ideas are presented and hypotheses raised. In Chapter 8, the final chapter, the different ideas and meanings are brought together and discussed, and possible models for thinking about self-harm are suggested.

The process of listening to, working with and reading about young women who are attacking their bodies has been a powerful, humbling and salutary experience. It is from this that my thinking about self-harm has emerged. Trying to avoid dogma and routine interpretive stances, a space can be found to think about such experiences and what we make of them. It is with this attitude that I have approached writing this book – a book which hopefully will be both thought provoking and clinically helpful for all those involved with people who attack their own bodies.

Chapter 2
Meanings – conscious reasoning and unconscious motivation

Women’s and girls’ understanding of their need to harm themselves

Generally, people who deliberately hurt themselves do so because they feel that they need to, and that the act itself makes them feel better for a while and more able to cope. People report overwhelming feelings of misery, emotional distress and hopelessness which lead them to the apparent solution of inflicting pain on their bodies. For some people who harm themselves the solution is felt to be the answer, but for friends, relatives and professionals the solution becomes the problem. To those who are self-harming, cutting serves as a way of owning and controlling the body, and seems to be a solution for those cutting to emotional upset. In situations where a young woman who cuts herself feels overwhelmed or upset by others, and by her own complicated and apparently uncontrollable needs, she can turn and attack her body, and through her aggressive action find some comfort and relief. Through these actions emotional pain becomes physical pain, and therefore easier to deal with, and the metaphorical distinction between body and self is diffused.

Anne, who was referred to the clinic for intensive psychotherapy, spoke of feeling very tense and anxious much of the time. She said this was because she kept thinking about things that had happened to her either recently or in the past. All of a sudden, images, flashbacks and feelings from the past filled her mind. For her, relief came and the tension eased once she had cut herself. She said that she felt quite sure she could not survive without cutting herself. When she cut open her skin, the pain meant that she had something else to think about, and the practical problem of her bleeding arms to deal with. She also spoke of hating her body and herself, and actively hurting herself seemed one way of coping with these feelings. When Anne said to me early in the therapy: ‘Don’t try and stop me cutting, I’ll die if I can’t cut’, she summarised the strength
of the enactive conflict, although it was several years before I gained a true sense of the constituent aspects involved.

My experience with the young women seen for psychoanalytic psychotherapy was that they tended to focus on the cutting as a way of dealing with an immediate difficult feeling or anxiety. The trigger was often a row within the family or with a friend which contained the threat of abandonment. For example, falling out with a friend, a hostile remark by a teacher, apparent rejection by a parent, were frequently given as the precipitant for the attack. Behind this immediate event there seemed to lie both anxiety about the young woman’s fear of destroying the person because of her unexpressed and usually repressed anger, alongside the loss of any hope of having her needs met and gratified by them. The trigger could then be seen to have some sort of link back or echo of the oscillation between opposing psychic forces of having and wanting to be rid of. It was as if the act of self-harm represented something simultaneously profoundly destructive and needy in the mind that broke through and formed the action.

The young women tended to develop their own sequence of events leading to the action, with feelings of indignation and slight that ‘justified’ what they had done. A few were reluctant to think any further beyond ‘this is something I do’ and ‘this is something I need to do to feel better’, and were worried that by coming to the clinic people would try and stop them. Some had a sense that there were more complex reasons that might be contributing to their need to harm themselves, and quickly linked their feelings to upsetting events in their childhood. For many, difficult experiences in childhood had been followed by a disturbing adolescence, and these early experiences, and the angry and upset feelings about them, seemed to underlie their self-destructive behaviour. In my experience some of the young people did find therapeutic value in understanding the origins of their actions, while the more disturbed were unable to make use of such insights. They were struggling to deal with unpredictable sensations, and barely managing the uncontrollable force of emotion.

Over time, many of the patients were able to express their feelings about these experiences in psychotherapy, and most eventually realized there was a link between earlier distress and later symptomatology. Some had experienced serious trauma, while for others there were no obvious reasons for their distress. Out of the fifteen young women who were referred with deliberate self-harm, four had been sexually abused; eight were from families where there had been separation and divorce, often with very little further contact from the absent parent; four had been left by their mothers and four by their fathers. Another was adopted, and felt she had been left both by her mother and father. Four of the young women were at boarding-school and generally felt emotionally neglected or rejected by their families, and three were overly involved with their families and felt under great pressure to be successful. While some had obviously experienced more than one trauma, others felt they were neglected or emotionally abused in a general sense rather than because of a specific trauma.

Lucy was referred at age 18 because of repeated cutting and an overdose attempt. She said she had taken an overdose following a quarrel with a friend who Lucy accused of being too interested in her boyfriend. She had a problematic relationship with her father who had left the family home when she was a baby, and who now lived and worked abroad. As a child she had spent holidays with him, but had found him bad-tempered, and she had not liked his then girlfriend, and so, from the age of 13, Lucy and her father had had little further contact. In therapy Lucy said she felt confused about her feelings towards her father, and angry and disappointed with her mother who was so critical of him.

Eventually Lucy decided that she would like to see her father again, and we talked about the possibility that she might telephone or write to him, and eventually try to arrange a visit. Consciously hoping for his sympathy and understanding, Lucy decided to tell him immediately on the telephone about her cutting and overdose. Her father dismissed this as ‘a lot of nonsense’ and Lucy for ‘being silly and dramatic’. Lucy was furious and upset by the conversation and afterwards cut her arms badly. In later sessions she was able to think about her strong need to shock her father into responding to her, her anger towards him for his abandonment when she was a baby and his subsequent lack of interest. The cutting was a response to her familiar disappointment in him, and the fear of the strength of her angry and loving feelings towards him. In that sense it was a paradoxical gesture in that she longed to be held safely by him, but her upset at his indifference was represented by the damage to her own arms. By attacking her own body Lucy had wanted to show her parents and friends how angry she was, and how much she had been hurt by them. She also wanted to find out whether her father cared.

The types of difficult life experiences found in the young women attending for psychotherapy are confirmed by a Bristol survey in 1995 where most of the adult women who responded (62 per cent) believed that childhood experiences alone had led them to self-injure, and a number felt that both childhood and adult experiences had contributed. When the women were asked about their childhood experiences, most reported...
multiple forms of abuse and deprivation. The two most common forms were sexual abuse and neglect (49 per cent) in each category. A similar number reported having suffered from emotional abuse, and a quarter from physical abuse. As the authors of the survey point out, there were clear associations between different types of abuse and neglect, so, for example, most of the women who had suffered neglect or emotional abuse also reported physical or sexual abuse. Some had witnessed family violence although they had not been abused themselves. Separation through death or divorce, and parental illness or alcoholism were also significant contributory reasons. Many felt that lack of communication in the family had led to them seeking out harming themselves as a way of expressing their distress. The survey suggested that for some of these women early experiences of abuse and neglect are repeated in adult relationships, and this contributed to their continuing need to injure themselves (Bristol Crisis Service for Women 1995a: 10).

Some analytic findings

A theme of this book is that the underlying meaning of self-harm originates in early childhood experiences — the events that trigger the action have their roots in old patterns and old wounds. Clearly the psychodynamic and psychoanalytic explanations of self-harming behaviour stress the early relationships in a person’s life. In particular, they focus on how any traumatic or abusive events are inwardly responded to and taken up into a person’s imaginative and fantasy life. In this sense self-harm is basically a symptom expressing disturbance originating from an earlier, prepubertal time, though for reasons explored in Chapter 4 it often emerges during adolescence, and is characterised by an adolescent mind-set. It is as if the attack on the body becomes the only way to communicate deep distress, which, both at the time it was experienced and the time it re-emerges, cannot be put into words.

The psychoanalytic literature highlights loss, separation, abandonment, abuse and neglect as key aspects — findings that confirm the experiences of the young women in the study. The central themes in the analytic literature on the sexual and aggressive elements — self-harm as a self-destructive impulse, namely an attack on part of the body serving as a substitute for the whole; and the hatred and confusion towards the sexual body — are explored in depth in Chapters 3 and 4. In this chapter my central schema is the idea that attacking the body is a paradoxical gesture which emerges in a number of ways, including the ritual use of implements, and the skin as a medium for communication.

An overall and not unexpected finding in the analytic literature is that inadequate or disruptive early object relationships are seen as a central contributory factor to self-harm, and such experiences are reflected in later difficulties with forming close attachments and meaningful relationships. The infantile experiences with the environment are internalised, and, as inner object relations, affect later relationships — including the transference relationship as it emerges in the psychotherapy. The regressive quality in relationships is generally acknowledged, as if the person is continually in touch with the need to satisfy earlier deficiencies. This links with another common finding which is a narcissistic orientation in the person who is attacking her body, and the auto-erotic aspects of the act are also recognised. It is generally agreed that traumatic events such as neglect, and physical and sexual abuse, are linked with the later need to harm oneself, and can lead to basic alterations in the experience of the body, and the internalisation of early negative caretaking processes and negative attachment. The few specific studies on young people suggest that they are caught up in complex struggles around issues of separation, individuation and differentiation, exacerbated by inadequacies in their early attachments. I shall now look at some of the more useful studies that focus on the reasons for self-harm. These analytic studies tend to be based on a small number of patients, or on treatment with one individual.

One of the most valuable collection of papers comes from a symposium on self-mutilation and self-cutting in the late 1960s (Burnham 1969; Kafka 1969; Pao 1969; Podvoll 1969), where the findings outlined above were emphasised. In his paper, Podvoll (1969) writes of the loneliness of the act, performed alone, on the person’s own body and shared with no one. It takes place at a time when the person feels most detached and removed from others, and involves a splitting phenomenon. He emphasises three dynamics. The first is the “flight from deeply dependent, even symbiotic wishes toward a more primitive love object to a reliance on the auto-erotic use of one’s own body” — in other words, a reactive move from dependency on another to separation and increased self-sufficiency. The second is a “capacity to treat one’s own flesh with scorn and contempt necessary to allay more narcissistic urges” — in other words, hatred of the body; the third is the diversion by the patient of aggression on to herself “a fixed and seemingly indestructible object, in this way the patient manages to preserve intact her split off and idealized object”. Here, aggression turned inwards is safer than the possibly destructive aspects of what may feel like uncontrollable aggression towards another (1969: 220).
Pao’s paper (1969) focuses on young female hospitalised ‘cutters’, who in his view seemed to vacillate between being psychotic and being ‘normal’. Each young woman also had other symptoms, such as eating disorders, other ways of harming themselves and suicidal thoughts. The symptoms had emerged between the ages of 12 and 14, and had led to outpatient treatment and eventually to several hospitalisations. These patients’ developmental histories revealed that the mother had played a central part in the family system, in contrast to the father who tended to stay on the periphery. However during infancy there appeared to be a lack of maternal handling, or frequent changes in the quality or quantity of maternal care due to circumstances such as mother’s illness, other siblings or a poor relationship between the parents. Pao reports that the patients were fearful of their own aggression, and expressed repugnance towards female sexuality. They were often socially isolated and had problems sustaining same-sex relationships.

An interesting observation is that Pao found that, at the time of cutting, his patients were in an altered ego state where they became self-engrossed, unaware of their surroundings and auto-erotic in the sense of being totally unrelated to anyone else at that moment. He describes it as ‘a regressed ego state with surrendering of autonomous ego functioning to a drive-dominated act which was simultaneously sadistic and masochistic’ (1969: 198). While consciousness was suspended the patient was able to retain physical control, and was able to remember what she had done. This state of mind has similarities to the experience of depersonalisation and derealisation, but, as Pao reminds us, in depersonalisation the person’s sense of their participation in the action is lessened although they are highly self-aware, while in cutting the reverse is the case. In other words, the young women were very involved in the immediate experience, but had little if any self-awareness at that moment. In the clinical material he describes, both patients cut themselves when aggressive feelings arose over loss and separation. Sometimes this was an actual separation (for example, when the therapist went away on holiday), while at other times the patients engineered a separation (for example, leaving the hospital ward). This finding leads Pao to suggest that as early as possible in the treatment the patient’s difficulties over separation and abandonment need to be dealt with, even though this carries the risk of further cutting. The therapist in the early stages of the treatment has the responsibility for making connections until the patient progresses to a stage where she can make such links herself.

In both of these papers Podvoll and Pao are describing dissociation – though they use different terms – which is a concept of great relevance in self-harm. In a dissociated state, where there is an interruption in awareness, a person either feels no pain when she hurts herself, or does it so that she can feel something. Dissociation is a specific, adaptive, automatic and dynamic response to severe trauma which separates and isolates the original traumatic experience, so that the central self escapes from the pain and reality of what has happened, and emotional distress is avoided (Gardner forthcoming). If there is a threat of an associated experience the person again emotionally ‘cuts off’, and ironically uses actual cutting as a way of dealing with what is happening. Worth noting here is the work of Orbach (1994) who found dissociative tendencies a unique factor characteristic of destructive behaviour, as it is a process which restricts both one’s sense of one’s body and one’s experience of the self and world. As I explore later, there is an inability to think about either the trauma or the associated trauma, and, as there can be no symbolic mental representation for what has happened, all this has to be managed in the therapeutic work.

A useful study of adolescent self-harm has been made by Simpson and Porter (1981) who describe their work with twenty young people – sixteen girls and four boys – who were harming themselves, usually by cutting or burning parts of their bodies, and who had been hospitalised. This study has very similar findings to my own study, with the familiar range of harming behaviour and damaging childhood experiences, and the poignant desperation involved in the attacks. Twelve of the young people had also made serious suicide attempts, and another six reported thinking about suicide, but none of them intended to kill themselves by cutting or burning. Most of them abused alcohol and/or drugs. The authors studied variables of physical abuse, sexual abuse and the sense of abandonment and the link with the self-harming behaviour. The findings demonstrated that most, if not all, of the young people had experienced some form of actual disruption in early childhood. One or both parents had left the home, and replacement caretakers were often inadequate. Twelve of the girls and one of the boys had been physically abused by a parent, and nine of the patients referred to inappropriate sexual involvement with a close family member. The authors note the desperate sense of isolation and the feeling that they were unlovable, which was expressed by nearly all the participants. While they searched for relationships, many refused to form meaningful attachments. For the young people, harming themselves appeared to act as a form of physical stimulation almost akin to the physical pain experienced in childhood. It also acted as a focus for aggressive feelings and contained an element of self-punishment, often for sexual feelings and behaviour. Finally the
harming was also seen as a non-verbal statement of their despair and a cry for help.

In his paper Daldin (1990) focuses on psychotherapy with a 14-year-old girl, but shares his experience that many patients who inflict injury on themselves are characterised by having a tragic and chaotic life which is dominated by loss and leaves them depressed. He also notes a study with the unusual finding that many patients had experienced early physical trauma or surgery, usually before the age of 6, and that most perceived menstruation as something that made them miserable or that frightened them. Daldin’s patient, Chris, had a disrupted and difficult early childhood; her parents’ marriage broke down when she was 2, following verbal and physical fighting. Subsequent care of the young children was confused and there were major disruptions. Chris was seen for intensive analytic psychotherapy during the six weeks she was in hospital, and this continued on an outpatient basis. Daldin’s account is helpful because he looks in detail at session material. For example, during one session as an outpatient, when Chris reported having cut herself, her associations to this were to her discharge from hospital, and to earlier experiences of being abandoned by her parents. Daldin notes that Chris became increasingly angry and depressed and said she felt ‘alone’. Chris pulled a pin from her jacket and stuck it through the skin of her left forearm and then through the skin between her thumb and first finger. She said, ‘See, I can stick it in . . . and pull it out . . . and I don’t feel a thing’ (1990: 285). Dadin interprets her anger as the result of rejection by him because he had discharged her from hospital. He feels that her anger turned into carrying out an action that would force him to readmit her. Chris confirmed this and threw the pin away. Daldin comments later in his discussion that Chris was not able to manage and hold on to her sexual and aggressive feelings as thoughts; rather she felt she had to act them out – on some occasions in the sessions.

The well-known work by the Laufers (1984) can be added to these papers on adolescent breakdown. This provides a valuable conceptual framework. They emphasise the use of the body as the channel for the expression of all the adolescent’s feelings and fantasies. Adolescents who have difficulties in forming relationships are especially vulnerable, and are seen as in a state of ‘developmental deadlock’ where there is no possibility of moving forward into adulthood nor regressing back to dependence. It is as if the only route is via self-destructive action, and the body becomes the site for representation of this. This is explored further in Chapter 4.

Paradoxical gestures
As I have proposed, attacking the body is essentially a paradoxical gesture in that the apparently destructive act reflects a desire to continue to live and get on with life. Cutting can function as a way of cutting off from internal pain by providing a distraction. A further paradox is that for some, the physical pain caused by the action can instil some sort of feeling, in contrast to emotional deadness. As a result of the pain they had inflicted on their bodies, which ironically some of the young women did not experience as pain, these feelings of dissociation left them, and some reported feeling alive again. Some of the patients seen at the clinic spoke of feeling half alive, empty or even unreal before they wounded or poisoned themselves. The feelings of emotional deadness were replaced through self-inflicted physical pain. Some of those who cut or burned themselves felt that they could concentrate on the wound, rather than on their other worries. They felt that hurting themselves had been a solution, a way of releasing tension and coping with problems that enabled them to get on with their lives. For a few of the patients the pain served as some form of punishment, and eased their bad feelings and hatred towards themselves. Another function was that some of the young women felt that the attacks on their bodies helped them to feel in control of themselves, and what they were feeling.

Rosie would burn her arms by pressing a lighted cigarette on her skin until she could hear and smell the burn. Rosie asserted that it was only at that point that she could feel the pain, and in her words ‘feel real again’. It was hard for her to explain what she meant by this, but she described often feeling unreal and strange. The experience of self-inflicted burning seemed to force her to reconnect to herself, and she reported feeling in charge and in control once more.

Addiction and fantasies around risk, danger and death
I now turn to an understanding of the repetitive aspect of the behaviour, and highlight the addictive aspects of repeated self-injury. While the initial act of cutting can serve as a form of self-help, by releasing tension or as a way of coping with unbearable feelings, the way in which the act is responded to influences whether the person does it again. In general, repetition seems to be influenced by a number of factors: whether the original circumstances still apply; the person’s own beliefs about the action of cutting, hitting or burning her body; her own and others’ emotional
response to the original act; and good mood changes produced by the action (Holmes 2000). Tantam and Whittaker (1992) usefully suggest two main reasons for this, which may often be combined. The first is that the behaviour can be coercive, in that the self-harming produces a wanted response from others; second, that it is relieving, in that the action produces a lightening of mood, either through biochemical alterations and the associated release of endorphins (the body’s own analgesics), or conditioning, or symbolically. I would add two further points, which are that once the threshold has been crossed it is easier to act again; and second, that included in the response is a form of fearful excitement which may never be regained after the first time, but is still longed for.

‘The manipulation of the idea of death is not devoid of pleasure’ (Haim 1974: 208). Here I want to emphasise as part of the sense of fearful excitement the strong attraction to risk-taking situations among some of the young women I saw. It can be seen as similar to the ambiguous pleasure of playing with fire, with the accompanying risk of burning oneself, a pleasure which includes a strong element of masochism. Attacking the body seemed one way in which these young women dealt with uncertainty and anxiety. The more extreme forms of cutting, burning and hitting led the young person to feel that she could bring death upon herself; that, despite life feeling out of control, she could in fantasy control the time and manner of her own destruction and even death. A further fantasy, perhaps belonging to a younger age, was that while the part feeling the painful and unbearable feelings could be killed off, another, happier part of themselves could then live. Despite feelings of dependence, the person who self-harms can demonstrate her autonomy and ultimate independence by such symbolic actions. Again this is a further paradox, for, in the young woman’s belief that she can kill herself, there exists her recognition that she is alive and free, and in that sense no longer a dependent child.

Inevitably the fear of death, and the terror of uncertainty, can lead to a fear of living, or a fear of becoming too attached to life. In the same way that some of the young women had experienced early failures of attachment with their mothers, and later had experienced abusive attachments, they were fearful of any further relationships, including the therapeutic relationship. Some form of deliberately hurting themselves, while reminding the young women that they existed, at the same time restricted their existence and the formation of intimate relationships. The fear of relationships can go together with a realisation that there is a need for intimacy, and part of the self-destruction connects to a wish to annihilate that need.

There is a large body of analytic theory linked to the concept of the death instinct. Freud (1920) first described the death instinct as aiming at destructuralisation, dissolution and death. He saw it as a biological drive to return to the inorganic. Segal has taken this biological concept and emphasises the psychological aspects, seeing it as a drive ‘to annihilate the need, to annihilate the perceiving experiencing self, as well as anything that is perceived’ (1993: 55). She describes how this often becomes a powerful projection in the countertransference which can lead to feelings of deadness and paralysis in the analyst, or stimulate feelings of aggression and persecution. Sometimes all the life force becomes the responsibility of the analyst, who is left feeling that they are keeping the process, and the patient, alive. The patient may be avoiding the pain caused by the awareness of their need for intimacy with another. This leads to emotional and sometimes actual physical attacks on the self and emotional attacks on the other person, the other person being hated and envied because they are so desperately needed. This is an experience that I found particularly in the work with the most disturbed patients I saw, and is examined in further detail in Chapter 6.

In a seminal paper Joseph (1982) takes the concept of the death instinct, and discusses the libidinal satisfaction linked to self-destruction. Her ideas on this are especially valuable. She particularly discusses the way such difficulties are constituted in people’s internal relationships, and therefore might emerge in the transference with an analyst. In a telling passage she pinpoints ‘the deeply addictive nature of this type of masochistic constellation and the fascination and hold on them it has’ (1982: 450). She also describes the addiction in terms of the patient being ‘enthralled’ by it, and linked to a mental activity of going over and over something – a process she terms ‘churning’. This process is the antithesis of thought and development. She writes that such patients have withdrawn into a secret world of violence ‘where part of the self has been turned against another part, parts of the body being identified with parts of the offending object, and that this violence has been highly sexualized, masturbatory in nature, and often physically expressed’ (1982: 455). The examples she gives are of head-banging, pulling at hair and so on, physical activities that mirror the equivalent verbal churning. The addictive quality means that it is hard for the patients to resist, and it acts as ‘a constant pull towards despair and near-death so that the patient is fascinated and unconsciously excited by the whole process’ (1982: 456). Here I equate this with the sense that I describe of the ‘fearful excitement’ engendered by the attack.

In the clinical example that follows, Shannon, who was referred initially to the clinic with an eating disorder, veered between dramatic
anorexic and bulimic phases. After several admissions to adolescent units where her weight was maintained, Shannon began to drink heavily, experiment excessively with drugs, cut her arms deeply and made several suicide attempts, usually by taking overdoses. On one occasion she climbed out on to the second-storey window-ledge of her mother’s home, where she threatened to jump, and involved a number of people in her rescue. Eventually she was ‘talked down’ by a neighbour. Later, Shannon confided how much she had enjoyed her stays in the units, where she and other residents would talk together for hours about their situations, and the various methods of hurting themselves that they had all tried. It seemed that Shannon needed the drama and excitement of her self-destruction. She could then talk about these events and what she was doing, without allowing herself to think about the reason or meaning that lay behind her behaviour. Her self-harm also served as a way of avoiding relating to her therapist in the transference. No meaningful relationship in the transference was possible, since her dramatic symptoms created a distance between herself and the therapist.

Again there is a paradox here, in that the addictive need for such excitement and the special attention that may result from it is in direct proportion to the lack or absence of the experience of having been treated as a person in their own right. Some of the young women felt they had merely fulfilled parental need, or experienced themselves as extensions of a parent’s narcissism, as well as their own form of comfort and way of solving their problems. The entry into the public domain, via an overdose or noticed body injury, gave some of them a chance to be special and different. Yet some who were harming themselves in a serious way seemed to be demanding an authoritative intervention from an adult, powerful enough to balance their own omnipotent ideas of the amount of damage that they could cause to themselves.

**Ritual and the implements of self-harm as transitional objects**

When the behaviour becomes addictive and is regularly repeated, ceremonial symbolism and ritual around the actual harming may in turn become crucial, or even addictive in their own right. I think that at this point we see elements of magic and superstition entering a process that becomes akin to healing and/or salvation. This hypothesis can best be illustrated with reference to the work with Mary, who is also discussed in a later chapter.

Mary kept her razors in a special wooden box, wrapped in a piece of velvet cloth. The box was kept under her bed. When her mother found out about the cutting, she made Mary hand over the razors. Mary bought some more and hid the box under a loose floorboard in her bedroom. Even when Mary stopped cutting she felt it helped her to know that her secret supply was still safe. Before cutting herself Mary laid out her razors on the cloth, and would choose one for that occasion. She would sometimes play certain music while she made her choice. After the cutting Mary followed a routine with cleaning up the blood and tending to the cuts, before putting on plasters, covering up her arms again, and cleaning and hiding the razor back in its special place. She said that just opening the box made her feel calmer.

Turning to Freud, we see that he terms such responses as ‘neurotic ceremonial’ (1907: 117), and classes the behaviour alongside obsessive neurosis. His comment is that although such routines and arrangements, which always have to be carried out in the same, or in a methodically varied, manner, give the impression of being mere formalities, and in themselves are meaningless both to the person performing them and to any observer, they cannot be changed. Any deviation from the ceremonial leads to great anxiety – this was certainly true in Mary’s experience. My emphasis is that such ritual may consciously have no meaning, but there is both function and meaning at an unconscious level. Freud links the need for such ceremonial back to earlier emotional conflicts, and although the original conflicts are no longer consciously remembered, he believes that the behaviour acts as an insurance or a protection against a sense of guilt and the anxious expectation of punishment. (I discuss this idea of an unconscious sense of guilt more fully in Chapter 3, in the context of the link between abuse and self-harming behaviour.) The symbolic ritual and ceremony around self-harm can be understood at an unconscious level as a protective measure against punishment and damage. Possibly Mary’s attention to detail around the act of cutting served as a displacement and a way of avoiding recognising the damage and punishment she was inflicting on herself.

I think the attachment to the implements of self-destruction, such as razors or knives, can be seen as a parody of the usual form of transitional object. Take Winnicott’s (1971) idea of the teddy bear or some special object as the first ‘not-me’ possession and a preparation for separation and weaning, and substitute razors or knives. I think for some of the patients attending for psychotherapy, these became special comforting objects that symbolised their need for safety and security and their capacity to act autonomously. For Mary the razor acted as a perverse...
transitional object. Among young people heavily involved with drugs, the substances and paraphernalia associated with certain drug use lead to ceremony and ritual, and an attachment to the objects and procedure as de from the effects of the drugs. The razor is an ordinary object in its own right with day-to-day and common associations. In that sense the object is free and available for all the projections that the person will put on to it – it can become a symbol of whatever is longed for.

One of the fantasies projected on to the razor is that it will change something, and possibly make everything better. If there is some change and the young person does feel relieved or altered by her use of the object, then the object itself will become further imbued with transformative properties, and her attachment to it will increase. The object becomes seen as a reliable friend, a constant companion, that can ease pain. It is clear that part of the relief brought by the ritual is that of control. The controlled use of an object such as a razor leads the young person to feel that the object can help her to contain all the chaotic feelings she is experiencing. Some of these conflicting feelings will be linked to sexuality, and in the following section I explore the actual bodily attacks as a reflection of aspects of auto-eroticism.

**Auto-eroticism**

In this context Hopper’s work on drug addiction is illuminating, especially his idea that the addiction to drugs, or in this context attacking the body, is primarily an addiction to certain fantasies and compulsions that are linked and helped by the action (1995: 1129). He believes that by using the drugs the addict is able to avoid the anxieties associated with the fantasies and compulsions. In other words, the drug-taking displaces the anxiety of certain types of fantasy, especially those that evoke feelings of shame and guilt. Central are those fantasies involving sexual identity and feelings. I want to take his idea and transpose it to repeated cutting and look at the behaviour as a way of dealing with conflicting feelings over sexuality. This is a central theme in Chapter 4 on predisposing factors, but it is worth raising in the context of the repetitive behaviour which in itself suggests some sort of masturbatory quality. I have already mentioned the idea of the entrainment or fearful excitement evoked by direct attacks on the body, which does appear to link to a form of auto-eroticism. It is worth remembering here that Welldon (1988) uses the word ‘ perverse’ to refer to self-harm, which she sees as a pathological manifestation of women acting as if their whole body were a sexual organ.

A quick word about definitions: in this context the term ‘masturbation’ is used in this context to cover all forms of self-stimulation, involving any part of the body, and as a part of the ritualised damaging of the body. The term ‘auto-erotic’ is used in the general sense of a type of sexual behaviour in which the person gains satisfaction from the use of their own body, and no other person is needed. This obviously links to narcissistic disorder which can be understood as an inability to really love and value oneself, and therefore the inability to love someone else.

As discussed above, there is a sense that some patients may become enthralled by their own capacity to destroy themselves, and associated with this has to be a form of sexual excitement and masochistic pleasure. Hopper (1995) reminds us that masturbation is one of the earliest forms of self-healing and self-soothing. ‘It offers opportunities for withdrawal into a sense of safety afforded by the isolation of a protective narcissistic bubble’ (1995: 1134). Hopper goes on to explain how fantasies associated with masturbation, or masturbatory type behaviour, can help make sense of a traumatic experience and can often be traced back to very early memories. Such early trauma may involve some sort of failure in early object relations between the mother and baby. Whatever the reason and circumstances of this failure, the baby internalises the experience, defends herself against the trauma and grows into a child who cannot place her trust in others, and who also has very strong destructive impulses.

This next clinical vignette illustrates the experience of such lack of trust. Amy expected nothing good to come from the outside world – none of her earlier experiences led her to expect otherwise. She was terrified of and hated relating to people. Perhaps to protect herself from painful memories she felt a deep antagonism to self-knowledge. Amy was given up for adoption by her teenage mother. It was not possible for the placement to be found immediately, so for the first six months of her life she was fostered by two different families. Amy told me that there had been difficulties with the first foster family who had lots of problems, and apparently she had not been looked after properly. The adoptive family chosen for Amy seemed also to have had difficulties looking after her, and from the age of 11 Amy was placed in boarding-school. She was expelled from two schools, and moved to a third in her GCSE year. It was at this point that Amy was referred both for cutting herself and an attempted suicide through taking an overdose.

When Amy first came to sessions she was silent and looked very sullen. She was quite overweight and also had a serious skin condition with acne on her chest, face and back. When I tried to encourage her to speak or suggested what might be happening between us, Amy appeared not to
hear me. She felt that the sessions were pointless, and eventually said that she saw me as another social worker who would make all decisions for her and not take any notice of what she wanted or said. It seemed that her expectation was that meeting with me for therapy would replicate her early infancy, and be experienced by her as punishing and non-nurturing. However, Amy continued to attend, mainly because she was regularly brought by someone from her boarding-school. It seemed that she was willing enough to come to the sessions, but at this stage was psychologically unable to take part in a relationship with me.

Amy gave me a strong sense of her mistrust and hostility. Over time she began to tell me about how awful she felt about her looks – she felt huge on the outside, misshapen, and her spots made everything seem much worse. Amy longed to have a boyfriend, but did not feel that she would meet anyone who would love her or who she could like. Over the months Amy began to speak about how difficult it was to make friends, and how, when she did, something happened to make it all go wrong, and the friendship broke up. Amy would brood about what had happened, going over and over every detail of how unfair it all was, and how horrible people were to her.

I gathered that when things went wrong, Amy would hide away somewhere on the school grounds, take out a razor from her collection, and carefully cut her arms and stomach. She told me she liked doing it, because she liked the feeling of the warm blood trickling down her skin, and the patterns she could make. At times like that Amy said that she felt very alone, but safe because there was just her. Amy had many unexpressed feelings about her natural mother, but she did say that she would like to have a baby which she would keep and love; on the other hand she was terrified that at some time she might become pregnant and so be like this sexual, all-powerful and rejecting mother. This internalised sexual, all-powerful yet rejecting mother formed part of the enactive conflict. Amy was captivated by this constellation but longed to be rid of it, as she too had been got rid of. Amy quite liked her adoptive parents, but said how anxious her adoptive mother was all the time. Amy felt that she could not tell her anything as this caused more worry, while her adoptive father appeared to her to be a remote and rather unpredictable man.

When Amy felt rejected by a friend she comforted herself by cutting her skin. This seemed to her a private special thing that she did to herself, which both excited and reassured her. The ritual around the cutting and the smearing of blood on her stomach and arms served as a displacement for her anxieties about relationships which always went wrong. This anxiety appeared to lead back to her earliest relationships, the rejection by her birth mother and the neglect in her first foster family. It seemed to me that there was a connection between the material that Amy brought about wanting a baby, and the cutting and smearing blood on her stomach. I thought that the actions were some sort of metaphorlic representation in that she had fantasies about being pregnant, but the experience of being rejected was so strong that she needed to enact the anger and destruction on her own womb. I think that for Amy the stimulation and pain to her skin caused feelings of excitement and comfort. It was also something that she could rely on and do for herself – in that sense her behaviour was a form of masturbation. Over time Amy was able to speak a little bit about her past, but generally she found that it was too difficult to think about it and to manage the painful feelings she experienced.

Following an altercation with a teacher after bringing alcohol into school, Amy took an overdose and was asked to leave. She returned home. We continued our relationship by letter, and Amy reported that she felt better at home, and was surprised to find that she could talk a bit more to her mother. Amy found a job working as a nanny for a family friend who had two little girls, and she wrote that she enjoyed this. She sent me photos of the little girls in the bath, and of herself to show me that she had lost some weight and that her acne had improved with drug treatment. When I last heard from Amy she had enrolled on a health and beauty course, although of course her early experiences remained unresolved, and her deep suspicions about relationships had been only slightly alleviated.

The skin as a medium for communication

In behaviour such as cutting, burning and hitting, the skin is directly damaged, and this is symbolically meaningful. After all, our skin acts as a container for our sense of self and the most primitive parts of our personality, and is also a boundary between ourselves and others, and what is inside and outside ourselves. It is the border or the edge between our inner selves and the social world. It acts as a membrane that protects us, but is also the actual surface of what we present to the outside world. The skin can conceal but also demonstrate. Given this understanding, skin can be seen as the surface where feelings that are not verbalised are sometimes expressed. In other words, the body and the skin that surrounds it show other people and ourselves what we are. Through awareness of our body we understand that we are alive and have a self. Both body and skin, and what we do to them, can be seen as the locus for our anxieties
about being alive including our fears of falling apart, and the differentiation between ourselves and others.

There has been much analytic thought about skin and its function. Pines (1993), for example, explores the relationship between the baby and mother as expressed through touching the skin. Clearly the way a mother touches her baby reveals a wide range of feelings, including tenderness and disgust. The infant will respond—sometimes through her skin, and feelings that cannot be spoken about are sometimes expressed through a sore or irritated skin condition. The mother serves, if she can, as a containing object for the baby’s distress, and as Bick (1968) writes in her well-known paper, is experienced concretely as a skin. The mother’s successful capacity to do this results in the baby’s introjection of the experience of feeling contained. In Britton’s formulations, if the mothering person is receptive and capable, she can make sense of the infant’s experience and transform a bodily sensation (Beta elements) into ‘something more mental, which could be used for thought or stored as memory’ (Alpha elements) (Britton 1991: 105). If this process of introjection is faulty or inadequate, the baby may develop a ‘second-skin’ formation where the baby’s dependence on the mother to contain the distress is replaced by a pseudo-independence; this leads to a ‘general fragility in later integration’ and ‘manifests itself in states of unification . . . as either partial or total type of muscular shell or a corresponding verbal muscularity’ (Bick 1968: 485). This quality is one that I recognised in several of the more disturbed patients seen for psychotherapy at the clinic. At its best, the analytic environment can at times function as a mental skin for patients unused to containing strong emotional experiences. If the psychotherapist is receptive to certain emotional somatic experiences in the patient, these can be processed and transformed by words into a mental experience that is then thought about.

Interestingly, Kafka’s (1969) work with a patient who cut herself and sometimes swallowed pills indiscriminately provides clinical material that focuses on the issues discussed above, including the patient’s use of her body (rather than razor) as a transitional object and her narcissistic and erotic approach to her surface skin. The young woman’s parents were separated, but there were intimations of an overly involved and erotic relationship with her mother. Difficulties around touching and skin sensitivity related back to the patient’s infancy, when the little girl suffered from a generalised dermatitis which had led to almost her entire body having to be bandaged for the first year of her life. Although hungry for contact, the parents recalled the acute pain for the baby as a result of that contact. Furry pets and dolls played a central part in the family, and seemed to link to the importance of texture and touching later in her adolescence. In his analysis Kafka links the symptom to the early skin disorder, and feels that the patient did treat parts of the surface of her body as though she were not dealing with quite living skin. He writes: ‘she was very much preoccupied with the, for her, very much unfinished business of establishing her body scheme’ (Kafka 1969: 211).

The skin can become the channel for the communication of pre-verbal feelings and feelings that cannot be expressed. In some of the patients seen for psychotherapy the wounds on their skin served as symbolic scars representing their earlier history, and once the cutting became public it appeared as a desperate attempt to communicate and tell this story. Earlier memories of past traumas are remembered through the body and bodily sensations, though they are not necessarily consciously accessible (Scott 1998a). The young women I saw were unable to find a way to speak. Instead they had to act through bodily sensations, and to represent their feelings through their actions. As Scott notes elsewhere, ‘the body is both the site of the traumatic event and the site of memory, and has to do the work of a “monument” . . . at the same time as the subject lives her life’ (1998b: 4). Although the body is often silent, when the skin is ruptured through an attack, the wound becomes the route of remembrance.

In this way self-harm is a statement about the self, but one that is expressed through the attack on the body. External events and the way they have become internalised and fantasised are registered and noted through self-destruction. Here we have the intriguing connection between surface and depth. What is shown through appearance following cutting is linked to the inner conflict and the self of the person. In that sense the deep inner trauma is made visible on the surface of the body. Internal objects and the experiences of them are projected outside and then identified with on the skin surface. The opening up of the skin is an explicit opening up of the boundary of the body, and an implicit opening up of the self. However, the action is ambiguous in that frequently it is private, secret and covered up. The scars and wounds may ‘speak’, but there is often no one to listen, and no reply is asked for. It is only when the attack is uncovered that the opening up can be acknowledged and becomes public, and there is often intense ambivalence about the discovery and ensuing dialogue.

There is an opportunity for the scars to speak and get a reply in the psychotherapeutic relationship. In other words, the attack on the body can then lead to a relationship and so become a transformative action. Theoretically the establishment of a containing space, a type of mental skin or boundary where ideas can be held, allows the process of thinking...
to become established, so that over time the capacity for self-knowledge can be developed. The idea of the psychotherapeutic relationship acting as a second skin allows for the release of the pressure on the person’s actual skin, and attacks on the therapy can be held and dealt with by the psychotherapist.

Chapter 3

Turning the anger inwards
Masochism and mastery

This chapter is about the terribly destructive nature of cutting, and the way aggressive instinctual processes are affected and linked with both the early parental environment and later traumatic experiences. In the first chapter, Glasser’s (1992) core complex was outlined: briefly summarised as the fantasy of fusion leading to annihilation anxiety; the concurrent defensive responses from that, and also from the fear of the mother’s indifference; both these defensive responses leading to aggression turned inwards against the self, and enacted on the surface of the body. The enactive conflict that I suggest as a central unconscious psychic formation among the young women seen for psychotherapy who were self-harming is a variant and possibly perverse side formation of this core complex. In this context, it is interesting to note that Glasser’s (1979) original concept was seen in the context of perversion. However, instead of fusion with an idealised mother, the enactive conflict involves the captivation by an avaricious object who overwhelms, and from whom there is ambivalence about separation. The fear of being possessed conflicts with the fear of rejection, and the psychic conflict leads to a defensive compromise. The solution to the conflict is hostility, which is turned inwards against the self and the body, rather than directed outwards on to an external object.

Writing about aggression and violence, Glasser (1998) refers to conscious, intentional action involving the actual assault on the body of one person by another. He separates out self-preservative violence and sado-masochistic violence. In the former type the aim is to negate danger, while in sadism the aim is to inflict pain and suffering. For the young women who were cutting, the attacks seemed to involve a combination of both these types of aggression. Instead of attacking another person, the young woman turned her violent action against her own body, but as if attacking another person, or a separate part of herself. It seemed that her