the same way it does their flesh. It pushes back memories and quiets the voices that need to be head-the voices that need to be heard by us all (Scott, 1999)."

LIMITATIONS

A main concern was the small sample size of clients for the project, and that many of the adolescents would drop out or miss sessions. Having a limited number of sessions felt nearly impossible for some of the clients and for that reason some flexibility was necessary. It was also difficult to assess who was ready to do this kind of work and who was not ready. It was important to develop a good understanding of the people that I worked with before starting the project.

This study was tailored to individuals who were ready to talk about their past and current relationship to self-mutilation. Some adolescents with issues of self-mutilation find it very difficult to speak about their disorder, and many who have recovered do not wish to remember or re-live their illness experiences. For some this very private

experience can be daunting to share with a stranger. This thesis did not work well for those that were not able to talk about it at this time. Those individuals who were unable to talk about the issues may benefit from the opportunity to write about their experiences in conjunction with the creation of a stain glass window.

There still may be some question around the validity of the research and how to understand how much this project will actually help decrease the incidents of self-mutilation. It could be helpful in the future to create a system where they would write down the number of self-harm incidents weekly during the stained glass window process. If the participants were willing to do this honestly one could gage more accurately the success and validity of the research. Having a larger sample size would also help to bring more validity to this research.

Working with the adolescent population is not only difficult to access for honest answers, but at this stage in development they may not know themselves well enough to give the most honest answers. The information gathered is two fold in that the narrative is shared along with the energy that is presented in the art pieces. Where many were unable to discuss their intimate issues around self-harm, the art worked as a metaphor to present their past issues.

RECOMMENDATIONS FOR FUTURE RESEARCH

There has been little research done around the use of glass while working with clients who self-mutilate; this alone shows a need for more research in the future. By looking at the literature review and the data collected one can clearly see the benefits in creating a stained glass window with this population. However, as this is only the second

study done, it marks only the beginning of research in this area. It would be beneficial in the future to give this directive to a small group of individuals with a few therapists to supervise. Within this population many feel great shame and isolation. Having a process group could act as a support group with peers who have shared experiences.

One should also consider creating a longer period of time to complete this intervention. For some it took less than eight session and some it took well over ten. It could also be important to find some sort of assessment tool to test out where the clients are at with their self-mutilation. Considering the exceptionally high rates of relapse with this population having a longitudinal test could provide validity that this intervention was indeed helpful.

Furthermore, on the basis of the narratives discussed in this thesis the problem of self-mutilation is not an individual issue, it stems from deep problems within the family system. Ironically these adolescents who need to be heard, learn to hide, deceive and manipulate the core issues involved in this disorder. In the future having family education around the intervention could be of great benefit.

CONCLUSION

The main purpose of this study was to further expand upon the research Jenny Warren had started in 2002, using a larger sample size, using both males and females, and creating a longer period of time. This study confirmed that the creating of a stained glass window had a very positive effect on the majority of individuals. The study showed that there was a positive effect on these individuals' sense of containment and protection, self-

object and transitional object, destructive and creative process, symbolic expression, power and self-esteem.

Continuing this type of research is very important, not only to the field of art therapy, but also to the ever-increasing population of self-mutilators. This population has become stigmatized by most of society making it more difficult for them to get the attention and help they need. Self-mutilators strengths are often overlooked by society, leaving many to continue for years to cope with difficult emotions by cutting or burning. Creating a stained glass window with adolescents who have physically hurt themselves in the past, gave them the opportunity to transfer these destructive feelings into the art.

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Appendix A: Consent Form

Dear Parent(s),

I am writing this letter in regards to an art project that I am conducting at New Directions. My name is Jocelyn Fitzgerald and I am an art therapist intern at New Directions. I will be the primary person involved in a master's project assessing adolescent experiences by creating a stained glass window. This letter is to request your consent to include your child_____ in the project. The information obtained from this study will only be used for educational purposes. Your child's privacy and confidentiality will be respected. No personal identities will be disclosed. We hope this study will help us to see the benefits of using stained glass window making as a therapeutic intervention. There is no cost to you or your child. Below is an outline of the study and your child's role if approval is given.

Your child's participation in this project is completely voluntary. I hope that you can approve of your child's participation in this project. Please fill out and sign this form as quickly as possible.

Sincerely,

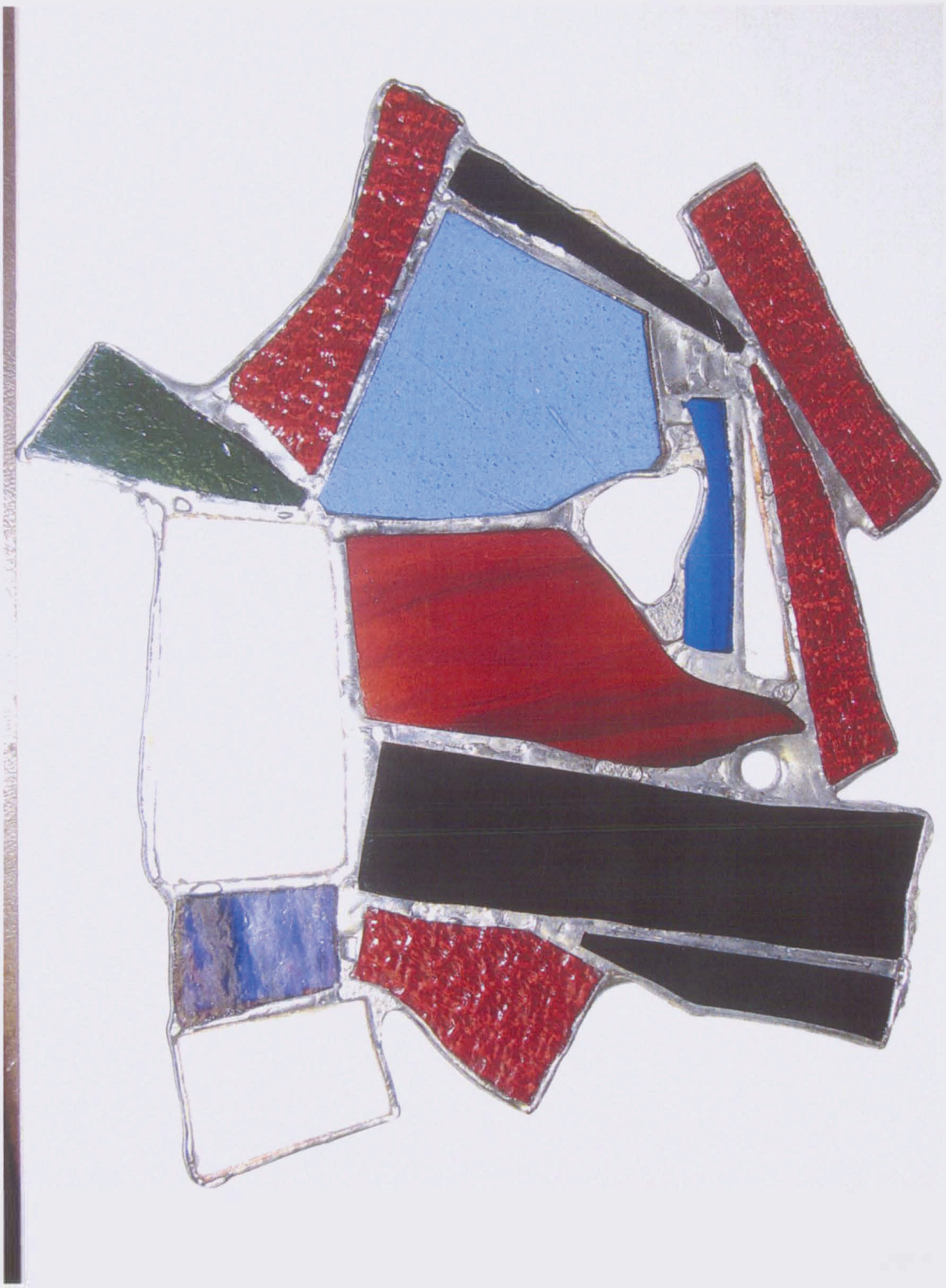
Jocelyn Fitzgerald
Notre Dame de Namur University
Phone # at New Directions
(707) 585-3700 ext.301

I, _____ the parent (or legal guardian) of_____ _ give consent for my child to be involved in Jocelyn Fitzgerald's project. I have read the above information and understand my rights and options.

Signature: _____ Date: _____ _

My Family
By: Kathy

The Manta Ray
By: Tim



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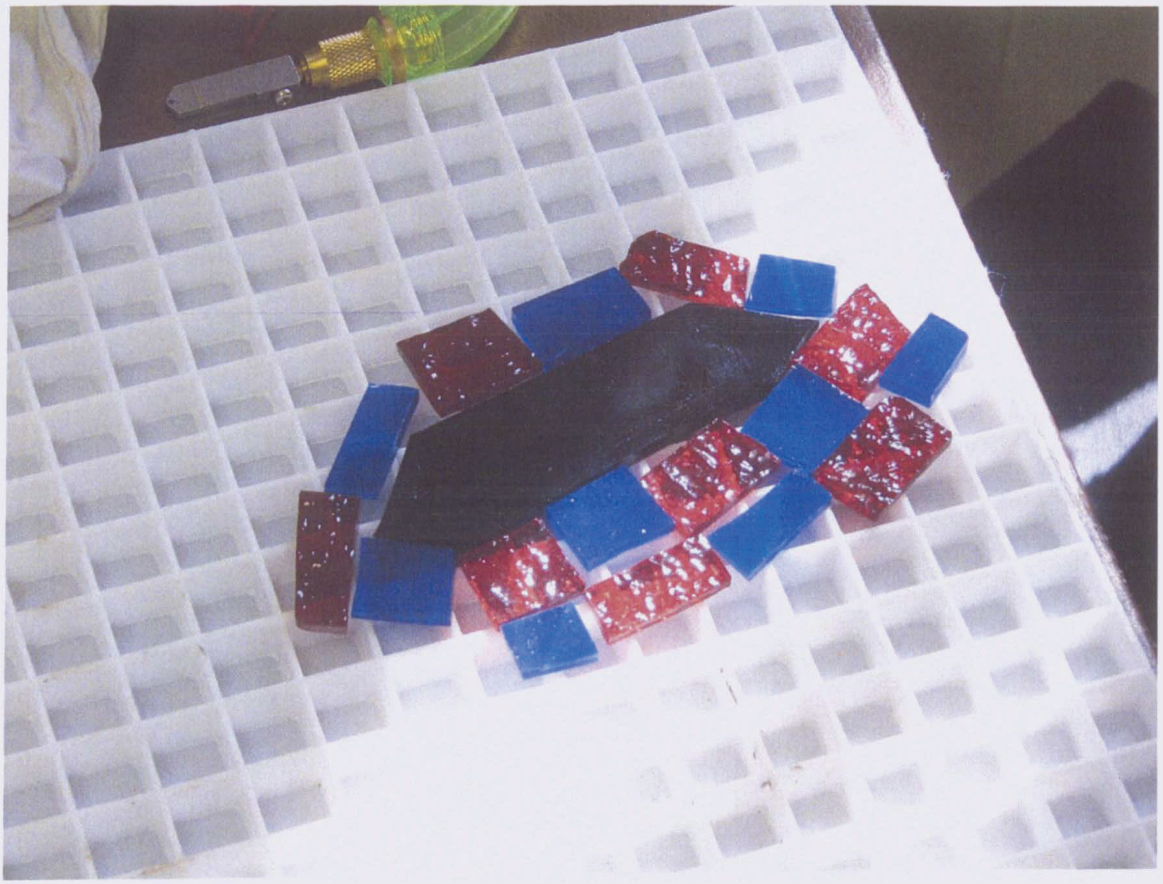
By: James



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By: Jason

Concept: The study will investigate the therapeutic power of stained glass when used metaphorically with adolescent's who have caused harm to themselves. Your child would participate in a contained environment in which he/she would create a stained glass window and will be given the time to express his/her experience in an interview that would follow the final session.

Risks and Benefits: The predicted risk to your child is small for the environment will be contained and skillfully observed and each tool and piece of glass will be accounted for at the beginning and ending of each session. If your child had any feelings or thoughts that came up as a result of the experience they would be able to discuss and process them with either myself or another member of the agency's staff. The benefits for your child include, personal growth, increased self-esteem, having fun participating in a creative self-expression, and a contribution to helping understand the value of stained glass as a therapeutic means.

Confidentiality: All information disclosed during this study will be kept confidential. The agency and Dr. Richard Carolan, Ph.D., of Notre Dame de Namur University, will provide supervision.

Appendix B

Session Contract

Date:

Checklist:

__ Glass pieces#

__ Foil

__ Flux

__ Soldering iron

__ Solder

__ Brush

__ Scorer

____Eye protection

L _____ __ agree that all the pieces of glass and tools are remaining in the art therapy room. I agree not to harm myself, and will ask for assistance if needed. I also agree that I will not take drugs or drink before a session.

Check in:

Check out:

Appendix C

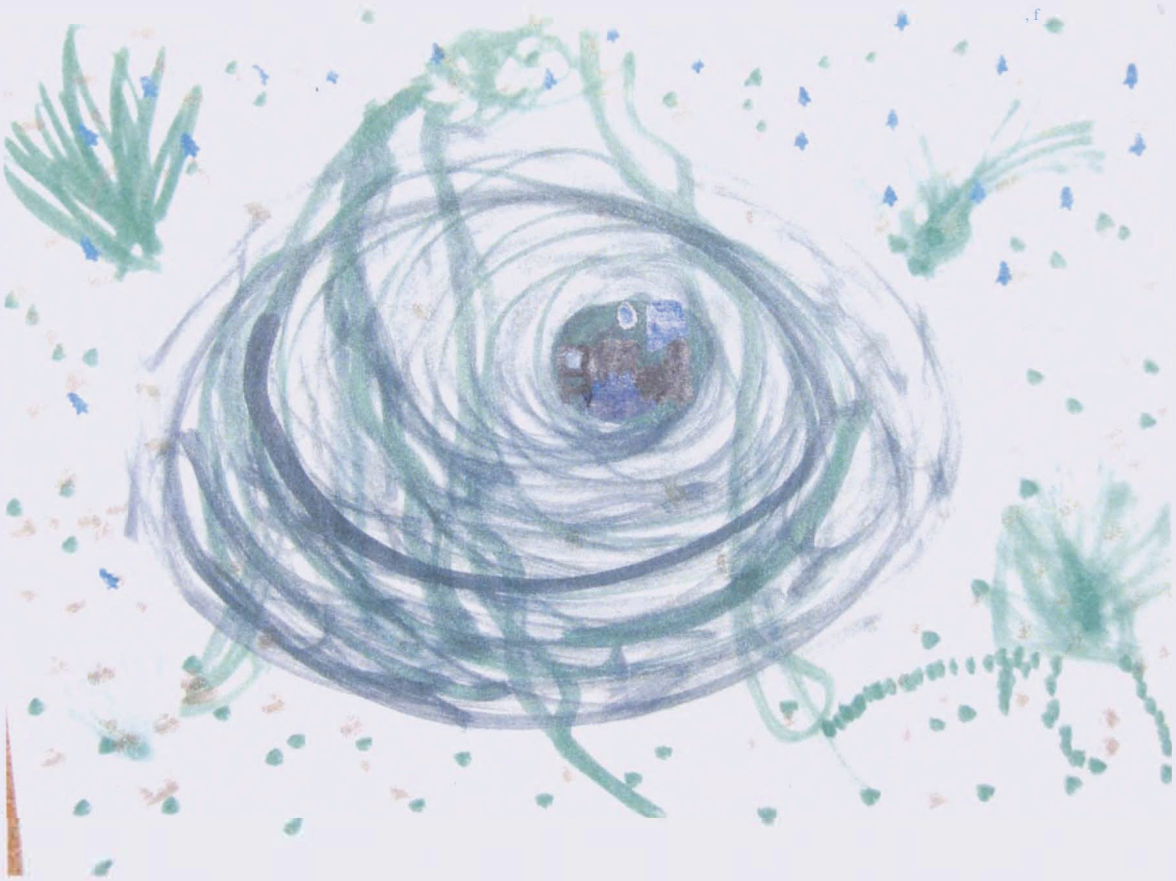
Interview Questions

1. How would you describe your experience in creating a stained glass window?
2. What did you like most about working with glass?
3. What did you like least about working with glass?
4. What was your first feeling when cutting the glass?
5. What was your first feeling when foiling the glass?
6. What was your first feeling when soldering the pieces together?
7. What came up for you while working with the glass?
8. Would you want to work with glass again?
9. Is there anyone you would recommend stained glass to? Why?
10. Is there anyone you would not recommend stain glass to? Why?
11. How does it feel to have your stained glass window hanging up?
12. Would you allow anyone to see it?
13. How has participating in creating a stained glass window affected how you see yourself?
14. What are the benefits of creating a stained glass window?
15. What are the risks of creating a stained glass window?
16. Did you ever feel in danger of hurting yourself?
17. How has participating in the creation of a stained glass window affected your sense of protection?
18. How has participating in the creation of a stained glass window affected your sense of power, self-control, and self-esteem?

19. Did you discover a way to talk about the cutting that was not intrusive?
20. If you were the one conducting the interview are there any questions you would ask that have been left out?

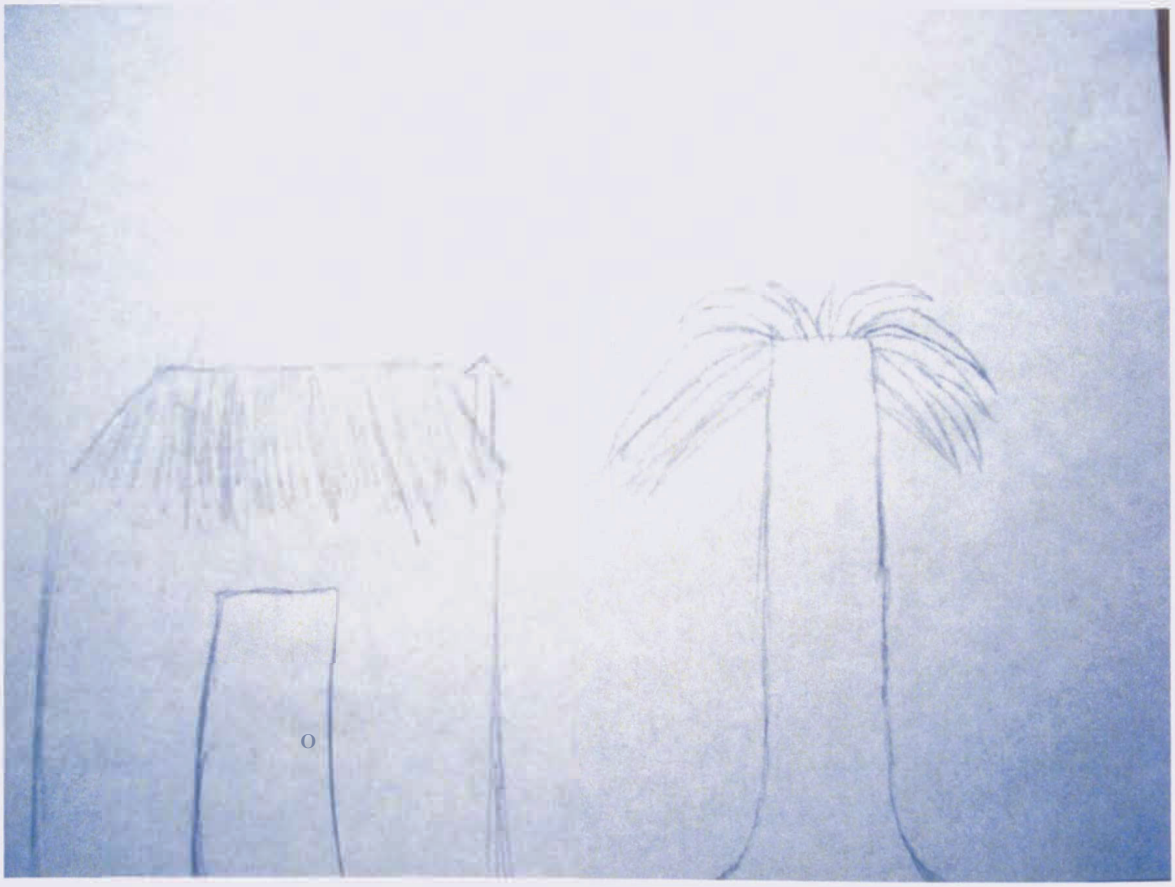
Appendix D:

Examples of the directive 'Draw a Safe Place'

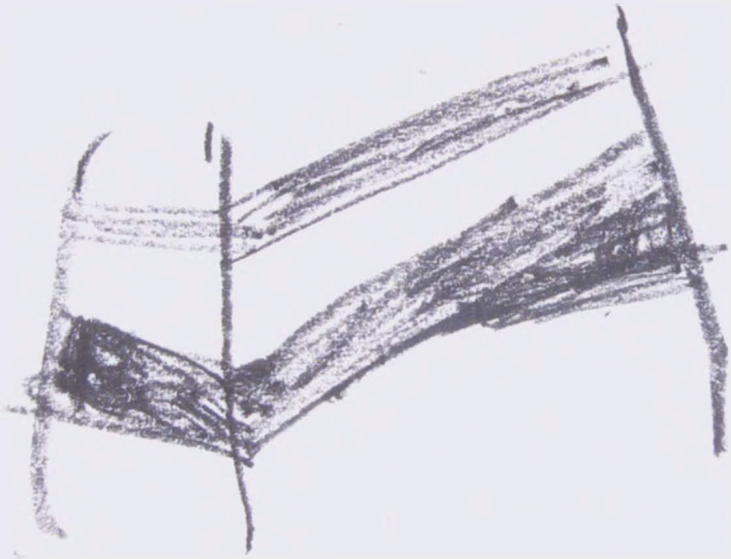


Safe Place Drawing
By: Matt
My Cave

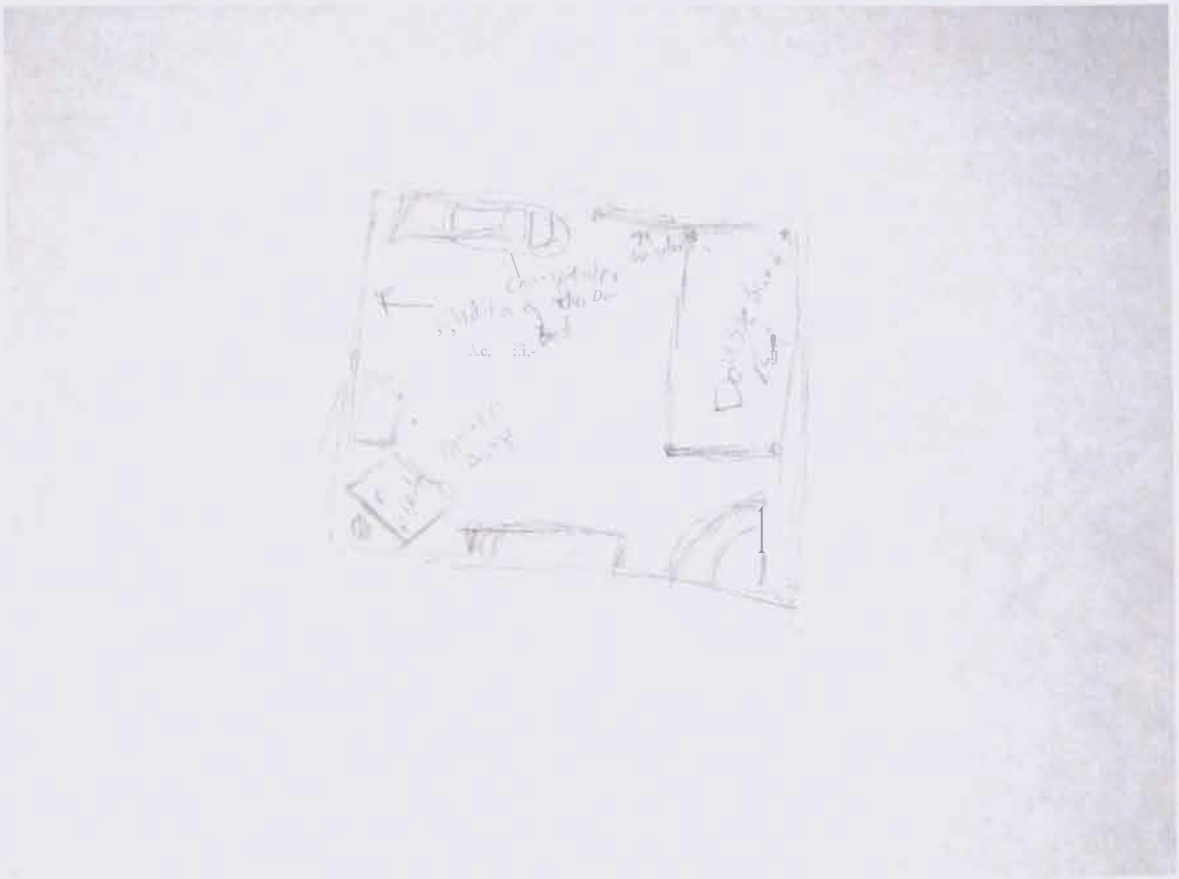
Safe Place Draw·
By: Kathy mg
Clown Balloons



The Safe Place Drawing
By: Tim
A House and a Tree



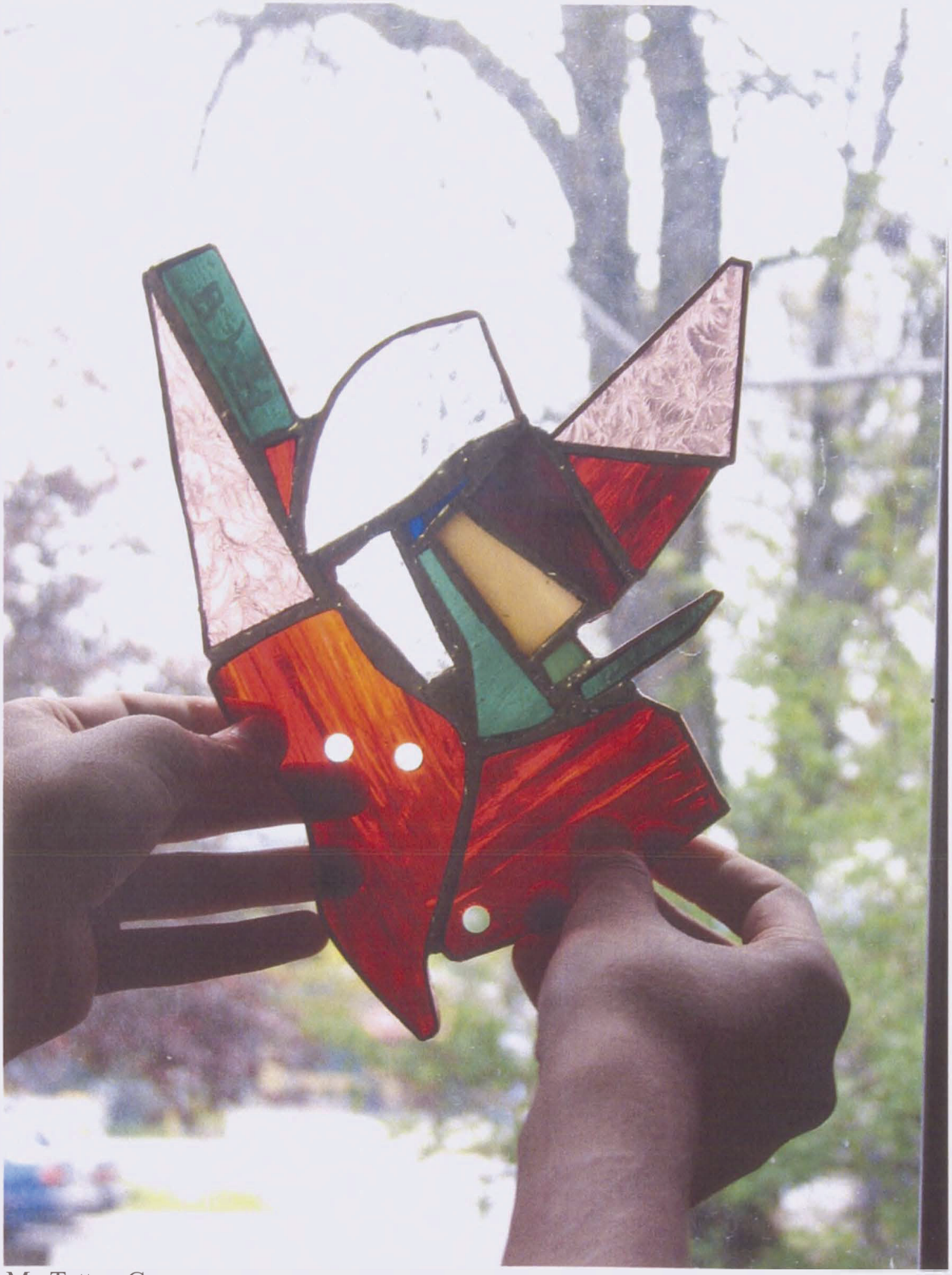
Safe Place Drawing
By: James
My Bunked



The Safe Place Drawing
By: Jason
My Friend's Room

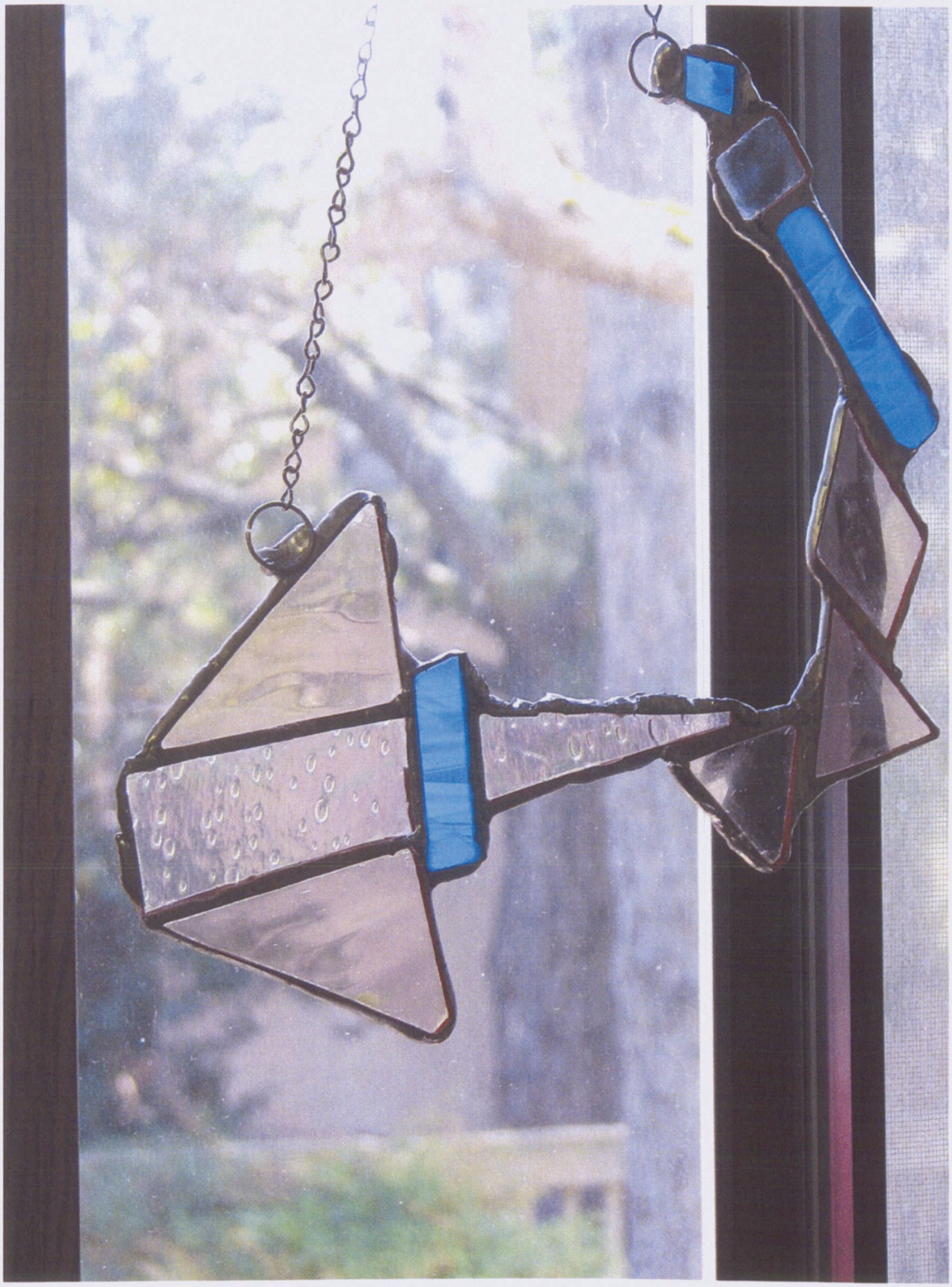
Appendix E:

Photos of Stained Glass Windows

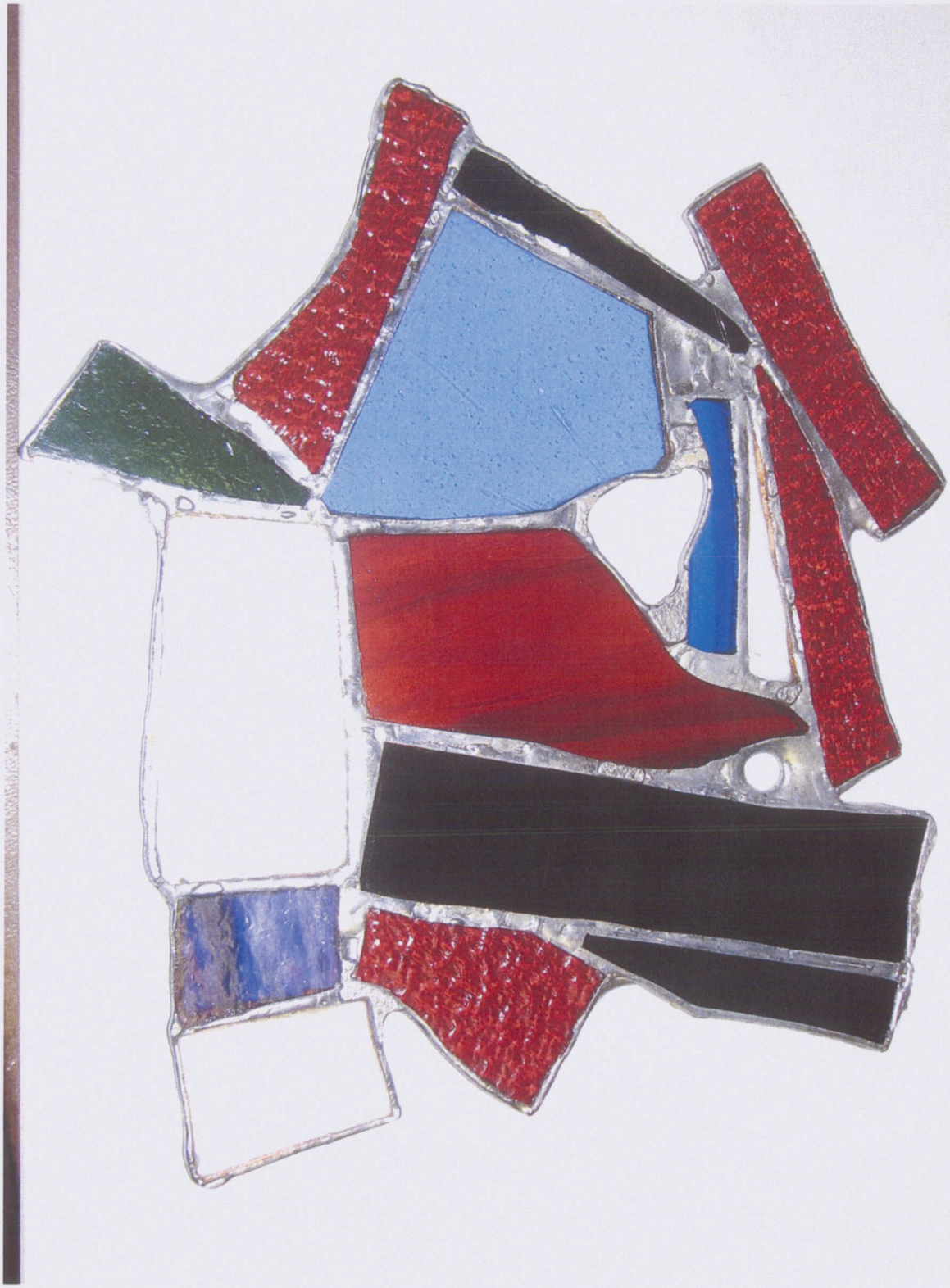


My Tattoo Gun
By: Matt

My Family
By: Kathy



The Manta Ray
By: Tim



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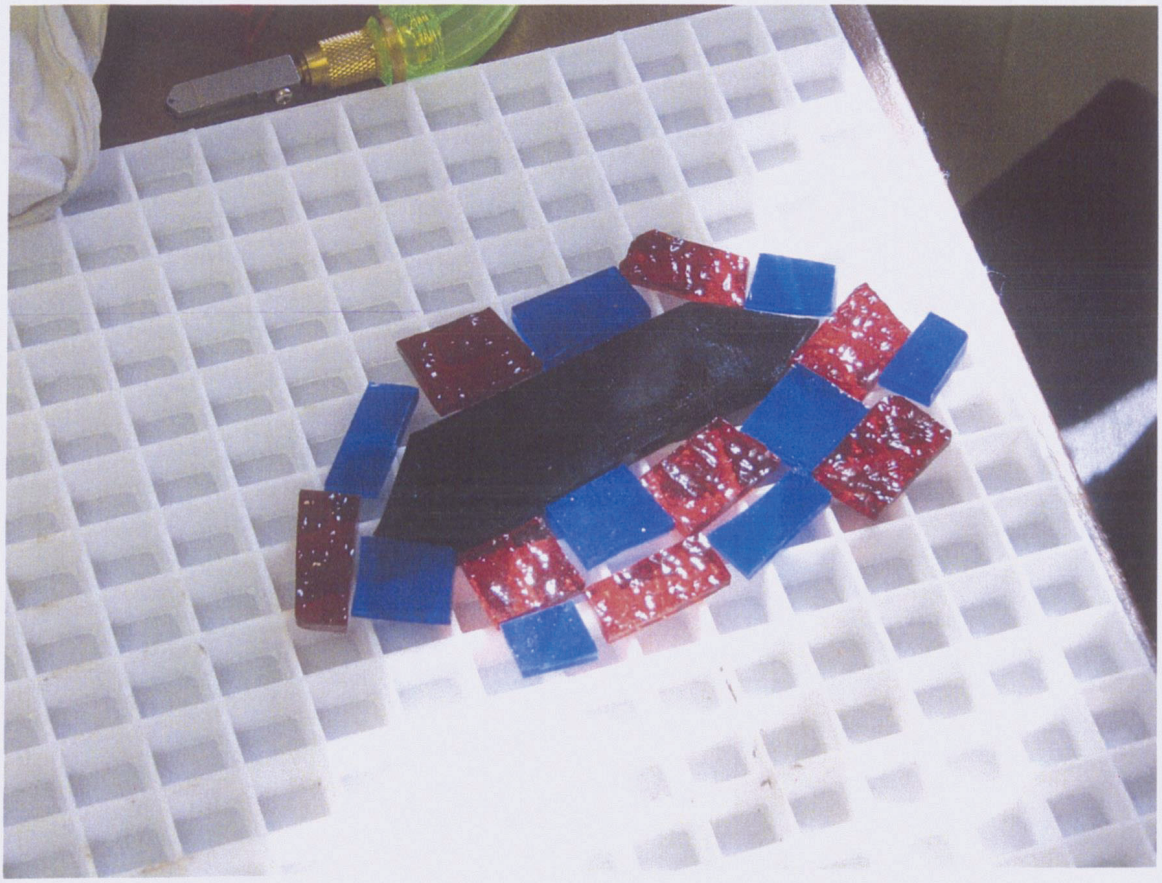

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By: Jason