TORN BETWEEN SKINSHIP AND KINSHIP:

The Phenomenology of Self-Mutilation

THESIS

Submitted in partial fulfilment

of the requirements for the Degree of

DOCTOR OF PHILOSOPHY IN PSYCHOTHERAPY

of Rhodes University

Grahamstown

by

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December 1994

ACKNOWLEDGEMENTS

I wish to thank:

Professor Dreyer Kruger for initiating the first directed psychotherapy Ph.D. in South Africa.

Dr. Fogarty of Department of Health Services for granting me leave of absence to attend the Ph.D. programme in Grahamstown.

Professor Roger Brooke for acting as co-ordinator of the Ph.D. programme and supervisor of this thesis.

Dr. Jacqui Watts for taking over as thesis supervisor.

The subjects who participated in this study and openly shared a very private experience with me.

Nicola Coningsby for her sterling support, computer expertise, and superb editorial skills.

Dr. Sean Kaliski for such a fine printing job.

Joel Shapiro for stimulating peer supervision.

Dr. Kevin Kelly for his methodological advice.

ABSTRACT

The aim of this study was to describe the female self-mutilator's lived experience of cutting herself. A question which would elicit a description of the experience of this phenomenon was formulated. Five self-mutilators were interviewed. The four psychologically richest narratives were chosen for this study. Using the empirical phenomenological method, the four protocols were analysed in detail.

Self-mutilation is conceptualized as a cycle wherein the mutilator experiences a diffuse bodily felt-sense that mounts to an unbearable point. She has an irresistible urge to alleviate the distress. She isolates herself and cuts herself with a sharp blade. Upon seeing the blood appear she is overcome with a deep sense of satisfaction, power, and ecstatic pleasure. The blood is perceived to carry the distressing contents out of the body.

Concomitantly the self-mutilator recollects a sense of her feelings and her body as belonging to her. Her previously alienated body is felt to be a site of vitality. She also feels removed from further harm, encased in a cocoon of safety that renders her invulnerable to others. However, the cutting can never totally rid the body of distressing feelings. As a result the cycle of cutting will be re-enacted.

The cutting cycle is conceptualized as a process whereby the self-mutilator suffers from a traumatization of the psyche such that the psychic container is fractured and rendered painfully porous. The act of cutting rids the psyche of unwanted contents such that a sense of going-on-being is restored. The cutting acts to temporarily shore up the rent fabric of the

psychic envelope and thereby consolidate a sense of personal boundary. This is a temporary respite from the fracturing of the psychic container in that, once again confronted with interpersonal existence, the self-mutilator begins to feel vulnerable and defenceless. When it seems as if disintegration is again imminent, a cycle of cutting is reconstituted.

The findings emergent from the interviews were dialogued with the literature on psychic containers, particularly that which addresses the role of the skin in the formation and functioning of psychic containers.

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Then I came to the analysis of patients who proved to be borderline, or who came to have the mad part of them met and altered. It is work with borderline patients that has taken me (whether I liked it or not) to the early human condition, and there I mean to the early life of the individual rather than to the mental mechanisms of earliest infancy.

* D.W.Winnicott

* D.W. Winnicott, 1963. A theory of psychiatric disorder. In *The Maturational Process and the Facilitative Environment* (1965).

Chapter One

INTRODUCTION

The Nature of Self-Mutilation

> Self-injurious behaviour is a dramatic but poorly studied phenomenon. Successful treatments of this behaviour remain equally elusive (Winchel & Stanley, 1991, p. 306).

Self-mutilation takes many forms but its essential element is the deliberate destruction or alteration of body tissue without conscious suicidal intent. Pathological self-mutilation is mentioned in DSM-III-R in conjunction with only five diagnoses: borderline personality disorder, multiple personality disorder, sexual masochism, factitious disorder with physical symptoms, and trichotillomania. However, the brevity of the diagnostic list is misleading because self-mutilation may well be associated with a variety of mental disorders. For example, the literature on mutilation of the eye includes descriptions of patients with organic mental disorder (Favazza, 1987), schizophrenia (Ananth et al., 1984), major depression (Favazza, 1987), obsessive-compulsive disorder (Stinnett et al., 1970) and antisocial personality disorder (Segal et al., 1963).

Self-mutilation has also been reported among patients under the care of non-psychiatric physicians. Head-hitting and banging, self-biting, and skin scratching are relatively common among severely and profoundly retarded patients. Self-mutilation of the hands and feet is associated with neurological disorders characterized by a sensory deficit, such as congenital indifference to pain.

Only a few small studies have recorded the prevalence of self-mutilation in psychiatric patient populations. A study of patients with multiple personality disorder reported that 34 percent mutilated themselves (Putnam et al., 1986). In other studies, 24 percent of prisoners with antisocial personality disorder (Virkkunen, 1976), 35 percent of patients with anorexia nervosa (Jacobs et al., 1986), and 40.5 percent of patients with bulimia (Mitchell et al., 1986) engaged in self-mutilative behaviour. The rate of self-mutilation has been estimated to be 750 per 100,000 people in the general United States population (Favazza et al., 1988).

Favazza (1989) has derived a typology of self-mutilation ranging from severe to moderate and slight self-mutilatory behaviour. The explanations of patients who engage in major self-mutilation usually reflect psychopathology associated with major depression, mania, or schizophrenia. Also implicated are transsexualism and organic mental disorders. Pao (1969) was first to distinguish delicate self-mutilation involving superficial, delicate, repeated incisions often not accompanied by pain, from coarse self-mutilation, which involves a "single, deep and coarse incision close to vital points" (Pao, 1969, p. 195). Moderate to light self-mutilators are reportedly (Winchel & Stanley, 1991) predominantly individuals with character disorders. The predominant form of moderate and mild self-mutilation is that of cutting or making incisions on the skin of the forearms, inner thighs, stomach, and sometimes neck.

Gardner and Cowdry (1985) describe the range of self-injurious behaviours they encountered in a study of self-mutilatory patients with borderline personality disorder. These include cuts on the wrist and the body, cigarette burns, scratching with fingernails, carving words on the skin, arm and head-banging, sandpapering of the face, dripping acid on the hands, and trying

to break an arm with a hammer.

Pattison and Kahan (1983) review 56 published case reports of self-injurious behaviour and identify a pattern that describes a large portion of the reported patients. These traits include low lethality of acts, multiple self-injurious acts, and typical onset in adolescence. The authors choose to define this group as engaging in a *deliberate self-harm syndrome*. Other authors substitute this term with *borderline self-mutilator* (Leibenluft et al., 1987).

The Phenomenology of Self-Mutilation

Self-mutilatory behaviour by the category of borderline self-mutilator has been described as bearing several consistent features. Leibenluft et al. (1987) describe five stages of the self-injuring act:

> (1) the precipitating event, (2) escalation of the dysphoria, (3) attempts to forestall the self-injury, (4) self-mutilation, and (5) the aftermath (for example, the relief from tension). (1987, p.319)

This cycle is exemplified in the reflection of one of Gardner and Cowdry's respondents:

> The impulse ... overcame the strength of my resistance not to ... As I started to cut, the physical pain and blood became a welcome distraction. As I cut deeper ... my mind began to feel relieved of the torment, my body eased of the tension, and I began to feel comforted. (Gardner and Cowdry, 1985, p. 394)

The phenomenological sequence collated from other authors reveals a similar sequence: the patient feels a compulsive, almost addictive need to cut (Novotny, 1972); the act itself is usually conducted secretively, in a semi-masturbatory fashion (Kafka, 1969; Podvoll, 1969); the action has a cathartic, self-purifying function in that it modulates states of anxiety, sexual

tension, anger, or dissociated emptiness, and brings about a tremendous quasi-physical sense of relief (Burnham & Giovacchini, 1969).

Doctors (1979) gives an account of a similar sequence imbedded in the act of self-cutting:

> a heightening of feelings of frustration and simultaneously, a heightened intolerance for feelings of tension (experienced as physical tension); a lack of faith in others to provide help (and a markedly impaired capacity for self-soothing); a very limited capacity to verbalize affect and a deficiency in the capacity to represent experiences in higher symbolic modes; and a definite propensity to turn passively experienced diffuse distress into active, focal experiences designed to achieve a feeling of control over self and, thereby, a feeling of relief. (p. 444)

With regards to the profile of the self-mutilating patient several features are consistently reported. First, the behaviour is predominantly a phenomenon of women (Graff & Mallin, 1967). Second, early experiences of illness and injury are reported in the histories of such people (Kafka, 1969). Third, a high percentage of these patients report experiences of being spanked, hit, or beaten during puberty (Doctors, 1979). Fourth, "the number of occurrences of rape in the lives of the girls studied was striking" (Doctors, 1979, p. 450). Fifth, the act seems related to conflicts around the experience of the genitals and the genital sensations in an important way - it does not occur before the menarche (Siomopoulos, 1974) but tends to occur around the time of menstruation (Rosenthal et al., 1972). Sixth, many investigators have pointed to the importance of disturbances in early object relations and the sense of self in these women (Cross, 1993; Graff & Mallin, 1967; Pao, 1969).

Further to these findings, in Doctors' (1979) sample, all of the patients reportedly maintained a strict prohibition in their attitude towards masturbation, all were markedly phobic about the notion of touching themselves, all of the subjects were sexually active and had all begun

having sexual intercourse within months of the menarche, and all demonstrated confusion in the face of sexual excitation, becoming hyperactive, spasmodic, and diffusely upset. They also despaired of achieving sexual relief. Favazza (1987) also reports a common "disgust over menarche, menstruation, and intercourse" (p. 203). These findings suggest a disowning of the sexual body by the self-mutilator. These patients have also been reported to manifest extremes of sexual behaviour from complete and fearful abstention to indiscriminate sexual encounters with sadomasochistic overtones (Burnham & Giovacchini, 1969).

A further feature of the self-mutilatory syndrome is the reported (Cross, 1993; Favazza, 1987; Grunebaum & Klerman, 1987) difficulty these patients have with identifying, verbally expressing, and regulating all forms of physical tension. These writers cite a primitive inability to verbalize emotion, no matter how articulate the patient is otherwise (Offer & Barglow, 1960). These patients are therefore subject to incommunicable states of tension which they cannot soothe, and to opposite states of deadness and emptiness which they cannot enliven (Cross, 1993; Graff & Mallin, 1967). The difficulty in languaging their pained emotions are hypothesized as having early developmental aetiological roots:

> the inarticulateness of these girls seems related to failures in the growth of trust and an associated capacity to perceive the symbol in its own right in a way that ordinarily enables the child to move beyond the illusion of omnipotence and beyond hopelessness about communication . This lack of access to the use of symbols as abstract modes of expression limits their ability to ease their own feelings of frustration and is probably related to their propensity for motor expression of feelings of frustration, an example of which is delicate self-cutting (Doctors, 1979, p. 448).

Psychodynamic Explanations

Theoretical psychodynamic discussions of self-injuring individuals have been sparse. In general, such formulations have viewed these patients as having significant defects in early stages of ego development. Although the complexities of the few psychodynamic explanations of self-mutilation are beyond the scope of this thesis, the main points of the most salient and applicable are summarized here.

Self-mutilation has been considered an attempt to differentiate ego boundaries (Novotny, 1972) and an autoerotic (Cain, 1961) or tension-reducing act of gratification analogous to masturbation (Storr, 1968). Other theories have maintained that self-mutilation is a redirection onto a localized portion of the body of anger towards the self (Freud, 1949). Self-mutilation has also been understood as a symbolic wish for sexual penetration by the father (Novotny, 1972) or as punishment for an unconscious wish to injure the frustrating mother (Erikson, 1950). Self-mutilation has also been described as a relieving enactment of revenge following on from feelings of resentment, rage, and impotence over the inability to control an important person, particularly one who leaves the self-mutilator feeling abandoned (Kernberg, 1987).

Self-mutilation has also been theorized to be a way of dealing with sexual conflicts. It has been proposed that self-mutilators who were sexually assaulted in childhood may eventually harm themselves in an attempt to punish the original perpetrators in effigy by using their own skin as a symbol for the offending persons (Stone, 1987). Pao (1969) suggests that self-mutilation is a repressed ego state with alteration of ego functioning that serves to repress conflicts about castration, aggression, and separation-individuation. A further hypothesis is

that self-mutilators who received nurturance after enduring the pain of physical abuse as youngsters may harm themselves as a repetition of their childhood experiences because they believe that after suffering there is nurturance and forgiveness (Benjamin, 1987).

Several commentators believe that the behaviour occurs as a reaction to an actual or threatened separation (Pao, 1969), loss (Grunebaum & Klerman, 1967), or disappointment (Podvoll, 1969), whether in reality or fantasy. What the patient is most aware of is the experience of feeling utterly alone and beginning to feel very tense (Pao, 1969), or angry (Smith, 1989). Following this period of emotional isolation the patient decides to become physically isolated in order to self-mutilate. Cutting is virtually always a solitary act. Prior to cutting there is a shift to feeling numb, unreal, empty, or dead (Asch, 1971). The patients, virtually uniformly, do not experience extreme pain at the time of cutting (Novotny, 1972). The experience of mild pain is concomitant with the return of feelings of being alive and real again (Kafka, 1969). Asch (1971) notes that patients sometimes report cutting until they feel pain or they begin to see the sight of blood. The cutting is then almost immediately followed by the reported experience of satisfaction, calm, and relief (Graff & Mallin, 1967).

Further, there is considerable uniformity to the description of the act, including a shift during the course of the act which makes the act seem discontinuous rather than continuous in time (Asch, 1971). This is usually referred to as depersonalization. Miller and Bashkior (1974) suggests that skin-cutting is a means to terminate depersonalization. This effect, they argue, may be due to the shock of seeing blood which then directs the self-cutter's attention to the difference between the self and the environment. Cross (1993) suggests that the *out-of-body* dissociative states of the self-mutilator encourage a seeking out of physical pain that will

return the patient to her body. Kestenberg (1975) adds that important early experiences of pain may establish a prototype for externalization. Kestenberg's hypothesis is that the self-mutilator may seek out physical pain because deliberate pain constitutes a counterphobic triumph over previous, developmentally earlier, passive experiences of pain.

Need for the research

Despite the existing literature on the subject, Haughton (1988) summarizes his review of the field stating:

> Neither psychoanalytic or behavioural theories have been able to provide comprehensive frameworks for either the interpretation or treatment of the behaviour. (p.1)

Roumasset (1991) similarly concludes a review with the words "Future research is encouraged investigating the link between self-mutilation ... and unconscious mental functioning" (p. 1).

Favazza (1989) accounts for the shortage of research activity in this area by noting:

> ... despite the prevalence of self-mutilation, attempts to understand it have been hampered by negative social attitudes. Laymen usually perceive self-mutilation to be repulsive and purposeless, while mental health professionals often focus on their own feelings of helplessness and of being "torn apart" or "emotionally blackmailed" by patients who deliberately harm themselves. (Novotny, 1972, p.137)

Of all disturbing patient behaviours, self-mutilation is the most difficult for clinicians to understand and treat (Frances, 1987). In the author's experience, treating a patient who self-mutilates often leaves one feeling helpless, horrified, guilty, furious, betrayed, disgusted and

sad. The intensity and range of countertransference experiences is bewildering. Many times an otherwise promising treatment reaches a stalemate or ends because of the inability of the patient and the clinician to manage the self-mutilation in a fashion that will reduce or eliminate it. So often the patient succeeds in getting 'under the treatment team's skin' such that she is summarily discharged for her flagrant disregard for the prohibitions placed upon cutting in such therapeutic units.

Perhaps the most perplexing feature of the self-mutilator is the relative paucity of the patient's insights into the precipitating context of the act of cutting. Self-mutilators have difficulty in articulating the sequence of events, affects, thoughts, and fantasies that are implicated in a self-cutting episode. In the patient's recollections of her conscious experience, it is often unlocatable, indescribable, obscured so much by what precedes and what follows, and so foreign to the usual capacities of language that all or part of it may not be conceptualized or even registered in conscious experience. It is this very pre-verbal or pre-reflective nature of the symptom that renders it inaccessible to empirical inquiry and indeed motivated Haughton's (1988) call for a greater research effort investigating the link between self-mutilation and unconscious mental functioning.

The incompletely articulated nature of the symptom raises some unique methodological challenges and calls for, as shall be argued in the subsequent chapter on methodology, a phenomenological inquiry that can attempt to gather up the unconscious latencies that lie imbedded in the act of cutting.The very lack of conscious awareness of the context of the act demands an entry to the phenomenal world not solely reliant on empirically derived questionnaires or modes of data gathering. Those studies that have relied on such a

methodology have not grasped or brought to light the subtle psychological essences that lie latent in the symptom of cutting.

Borderline personality organization is the predominant psychopathology associated with delicate and moderate self-mutilation. Such patients characteristically resort to cutting of the skin, mostly on the forearms in the vicinity of the wrist, that is, delicate to moderate self-mutilation. However, very few studies have actually addressed the specificity of the symptom of the cut. That is, borderline personality disordered patients assume varied behavioural profiles, of which the cutters are only a sub-group. Why this particular sub-group elect this specific pathway, or more accurately, are compelled to seek solace in their incisions into their own bodies, remains an unaddressed question. Is this a particular sub-type of borderline personality disorder? And what does this symptom of cutting into the very bodily border, the skin, have to do with the borderline status of these patients? The psychological meaning of the cut lies latent, awaiting articulation, as does an inquiry into the sources of motivation for self-mutilation.

Favazza (1987) provides the closest to a phenomenological inquiry into the symptom. However, the vignettes he presents are snippets, rather than full articulations, and are presented to illuminate the existing psychoanalytic theories thus far forwarded to account for cutting. Also, the fact that the *skin* is cut is not amplified by Favazza, other than his commenting upon the self-destructive and masochistic roots of cutting. In light of the foregoing lacunae in the literature, this study aims at an illumination of the lived-world of the self-mutilator during the process of cutting her skin.

Aim and Method

The aim of the current research is to accurately describe the self-cutter's lived experience of cutting the skin. By providing an experientially-oriented research inquiry it is hoped that the gap in the understanding of self-mutilation can begin to be filled.

In order to obtain a deeply reflective understanding of the phenomenon, whilst maintaining a fidelity to the lived world of the self-mutilator, the chosen method is the empirical phenomenological method as described by Giorgi (1975, 1985), Kruger (1988) and Wertz (1983). Using carefully constructed questions, the researcher interviewed five self-mutilators. Four transcribed interviews were ultimately explicated in full.

The findings of the study are dialogued with the existing literature on borderline personality disorder, bodily borders, psychological borders, and self-mutilation. This dialogue is warranted given that self-mutilators, commonly borderline personalities, cut into the bodily borders to effect a dramatic change in their psychological state. It is hoped that such a dialogue will lead to useful insights and developments in the theory and treatment of this vexing clinical phenomenon. This will be particularly valuable, given the acknowledged paucity of in-depth empirical inquiry into self-mutilation and the regularity with which the treatment of these patients breaks down in mutual misunderstanding (Montgomery, 1989).

Chapter Two

THE EMBODIED BORDER AND THE BORDERLINE BODY

The Formation of Psychic Borders

There is a multiplicity of interchangeable terms in currency that attempt to describe the formation of a psychic border. Body surface, membrane, limiting organ, body wall, body schema, body boundary, protective shield and holding membrane are the more commonly used terms. They all address the essential process in infancy of the formation of some form of bodily-based boundary that distinguishes self from non-self. The boundary is one that both contains the self whilst also establishing a structural differentiation between inside and outside. It is a volatile area of mutual influence and exchange, forming and re-forming as a result of what is happening inter and intra psychically. This initial body differentiation sets the stage for an ongoing process of experiencing a reciprocity between me and not-me. Indeed:

> the emotions involved in coming up against the not-self affect the capacity both to separate and to engage and the sense of inner and outer process, of time, change and the future. (Yariv, 1989, p. 103)

All of the early disorders, from narcissism to psychosis, have been considered to have their roots in a fracturing in the formation of body borders. In varying degrees, these pathologies have been considered analogues of the failure to negotiate a boundaried passage out of the state of primary fusion (Fordham, 1976). This state is variously referred to as primary narcissism, primitive identity, primary unintegration, harmonious interpenetrating mix-up, the original objectless condition, basic unity and symbiotic fusion (Yariv, 1989).

The uroboros is evoked as a symbol for this undifferentiated state. The concept of a uroboric

circle implies that there is a border between inside and outside. However, when a uroboric skin is a thick one, it can indicate a defense that does not allow interaction between what is inside and what is outside, or between self and other. The uroboros then, an ancient symbol of transformation and the eternal cycle of recurrence, can represent creation but can also represent the vicious circle that will not allow difference and which becomes an atrophied entrapment. Another image of the uroboros is of its shedding its skin in the service of regeneration. At such points it is vulnerable to outside influences without natural defences. If impinged upon whilst in such a vulnerable condition then it is at risk of not being able to reconsolidate its process of recreation.

In this way borders form around the psyche. Where and how they form, both inwardly and between self and object, and whether they are non-existent, flexible or rigid, pivot around the degree of creative interchange between the early self and other. A sense of boundary or border is a dynamic process that needs to be felt at a bodily level to be organic to the whole personality so that it can be let go of without fears of disintegration or absorption into the other, and that there can be a creative interaction with the other conducive to growth (Yariv, 1989).

Psychopathologies can be thought of as variants of either an overconsolidation or an over-vulnerability of the uroboric boundary. Excessive needs to fuse with, identify with, or incorporate the object are sequelae of painful experiencing of the distinction between self and not-self. The borderline boundary is one such compromised formation that is a sequel to such a painful demarcation.

The Phenomenology of the Borderline

A plethora of etiological theories abound in which the roots of borderline pathology have been variously linked to schizophrenic or affective illnesses (Akiskal, 1981; Akiskal et al., 1985), to derailments in the separation-individuation process (Kernberg, 1975, 1976; Mahler and Kaplan, 1977; Masterson and Rinsley, 1975), to actual early losses and separations (Paris et al., 1988; Soloff and Millward, 1983a, 1983b), to severe empathic failures during the first years of life (Adler and Buie, 1979), or to more general family-based pathologies (Frank and Paris, 1981; Grinker et al., 1968; Gunderson and Englund, 1981; Gunderson et al., 1980; Links, 1990; Walsh, 1977).

A series of recent research findings has added to the debate by supplying strong evidence of a highly significant correlation between borderline psychopathology and experiences of repeated childhood trauma, including sexual abuse (especially incest), physical abuse, and the witnessing of severe domestic violence (Bryer et al., 1987; Herman et al., 1989; Saunders and Arnold, 1993; Westen et al., 1990; Zanarini et al., 1990).

It is not within the scope of this thesis to detail the complexities of the etiological and treatment controversies and to lay bare the arguments of the various protagonists. Rather, the concern is with understanding why a sub-group of borderlines are compelled to cut their skin and live their *borderline status* out on the surface of the body in this self-mutilatory manner. It is hoped that such an understanding of the action will necessarily cast an additional focus on the borderline debate in general. Thus, in order to understand delicate and/or moderate self-mutilation, it is fruitful to first consider borderline personality organization with respect to the presence or absence of borders in these individuals.

The Borderline and Psychic Borders

The borders encountered in life are various, ranging from lines and surfaces with or without circulation through the frontier to osmotic membranes which allow a filtering in and out of the border. The osmotic border can protect itself when endangered by opening up to dispel unwanted materials. Other protective measures are the stultification of the line or the blurring of the border, creating instead a fragile limit, a no-man's-land. To be a borderline implies that a border exists that attempts to protect one's self from crossing over or from being crossed over, from being invaded and in doing so becomes a moving border (Green, 1986).

Etymologically, a borderline state is one on the border between neuroses and psychoses, possessing features common to both of these traditional categories. In fact, a patient in such a state is suffering from an absence of solid borders or limits. She is uncertain of the frontiers between the psychical and bodily egos, between the reality ego and the ideal ego, between what belongs to the self and what to others. She experiences sudden fluctuations of these frontiers accompanied by descents into depression. She is unable to differentiate erogenous zones, confuses pleasant experiences with painful ones, and cannot distinguish between drives, leading her to experience the manifestation of a drive not as a desire but as violence. The patient is also vulnerable to narcissistic wounds through the weakness of, or flaws in, the psychical envelope. She experiences a diffuse sense of ill-being, a feeling of not being inside her life, of watching the functioning of her body and mind from outside, of being a spectator of something which is and is not of her own existence (Anzieu, 1989).

The borderline status is one then of fractious, amorphous, painful, and sometimes ecstatic border crossings. Ecstatic for the emotional fluidity it entails, but painful and terrifying by

virtue of the lack of a reliable, identity-confirming border or boundary that limits, constrains, and contains the self-experience. The borderline accordingly feels an existential promiscuity - etymologically defined as being scattered all over the place. This diaspora of selfhood occurs across interior boundaries and across the external boundary that holds vigil between inner and outer, between me - not-me, between intrusions and extrusions, incursions into the self and excursions from the self.

The growing evidence (Herman et. al. 1989; Briere & Zaidi, 1989; Sheldrick, 1991) of histories of childhood sexual abuse in self-mutilatory borderline samples is noteworthy. This is especially so when neglect and lack of positive parent-child attachments are also involved (Van der Kolk et al., 1991). These studies suggest that these young women self-mutilators had childhoods where their bodies, and by implication bodily boundaries, were painfully and repeatedly violated. Sheldrick (1991) notes that self-harm appears to be particularly common after the disclosure that sexual abuse has occurred.

A further feature of borderline self-experience is the marked terror of being alone (Adler & Buie, 1979). These authors comment that this terror of aloneness relates to the absence of an internal, soothing image. As a result, the borderline personality easily loses cohesion in the face of interpersonal frustrations. To be alone is to be without a means of restoring a sense of intactness and goodness. Thus to be alone is like being annihilated, to not be, to lose all sense of a self of substance and boundedness and a reliable and time-traversing boundary.

Green (1986) speaks of the insufficiency of the borderline border, or limiting membrane, that defines self from not-self. His view is that splitting and projective identification, considered primary borderline defenses, are determined by the constitution of a sufficient ego membrane

or border, an ego holder or ego envelope whose limits are well delineated but do not function sufficiently as a protective shield. Rather, ego boundaries are seen as largely elastic. However, though present in the borderline, this flexibility is not conducive to adaptive behaviour. Rather, it acts like a fluctuation of expansion, retraction, or both, in coping with separation anxiety, intrusion anxiety, or both. Therefore it does not smoothly modulate anxiety. This fluctuating variability of ego boundaries is not felt as an enrichment of experience but as a loss of control, as the last defensive measure against implosion, disintegration, or loss. This ego envelope, this insufficient shield, barely protects the vulnerable ego, which is both rigid and lacking in cohesiveness. The challenge presented to this researcher is to understand why a self-mutilator would cut addictively into her bodily surface when already suffering from a poorly consolidated bodily border. What is the relationship between the act of cutting and the status of the embodied border in the phenomenology of the borderline?

Concluding Comment

Green (1986) notes that one cannot conceptualise of a boundary without the idea of a container that is defined by the border at its periphery. The following chapter traces the discourses which have addressed the question of a psychic container which holds the contents of psychic life and the relationship between the psychic container and the contained. Before going on to examine the unique relationship the self-mutilator has to her embodied border, it is first important to trace the idea of a psychic container which is linked to yet not synonymous with the embodied border. In particular, the status of the borderline psychic container will be considered, in that self-mutilation is arguably an incision into the bodily boundary of the psychic container.

Chapter Three

PSYCHIC CONTAINERS

Freud and the Psychic Container

Freud addressed the importance of the container in his earliest formulations of the ego but these somehow became subverted by the focus on the contents and interiority of psychic life. In *The Interpretation of Dreams* (1900), Freud introduced the original expression *psychical apparatus* which is composed of three systems he called *agencies*; the conscious, the pre-conscious and the unconscious, whose particular interactions derive from a topographical fact, namely that they are separated by the two censorships.

However, in *Beyond the Pleasure Principle* (1920) and the *Ego and the Id* (1923), Freud broke with this topographical model to consider the ego as an outer envelope of consciousness. The accent is shifted from conscious and unconscious psychical contents to the psyche as a container. In *Ego and the Id* (1923) he states:

> A person's own body, and above all its surface is a place from which both internal and external perceptions may spring. It is seen like any other object, but to the touch it yields two kinds of sensations, one of which may be equivalent to an internal perception. Psycho-physiology has fully discussed the manner in which a person's own body attains its special position among other objects in the world of perception. Pain, too, seems to play a part in the process, and the way in which we gain knowledge of our organs during painful illness is perhaps a model of the way by which in general we arrive at the idea of our body. The ego is first and foremost a bodily ego, it is not merely a surface entity, but is itself the projection of a surface. The ego is ultimately derived from bodily sensations, chiefly from those springing from the surface of the body. It may thus be regarded as a mental projection of the surface of the body, besides ... representing the superficies of the mental apparatus. (SE 19, p. 26)

In this Freud moves towards an articulation of the ego as a psychical *envelope*. This envelope is not merely a containing sac; it plays an active role in putting the psyche into contact with the external world and in gathering and transmitting information. Freud affirms that every psychical phenomenon develops in constant reference to bodily experience by stating that the ego derives anaclitically from this bodily envelope. It is the presence of this containing envelope, with its direct developmental reference to the body, that makes it possible for contents to be gathered together and organized into thematic structures. On this basis, one can extrapolate to the conclusion that consciousness appears at the surface of the psychical apparatus, or better still, it is that surface.

Freud's original explorations into the ego as a surface entity have been submerged by the weight of his deliberations on the contents of the unconscious. Nevertheless, psychoanalysis has not entirely abandoned the bodily surfaces in favour of fantasy constructions. In fact, a thread runs through psychoanalytic thought that recollects the vital importance of the body and its surfaces in both normal and abnormal development. This thread was woven further by the post-Freudian and object-relations theorists who followed in Freud's wake.

Didier Anzieu and the Psychic Container

Didier Anzieu (1989) makes the point that orthodox psychoanalysis has presented itself almost exclusively as a theory of unconscious and pre-conscious psychical contents. The Freudian conception of a psychoanalytic technique which derives from this theory aims at rendering those contents pre-conscious and conscious respectively. But, as Anzieu contends, a content cannot exist without some relation to a container. The psychoanalytic theory of the

psyche as a container, though partially developed by Freud and his followers, is more fragmentary and insubstantial than the theory of psychic contents. However, according to Anzieu, the forms of pathology which the psychoanalyst increasingly faces in practice today, such as the range of character disorders, and particularly that elusive grouping called borderline personality disorders, derive from disturbances of the relation between container and content.

> The technical consequences of this epistemological about-face are important; not only has the psychoanalyst to interpret the fissures in and the defensive hypercathexes of the container, and to 'reconstruct' the early encroachments, cumulative traumatisms and prosthetic idealizations that gave rise to them, he has also to offer his patient an inner disposition and way of communicating which attest to the possibility of a containing function and allow him to interiorize such a function sufficiently. (1989, p.11)

What Anzieu is alluding to is the difficulty psychoanalytic thinkers have had with forwarding an ontology of the body. Freud's overemphasis on psychic contents at the expense of furthering his germinal ideas on the psychic container seem to have occurred because of his difficulty in overcoming Cartesian dualism in his theorizing. Indeed, this adherence to a Cartesian mind-body split has hampered psychoanalysis' comprehension of the lived-body in psychological life. Consequently psychoanalysis has struggled to present an understanding of psychsomatic phenomena and/or bodily implicated psychopathologies.

In elaborating the idea of a psychic container, Anzieu develops the ancillary idea of *formal signifiers*. In their most essential feature formal signifiers are primarily representations of psychic containers. These signifiers are psychic representatives, not only of certain instincts, but also of various forms of organization of the self and ego. Most importantly, rather than purely content representations, they are representations of space and bodily states. Anzieu

proposes the concept of the *Skin Ego* as a formal signifier that serves as a primary basis for the organization of psychic life. This concept will be elucidated upon in detail later.

Formal signifiers are made up of images that are proprioceptive, tactile, coenesthetic, kinaesthetic, postural, or to do with balance; they have nothing to do with the distance sense organs (sight and hearing) (Anzieu, 1990). The formal signifiers become distorted when there are confusions between inside/outside (while the action in phantasy scenarios is due to confusion between imaginary/real). These distortions do not

> involve a scene either in the theatrical sense or in the architectural sense, but a transformation of a geometrical or physical characteristic of a body (in the general sense of a portion of space), a transformation that brings about distortion or even destruction of its shape. (Anzieu, 1990, p. 17)

Pathological or distorted forms of the formal signifiers are all signs of a fault in the basic psychic envelope. These distortions manifest in feelings of the body shrinking, curving, flattening out, undulating, sucking-in, whirling, falling, emptying, tearing-out, piercing or exploding (Anzieu, 1990). Anzieu reports the case of Marie as illustrative of a distorted psychic signifier. Marie's primary symptomatic complaint was that her "skin was shrinking, this was driving her mad, and she was afraid of losing her identity" (1990, p.3). Her feeling was that her skin had lost all its elasticity and was slowly suffocating her. Importantly, the psychic signifiers, although encasing of psychic experience, have their originary nature in the object relational experiences of the child in relation to the maternal envelope. Thus, Marie's suffocating skin is an analogue of a primary experience in relation to her maternal skin envelope as suffocating at the beginning of her psychic life.

Object Relations and the Psychic Container

Susan Isaacs (1983) elaborates upon Melanie Klein's theory of infantile psychic development in linking early phantasies to the body. She argues that the earliest phantasies spring from bodily impulses and are interwoven with bodily sensations and affects. She states that these early phantasies express a subjective reality yet are bound up from the beginning with an actual, however limited and narrow, experience of objective reality. In her words:

> The first bodily experiences begin to build up the first memories, and external realities are progressively woven into the texture of phantasy. Before long, the child's phantasies are able to draw upon plastic images as well as sensations - visual, auditory, kinaesthetic, touch, taste, smell images, etc. And these plastic images and dramatic representations of phantasy are progressively elaborated along with articulated perceptions of the external world. (Isaacs, 1983, p. 93).

Although she does not speak directly of a bodily-grounded psychic container, Isaacs' line of argument indicates that early thought is grounded in bodily experiences and aims. In this sense, she proposes that the body is the container of thinking.

Wilfred Bion (1957, 1959, 1962), Melanie Klein's conceptual heir, develops a theory of the origins of thinking based upon the development of self-other boundaries. The *alpha function* transforms raw sensory impressions, *beta elements*, into a form that can be remembered. Sensory impressions not converted in this way do not constitute experience as there is no meaning attached to these impressions. Only after the sensory impressions are transformed into symbols can perception become meaningful experience. This capacity for generating meaningful experience develops out of the matrix of a particular interaction with the mother.

This interaction with the mother is characterized by the infant projecting beta elements into

the mother when in a state of displeasure. The mother, in turn, receives these projected beta elements and transforms them through her own alpha function. The mother thus transmutes the infant's unbearable beta elements into digestible elements which can then be absorbed back into the self and entertained as symbols. The infant thus gradually comes to serve as its own benign container, one that can hold onto and process sensory experience. Bion's concept of the *container-contained* is a fluid one rather than a static bipersonal process:

> I believe it is important to differentiate Bion's conception of containment from the mirroring mother as denoted by Lacan, Winnicott, and Kohut. Bion's "containment" is not so much an elastic or flexible impaction upon a silent maternal object as it is the mother's (and the analyst's) capacity to intercept the infant's inchoate communication (his orgasmic panic) and subject it to his or her own alpha function. Bion's conception is of an elaborate primary process activity which acts like a *prism* to refract the intense hue or the infant's screams into the components of the colour spectrum, so to speak, so as to sort them out and relegate them to a hierarchy of importance and of mental action. Thus, containment for Bion is a very active process which involves feeling, thinking, organizing, and acting. Silence would be the last part of it. (Grotstein, 1981, p. 134)

Later, Bion (1967) matures his concept of contact-barriers into that of the *mental skin*, which organizes experience foundationally. For Bion, the psychic container is bounded by the mental skin which makes the containment, linking and delimitation commented upon by Grotstein possible.

Winnicott (1965, 1969, 1971, 1975) also alludes to the primacy of a psychosomatic container that ensures the *going-on-being* of psychic life. He highlights the inextricably intertwined nature of the psyche-soma in his articulation of the infant's state of *primary disintegration*; a state of primary fusion with the mother where there is no distinction in the psyche-soma of the mother-infant dyad. Winnicott (1969) theorizes that the psychical ego develops from the bodily ego by anaclisis and by differentiation and splitting. He maintains that there is in

the human being a tendency towards integration, a tendency to bring about a unity of psyche and soma. This tendency, latent from the very beginning of the infant's development, is either facilitated by its interaction with the environment or thwarted by it. The primary state of unintegration is succeeded by one of integration; indeed greater levels of integration are attained by a cyclical process of unintegration/integration.

According to Winnicott, in this cyclical process the psyche blends with the soma, giving rise to a psychosomatic unity that is the *self*. He calls the environmental contingencies that make this process possible the *holding environment* which is mediated by *good enough mothering* (Winnicott, 1956).

Psychosomatic collusion occurs as a result of the process of *personalization* (Winnicott, 1965). Personalization means that not only is the psyche placed inside the body, but also that eventually, as cortical control extends, the whole of the body becomes the dwelling place of the self:

> the basis for this indwelling is a linkage of motor and sensory and functional experience with the infant's new state of being a person. As a further development there comes into existence what might be called a limiting membrane, which to some extent (in health) is equated with the surface of the skin, and has a position between the infant's "me" and his "not-me". So the infant comes to have an inside and an outside , and a body scheme. In this way meaning comes to the function of intake and output; moreover it gradually becomes meaningful to postulate a personal, or inner psychic reality for the infant. (Winnicott, 1960, p. 45)

This attainment of an *indwelling* of the body depends upon good enough environmental provision. Winnicott specifically links the *handling* of the infant with personalization:

> The ego is based on a body Ego, but it is only when all goes well that the person of the baby starts to be linked with the body and the body-functions,

> with the skin as a limiting membrane ... [and that] depersonalization means a loss of firm union between ego and body, including id-drives and id-satisfactions. (Winnicott, 1965, pp. 56-63)

Adaptive handling carries with it the implication that the person who is looking after the child is able to manage the baby and the baby's body as if the two form a unit. An inadequate responsiveness on behalf of that complex matrix of maternal presences called holding, leads to disturbances in the differentiation of the me and the not-me. An over-excessive response, without sufficient containment and reserve, lays the ground for a defensive hyper-development of the intellectual and imaginative capacities, whilst a denuded maternal environment sets the stage for a coarcted turning away from the soma and the environment. Thus, the way a mother holds and handles her baby leads to the development of a sense of her self, with her skin as the outer limit. Insufficient maternal response, in either of the above-mentioned directions, results in a distorted psychosomatic integrative effort and a distorted surface or boundary formation.

For Winnicott, a healthy negotiation of separation from the maternal envelope entails invoking the me-not-me transitional object. Interestingly, the child now relinquishes the need for the immediacy of the maternal presence and gains soothing and solace from the transitional object that becomes imbued with the qualities of the maternal envelope. The child resorts to keeping the transitional object in physical proximity and the predominant form of transitional object is one that can be related to via a sensuous interchange of smell, taste, and touch. The child is indeed linked to the object intersensorially. The transitional object then becomes a reassuring extension of the child's bodily borders.

Masud Khan (1963), heavily influenced by Winnicott's ideas on the maternal environment, also sees the mother as acting as an auxiliary ego during the first months of life. He refers to her as a *protective shield*, which if absent or fractured in some way, will lead to ego distortions. He coins the concept of the *cumulative trauma* to denote the repeated failures of the maternal envelope, which culminates in the formation of an infantile neurosis called *false-self organization*.

The important conclusions to be reached from both Winnicott and Khan are threefold. First, through physical contact with the mother, the capacity to identify with the body and establish a sense of limitation and reality is consolidated. Second, this physical interchange facilitates an understanding of the bodily processes of taking in, assimilating, rejecting, being in touch with the body's rhythms and growth, and trust in the body's capacity to heal itself. Third, there is the development of a three-dimensional sense, of insides, outsides, space between, and of complexity in relationship. These three accomplishments signal the attainment of a bodily or psychosomatic container that organizes psychic experience.

Concluding Comment

This chapter traces the development of the concept of an anaclitically-grounded psychic container that serves to contain and give form to psychic contents, as well as to afford a sense of coherence to experience. The container has its originary life in sensory experiences in the interpersonal matrix of the mother-infant dyad. Consequently, the maternal container transmutes into a psychic container that nevertheless retains its point of reference in sensory experience. The bodily container sets the conditions for the development of mental processes

and continues to inform the nature of those mental contents.

It has been highlighted how bodily sensations are elemental in the formation of the psychic container. The following chapter takes up the more specific relationship between the skin surface and the formation and functioning of the psychic container. Green (1986) makes the point that one cannot think of a psychic container without considering the skin. The next chapter looks at the role of the skin in the development and maintenance of psychic life by serving as the basis for both the content and containment of that psychic life. Self-mutilation, as a particular borderline behaviour, will be explored against the background of this connection between the skin and the psychic container.

Chapter Four

THE PHENOMENOLOGY OF THE SKIN CONTAINER

The Psycho-Physiology of the Skin

The skin is a very complex organ, or rather, a whole intertwined complex of different organs. Of all the sense organs it is the most vital. It is possible to live without the other sensory organs but impossible to survive if the greater part of one's skin is not intact. The skin is heavier (20 percent of the total body weight in the new-born child and 18 percent in the adult) and occupies a greater surface (2,500 square centimetres in the new-born and 18,000 in the adult) than any other sense organ (Montagu, 1978).

The skin is not merely an organ (or organs) of sense. It fulfils several other biological functions; it breathes and perspires, secretes and expels, maintains the tonus, stimulates respiration, circulation, digestion, excretion, and reproduction. Further, the skin performs a series of functions that are essential to the living body when looked at as a whole. It holds the body together around the skeleton and keeps it upright, protecting it against outside attack and picking up and transmitting an intricate array of information. The skin of a human is also a primary source of recognition. The characteristics that make it so are pigmentation, folds, wrinkles, furrows, the pattern of pores, hair, scars, texture, scent, and thickness. Indeed the skin is an integral dimension of the experience of aliveness.

Anzieu (1989) brings attention to a further element of the skin; its paradoxical nature. The skin shields the internal functioning of the body from exogenous disruptions yet its form and

texture, colouring and scars bear witness to the exogenous interface. Furthermore, a great deal is revealed to the outside world about the inner state that the skin protects; it mirrors our well-being or ill-being.

There are further paradoxes about the skin. The skin is both permeable and impermeable, superficial and profound, regenerative yet caught in a continual process of desiccation. It is elastic but once detached from the body it shrivels. It is the source of intense libidinal experience and gives equally intense pleasure and pain.

In common with the nervous system, the skin arises from the outermost of the three embryonic cell layers, the ectoderm. The central nervous system, which has as its principal function keeping the organism informed of what is going on outside of it, develops as the inturned portion of the general surface of the embryonic body. The rest of the surface covering, after the differentiation of the brain, spinal cord, and other parts of the central nervous system, becomes the skin and its derivatives. The nervous system is, then, a buried part of the skin, or alternatively, the skin may be regarded as an exposed portion of the nervous system.

Reference to the existential nature of the skin is often resorted to in order to describe the nature of one's experience of others or their impact upon one. Skin references often describe the quality and mood of an interpersonal contact in terms of its sensory impact. It is not uncommon to hear psychotherapists describe their experience of certain borderline patients as having 'got under their skin'. Certain idiomatic expressions implicate the skin to describe similarly disturbing experiences of others, such as 'she makes my skin crawl' or 'she gave

me goose-flesh'. Others talk about 'losing our skins' or 'jumping out of our skins'.

Everyday language is also punctuated with references to skin as a meaningful indicator of the mental and physical health of self and object. We speak of skin that is soft, smooth, glowing, peachy and so on. These commentaries indicate that a considerable amount of interest and narcissistic libido is invested in the body surface.

Psychoanalysis and the Skin

Freud, as commented, was not oblivious to the role of the skin in early ego development. However, his emphasis on the erotogenic character of the skin has resulted in the skin being seen by psychoanalysts as significant for sexual development exclusively. This erotogenic view of the skin has hindered recognition of its role in the development of other aspects of humanness in the growing child. As Montagu (1978) comments:

> It is notable that in our discussions of personality development in children and of sexuality, so little attention has been given to the tactual cutaneous experiences of the infant. Like all young mammals who are licked, nuzzled, cuddled, and kept close to the mother, the human infant likewise has apparently a similar need for close bodily contacts, for patting and caressing, for tactual soothing which calms him and restores his equilibrium when hurt, frightened, or angry. (p. 171)

Green (1986) similarly comments upon Kleinian psychoanalsis' neglect of the implication of the skin in psychic life:

> The fiercest partisans of the reference to the loss of the breast in contemporary psychoanalytic theory, the Kleinians, now admit, humbly watering down their wine, that the breast is just a word to designate the mother. ... One must retain the metaphor of the breast, for the breast, like the penis, is only symbolic. However intense the pleasure of sucking linked to the nipple, or the teat,

> might be, erogenous pleasure has the power to concentrate within itself everything of the mother that is not the breast: her smell, her skin, her look and the thousand other components that 'make-up' the mother. (p. 148)

Jung challenged the Cartesian split of existence into a mind-body duality more than Freud. Whilst Freud proposed the idea that the skin can function as an object of intense libidinal attachment, Jung went beyond Freud's psychophysiologisms and spoke more directly of the body as a locale of meaningful psychological life. This led Jung in 1907 to utilize the Galvanic Skin Response (G.S.R.) test as a means of bringing embodied psychic life to presence at the skin surface of the body. Severson (1977) notes that Jung discovered that

> ... the skin can bear a multiplicity of psychic meanings ... Psyche unveils herself in pale, cold, damp foreheads, hot flushed cheeks, sweaty palms, tingling, pricking goose-pimples. The skin is a peacock's tail, blackening, reddening, whitening, purpling with emotion. (p.132)

Thus Jung revealed how psychic life is lived and registered on the surface of the body and how the skin both contains and reveals the complexity of that psychic life. The implication of Jung's thinking is that the body and the skin serve as a container for the dwelling of psychic life as well as a vehicle of its expression. However, accent on the importance of the skin and touch in early human development did not come from psychoanalysts, but from ethological research into attachment processes in non-human primates (Schreier et al., 1965) and humans (Bowlby 1969, 1973, 1975).

Attachment Theory and the Skin

Bowlby (1969, 1973, 1975) proposes the primacy of an attachment drive for the human infant over and above instinctual gratification. The almost complete disappearance of fur from the

surface of the human body facilitates primary tactile exchanges of meaning between mother and baby and prepares the way for humans to acquire language and other semiotic codes, but renders less certain the satisfaction of the clinging drive in the young human. The catastrophe lurking in the nascent human psyche then, would be one of losing this tenuous clinging grip. When that happens the child plunges into what Bion later came to call a *nameless dread* (Bion, 1962).

There is now plentiful evidence to support Bowlby's view that sensorially-mediated attachment is basic to the human condition. Handling, carrying, caressing, and cuddling are emphasized, for it seems that even in the absence of a great deal else, these are the basic containing experiences the infant must enjoy if it is to have a chance of some semblance of physical and psychological health.

The activity of touching ushers in the beginning of differentiating one's body from the non-self. However, the precursors of differentiation of self and object derive mainly from the perceptual stimuli produced by the mother acting upon the infant in such a way as to provoke sensory experiences of a pleasurable or painful nature. Psychoanalysis has unfortunately focused on only one element of this early sensory interchange, namely the mouth, and the incorporation of the object via the mouth. However, as Biven (1982) argues:

> Other erotogenic zones and other functions may serve as its basis (incorporation via the skin, respiration, sight, hearing). (p. 222)

Object Relations Theory and the Skin Container

Barrie Biven (1982) notes that skin has not been a term commonly used by psychoanalysts or a term used in the literature despite her own experience of patients often referring to their skin in psychoanalytic sessions. Biven (1977, 1982) makes the crucial point that the stimulation of the skin plays an important role in the laying down of early object relations. The skin the infant comes to know in the first months is that of the mother's hands and breasts. At this stage the infant does not know of the skin as a separate part object. Initially, the child does not distinguish gratification that comes from the mother's body from that emergent from its own body. The child's sense of separateness develops out of accumulative experiences of the shared skin dividing to become two distinctly separate skin surfaces.

Biven's idea of a process of mutual envelopment by infant and object articulates the idea of the skin as a protective shield, psychologically as well as physically. Central to the development of a skin barrier, or autonomous skin, is that it evolves out of the experience of pain, as much as out of pleasurable excitation. Pain assists in delineating body boundaries during early life and in the distinguishing of self from not-self. The degree of the painful etching on the surface of the neonate's body will determine the psychological texture of the skin formation that will develop around that infant. The possible pathological skin formations that may develop are considered in the following chapter on pathologies of the skin container.

The tactile origins of the ego are taken further by Balbernie (1991). Like Biven, he places importance on the surface experiences in the formation of the ego and in these experiences

being the anaclitic grounding of the later emergent verbal ego:

> The surface of the body is of tremendous importance. It is the site of physical sensations which once defined a psychological event, the beginning of the ego, and it continues to be the bodily counterpart of the sense of identity. Skin can be both a signal and a source of emotions central to the sort of person we feel ourselves to be. In one way, what we might call the sensation-ego is a boundary to the verbal-ego as well as each being a component of the other while, in another way, it can provide a site for manifestly abnormal reactions or ideas. (p. 5)

Balbernie makes the point that the ego begins as a system of touch which underpins later verbal awareness, and that the concrete sensate events of infancy are more influential in shaping perception than phantasy and projection. Balbernie echoes Dinora Pines (1980), who similarly states:

> The infant may react through its skin to the mother's positive feelings by a sense of well-being, and to her negative feelings by a skin disorder, which can take varying forms. The child's non-verbalized affects may find expression through the skin. The skin may itch, the skin may weep, and the skin may rage. It will be dealt with by the mother according to her capacity to accept and soothe her blemished child. (p.315)

A *good-enough mother* (Winnicott, 1956), one that is present in the right admixture of presence and absence, pleasure and pain, enables the infant to experience bodily contiguity with her, such that separating out can be experienced as both from and with the object, in order for the boundary not to be felt as a shock of severance or a confrontation with an abyss. Bollas (1979) also emphasizes interactive processes and rhythms by seeing the mother as a *transformational object.* In her handling of her baby she continually transforms both her (the baby's) inner and outer world. This process gives the baby a distinct sense of being boundaried within her body, although there is a continual life-long search for objects that offer a safe surrender to the body's transforming process, not dissimilar to Winnnicott's

concept of a continuous cycle of *integration - de-integration* (1960).

Like Milner (1987), Bollas sees the transforming process as always leaving one with a desire for a return to the transformational object and a state of psychosomatic union. A sufficient boundary would allow this without a total loss of the possibility of a return to a state of integration and boundedness. If the longing to surrender to a process that alters the self is too great, the surrendering continues without the self being able to separate and re-form or having the strength to encounter the other as different.

Didier Anzieu and the Skin Ego

Didier Anzieu's (1989, 1990a) notion of the Skin Ego attempts to recollect the bodily basis of psychic life. The Skin Ego is a psychological membrane, a surface between inner and outer, that is first and foremost grounded anaclitically in the sensory experience of the body but also comes to be a psychological barrier, psychological container and filter of experience. It is an anaclitic psychic container.

The development of a Skin Ego is a response to the need for a narcissistic envelope that guarantees the psychical apparatus a continuous sense of well-being. Although grounded in sensory experiences at the surface of the body, the Skin Ego traverses the purely physical and becomes a mental image, which the ego of the child uses during the early phases of its development to represent itself as an ego containing psychical contents (Anzieu, 1989).

From its epidermal and proprioceptive beginnings, the ego inherits the possibility of

establishing a barrier and of filtering exchanges. Like the physical skin, the Skin Ego comes to serve as an interface which marks the boundary with the outside, and keeps that outside out. It is the barrier which protects against penetration or impingements emanating from the anxiety, aggression, or greed of others. Further, like the mouth, the Skin Ego serves as a primary means of communicating with others and of establishing signifying relations. It is an *inscribing surface* for the marks left by discourse, either verbal or nonverbal, with those others.

The infant's initial imagined configuration is that of a common skin that keeps the mother and infant bound together. This common skin ensures direct communication between the two partners, as well as reciprocal empathy and an adhesive identification. It is a unique screen which resonates with the sensations, emotions, mental images and bodily rhythms of the two who surface that common skin. Prior to the phantasy of a common skin, the neonate's psyche is possessed of an intra-uterine phantasy, which is one of primary narcissistic fusion, a form of autistic envelope that resists the movement towards a common skin which accedes to a degree of me-not-me. When the environment is not facilitative of such a move the infant remains trapped in an autistic-like shell similar to the *skin formations* described by Frances Tustin (1986, 1990).

Given environmental sufficiency of touch and holding, the interface transforms the psychical functioning into a system where mother and child function more and more openly. Yet the interface keeps the two partners in mutual symbiotic dependency. The next stage requires the suppression of this common skin and the recognition that each has her own skin, her own ego, a recognition which does not come about without resistance to this dawning separation,

nor without pain at the parting. Anzieu claims that it is at this very point that phantasies of the flayed skin, the stolen skin, the bruised or murderous skin exert their influence in the perception of the self. These are potential phantasized representations of the separation process.

The conception of the Skin Ego as an intermediary structure of the psychical apparatus is crucial to Anzieu's thesis. It is intermediate chronologically between the mother and infant, and intermediate structurally between the mutual inclusion of psyches in the state of primitive fusion and the differentiation of psyches. If the correct mothering experiences do not occur at the correct moment(s), the structure becomes distorted.

The Skin Ego, though anaclitically constituted, is not of the physical order. Rather, it is a reality of the order of phantasy; it appears in phantasies, dreams, everyday idiomatic expression, posture and bodily disposition, and in disturbances of thought. It also provides the imaginary space on which phantasies, dreams, thinking, and every form of psychopathological organization is constituted.

Anzieu argues that the primary reason the skin can exist as both a physical entity and a psychological reality is because of a unique feature of the skin, originally commented on by Freud; namely, its double reflexivity. That is, it is the only sense organ that can both touch and also be touched simultaneously. It is this quality that underpins Anzieu's (1989) notion of the Skin Ego and, as discussed later, Merleau-Ponty's (1968) conceptualization of *flesh*.

Anzieu (1989, 1990a) proposes that the Skin Ego has six fundamental functions which are

grounded in the physiological functions of the skin. The six physical functions and their psychic analogues are as follows.

First, the Skin Ego develops through the interiorization of maternal holding. It is a part of the mother which has been interiorized and which maintains the psyche in a functional state. It is by interiorizing this holding that the ego can put into operation the most primitive defense mechanisms of splitting and projective identification. These mechanisms occur against a backdrop of a sense of the coherence of one's own body and of the containing encirclement of the skin.

Second, the containing function of the Skin Ego corresponds to the skin as a covering of the entire surface of the body into which all the external sense organs are inserted. This function is set in process by maternal handling, with the Skin Ego emerging from the interplay between the mother's body and the child's, as well as from responses the mother makes to the baby's sensations and emotions. Initially, the Skin Ego is imaginarily represented as an outer shell and the Id as an inner kernel, with the two terms dialectically related to each other. The Skin Ego at this point cannot function as a container unless it has an interiority of drives to contain or localize in bodily sources. The failure of the containing function of the Skin Ego results in two forms of overwhelming anxiety. In the first instance, an instinctual excitation that is diffuse, non-localizable and unquenchable results when there is a kernel with no delimiting shell. The individual seeks a substitute shell in physical pain or psychical suffering. In the second instance, the shell exists but its continuity is punctured by holes. The Skin Ego in this instance is a colander through which thoughts and memories leak away. This feeling of one's interior seeping away is a cause of considerable anxiety.

The third function is grounded in the epidermis which protects the sensitive layer beneath it and shields the organism against physical assault. Anzieu states that the Skin Ego is a structure of protection, potentially present from birth, that is increasingly realized as the relationship between the baby and its primary environment unfolds.

Fourth, the skin is a surface with pockets and cavities where the other sense organs are located. The Skin Ego is a psychical surface which connects up sensations of various sorts and makes them stand out as figures against the original background formed by the tactile envelope. This is the Skin Ego function of *intersensoriality* (Anzieu, 1989, p. 104). Defects in this sensorial grid give rise to feelings of anxiety about the body being fragmented or dismantled (Meltzer, 1975).

Fifth, the baby's skin is the object of libidinal cathexis on the part of the mother. Feeding and attention are accompanied by skin contact of a pleasurable nature which sets the ground for auto-erotism, with the skin as a background to sexual pleasure. The Skin Ego thus becomes an envelope of sexual excitation. However, Anzieu warns:

> If the sexual protrubances and orifices become the site of algogenic rather than erogenous experience, it may reinforce the imaginary representation of a Skin Ego with holes, increase the level of persecution anxiety, and create an inclination towards sexual perversions aimed at converting pain into pleasure. (1989, p. 105)

Sixth, the skin provides information about the external world. The Skin Ego fulfils a function of registering tactile sensory traces, biologically and socially:

> Biologically, it is upon the skin that a first picture of reality is registered. Socially, an individual's membership of a social group is shown by incisions, scarifications, skin-painting, tattooing, by his make-up and hair-style, and by

> his clothes, which are another aspect of the same thing. The Skin Ego is the original parchment which preserves, like a palimpsest, the erased, scratched-out, written-over first outlines of an 'original' pre-verbal writing made up of traces upon the skin. (Anzieu, 1989, p. 105)

Anzieu and the Marsyian Skin

In the same way that Freud proposed the universality of the Oedipal position in all family dramas, Anzieu proposes the universality of phantasies of shared and separated skins. These phantasies are precursory to the Oedipal phantasies, with the Skin Ego as a primary ego-organizing construct. He offers the myth of Marsyas as illustrative of this grounding of psychic life in the skin. The myth is as follows:

One day, Athene made a double-flute and played on it at a banquet of the gods. She could not understand why Hera and Aphrodite were laughing silently behind their hands, although her music seemed to delight the other deities. She therefore went away by herself into a Phrygian wood, took up the flute again beside a stream, and watched her image in the water as she played. Realizing at once how ludicrous that blueish face and those swollen cheeks made her look, she threw down the flute, and laid a curse on anyone who picked it up.

Marsyas was the innocent victim of this curse. He stumbled upon the flute, which no sooner had he put to his lips than it played itself, inspired by the memory of Athene's music. Marsysas went about delighting the ignorant peasants who cried out that Appollo himself could not have made better music, even on his lyre. Marsyas was foolish enough not to contradict them. This provoked the anger of Apollo, who invited him to a contest, the winner

of which should inflict whatever punishment he pleased on the loser. Marsyas consented and Apollo impanelled the Muses as a jury. The contest proved an equal one, the Muses being charmed by both instruments, until Apollo cried out to Marsyas: "I challenge you to do with your instrument as much as I can do with mine. Turn it upside down, and both play and sing at the same time."

To accomplish this with a flute was manifestly impossible and Marsyas failed to meet the challenge. But Apollo reversed his lyre and sang such delightful hymns in honour of the Olympian gods that the Muses could only give the verdict in his favour. Apollo punished Marsysas by suspending him by the arms from a tree, a procedure which made it easy to cut up or bleed the victim. Whilst still alive, Marsysas was completely flayed by Apollo and his empty skin was left nailed to the tree. Marsyas' flayed skin was preserved at the foot of the citadel of Celaenae. It hung in a cave where the river Marsyas rose. The Phrygians saw it as a sign of the resurrection of their hanged and flayed god. Beneath the emblem of the immortal hanging skin of the flute-playing god Marsyas, the river Marsyas gushed forth noisily and impetuously, its abundant waters bringing a promise of life to the region, their low roar echoing against the walls of the cave to produce a music which enchanted the Phyrgians. Marsyas' hide, hanging in the cave of Celaenae, remained sensitive to the music of the river and the songs of the faithful. The sound of the Phrygian melodies made it quiver but it was deaf to the tunes played in honour of Apollo and unmoved by them. (Graves, 1960, The Greek Myths, 1, 77).

Anzieu extracts a number of mythemes from this myth that confirm for him the universality of a Skin Ego and the functions of such a psychological construct.

The first mytheme is the infliction of negative verticality upon the victim. Marsyas, in his helpless verticality, reproduces the original distress of the infant either not held or badly held by its mother.

The second mytheme of the victim hanging naked with his skin cut is found throughout the world. Christ was nailed to the cross with a gaping wound in his side, his forehead punctured with thorns, and his hands and feet pierced with nails. Oedipus had his ankles pierced and was hung horizontally from a pole.

The third mytheme of the flaying of a live victim's skin represents the protective envelope, the shield which one must take from the other in phantasy, either simply to have it for oneself or to duplicate and reinforce one's own skin. Jason's attempt to capture the Golden Fleece from a formidable dragon is an enactment of this mytheme. The skin of Achilles is of the same order; it is rendered invulnerable by his mother when she holds him by the heel and dips him in the infernal waters of the Styx.

The preservation of Marsyas' intact skin is the fourth mytheme, reflecting the intuition that a personal soul - a psychical Self - subsists only so long as a bodily envelope guarantees its individuality.

The fifth mytheme of the river gushing beneath the immortal skin represents, on the one hand, the life instincts with their force and power. On the other hand, this instinctual energy seems available only to those who have preserved the wholeness of their Skin Ego, which is supported on the surface of the skin.

Marsyas' hide's enduring sensitivity to the music of the river is the sixth mytheme, which illustrates the fact that the first communication between the baby and the maternal environment is a mirror which is both tactile and acoustic.

Extrapolating beyond the Marsyas mythemes, Anzieu adds a seventh mytheme wherein the skin destroys itself or is destroyed by another skin, ie. a murderous skin. The psychological correlative of this last mytheme is the notion of phantasized attacks on the container, and even of the container turning against itself. This notion may well offer some understanding of the problematic of self-mutilation. It is noteworthy that a cult called the Marsyians sprung up in Europe in the seventeenth century and their characteristic was the enactment of extreme bodily incisions and painful markings; a form of ritualized self-mutilation.

Thomas Ogden and the Autistic-Contiguous Skin

There is a broad overlap between Thomas Ogden's (1989) concept of the *autistic-contiguous position* and Anzieu's Skin Ego. Ogden revisions Kleinian theory by implicating the skin in psychic development. Cognizant of psychoanalysis' overemphasis of phantasy formations (particularly Melanie Klein), he has returned psychic life to the body. In doing so, he has attempted to redress the Cartesian neglect of the anaclitic grounding of psychic life. However, being an object relations theorist, Ogden has also been able to enrich Kleinian formulations with his expanded view of primitive psychic life.

Ogden's thesis is that prior to phantasy formations characteristic of the paranoid-schizoid and depressive positions (Klein, 1946), there is an *autistic-contiguous position* which is a sensory-

dominated, presymbolic area of experience in which the most primitive form of meaning is generated on the basis of the organization of sensory impressions, particularly at the skin surface. Attendant on this is a unique form of anxiety; a terror over the prospect that the boundedness of one's sensory surface might dissolve, with a resultant feeling of falling, leaking and dropping into an endless and shapeless space.

Ogden presents an extended theory of the nature of the psychic container and in doing so, acknowledges his indebtedness to the precursory ideas of Bick (1968), Meltzer (1975, 1986) and Tustin (1972, 1981, 1986, 1990), all of whom were equally influenced by Bion's (1959, 1962, 1963) conception of the *container and the contained,* and his theory of the origins of thinking. These influences directed Ogden's thinking in the following way:

> The autistic-contiguous position is a primitive psychological organization operative from birth that generates the most elemental forms of human experience. It is a sensory-dominated mode in which the most inchoate sense of self is built upon the rhythm of sensation (Tustin, 1984), particularly the sensations at the skin surface (Bick, 1968). The autistic-contiguous mode of experiencing is a presymbolic, sensory mode and is therefore extremely difficult to capture in words. Both rhythmicity and experiences of surface contiguity are fundamental to a person's earliest relations with objects: the nursing experience and the experience of being held, rocked, spoken to and sung in his mother's arms. These experiences are "object-related" in a very specific and very limited sense of the word. The relationship to the object in this mode is certainly not a relationship between subjects, as in a depressive mode; nor is it a relationship between objects , as in a paranoid-schizoid mode. Rather, it is a relationship of shape to the feeling of enclosure, of beat to the feeling of rhythm, of hardness to the feeling of edgedness ... Contiguity of surfaces (e.g., "moulded" skin surfaces, harmonic sounds, rhythmic rocking or sucking, symmetrical shapes) generate the experience of a sensory surface rather than the feeling of two surfaces coming together either in mutually differentiating opposition or in merger. There is practically no sense of inside and outside or self and other; rather, what is important is the pattern, boundedness, shape, rhythm, texture, hardness, softness, warmth, coldness, and so on. (Ogden, 1989, pp 32-33)

Most importantly, Ogden denotes the autistic-contiguous as a position in keeping with Klein's formulation of the paranoid-schizoid and depressive positions. Underlying this understanding is his view that this form of psychological organization is a fluid and ongoing mode of generating experience as opposed to a static phase of development. It has equal organizing significance as the paranoid-schizoid and depressive positions and dialectically informs both of these positions. This position is contiguous since the experience of surfaces touching one another is the principal medium through which the organization is achieved in this psychological mode.

The object-relational matrix of the autistic-contiguous position implies that the normal expansion of this mode of organization depends on the facility of the mother-infant dyad to generate forms of sensory experience that *make bearable* the realization of separateness in the mother-infant dyad (Tustin, 1986). When there is failure to provide such a bearable sensory experience, the holes in the fabric of the *emergent self* (Stern, 1985) become a source of unbearable awareness of bodily separateness "which results in an agony of consciousness" (Tustin, 1986, p.43).

Ogden's thesis is that bodily interchanges between the nursling mother and child set a sensory grounding for subsequent psychological organization. The child's and mother's bodies become templates of sensoriality that gather together perceptions into a coherent experience of the self, of being and aliveness. It is this basis of the intersensorial coherence of the infant that renders subsequent experience locatable in the sensory self. Thus, the bodily sensations come to be organized into a sensory or early psychic container that forms a dialectical interplay with subsequent phantasies and thoughts.

The skin surface is for Ogden, like Anzieu, the most primitive basis of the ego. It is the territory where there is a meeting, a sensory sighting, a touching, an etching of the infant's universe of presymbolic sensory impressions. It is where interpersonal objects that are not of the infant's own body entirely, become increasingly less so with every sensory etching. It is out of this meeting of membranes and surfaces that the infant will either move on to object relations, via the way station of *transitional phenomena* (Winnicott, 1951), or will elaborate sensory-dominated ways of being, that are designed to provide a protective insulation for the potential self from all the potential object surfaces that lie outside the perimeter of her sensory-dominated world.

The strength of Ogden's formulation lies in the bridge he makes between the sensory and the ideational and between psyche and soma. He makes the crucial point that the autistic-contiguous, the paranoid-schizoid, and the depressive positions, stand in both a diachronic and synchronic relationship with each other and that all forms of psychopathology emerge out of that dialectical matrix. That is, all forms of psychopathology are informed by all three positions in varying degrees and configurations, as is psychic health informed by a well balanced configuration. All three positions are thus implicated in both psychic health and in psychopathology. Although Ogden's views have the potential to offer an understanding of self-mutilation, they have, to date, not been extended to an examination of borderline psychopathology. The next chapter will extend Ogden's ideas in relation to the skin container. In particular, his theoretical concepts will be dialogued with the data emergent from the interviews in this study.

John Grotstein and the Back-Ground Skin

John Grotstein (1981), not unlike Ogden (1989) and Anzieu (1989, 1990a), notes the child's need for the mental representation of sharing a common skin with a supporting background object. He proposes two forms of phantasy representation: in the one, the child's back is against the stomach of the supporting object (his *Back-ground* object) and in the other, the child's own stomach is against the object's back. Grotstein cites the dream of a little girl whose mother was a patient of his as evidence of this phantasy formation:

> The daughter apparently awakened in the middle of the night seeing snakes everywhere, including the very floor on which she was walking. She ran to her mother's bedroom and mounted her mother with her back to her mother's abdomen. This was the only place where she could find relief. Although the mother, not the child, was the patient, her associations to the event soon established that she had identified with her child. She was the little girl who wished to lie down on top of me to get the 'backing', protection, and 'rearing' which she felt deprived of by her own parents. (Grotstein, 1981, p. 79)

In this case report, Grotstein's implies that psychopathology such as borderline personality organization is underpinned by an insufficiency in the consolidation of a *back-ground skin.*

Maurice Merleau-Ponty and Flesh Consciousness

While Grotstein (1981), Anzieu (1989), Ogden (1989) and Winnicott (1934, 1951, 1956, 1965) concern themselves with the role of sensory experiences in early psychic development, Maurice Merleau-Ponty (1965, 1968) goes further, by recollecting the essential ontological status of the body. For Merleau-Ponty, the core of Freud's discovery is that no human behaviour can possibly be the result of only either organic functions or consciousness. Our instinctual or impersonal life, which is generally physiological, is permeated through and

through by our personal, meaningful and symbolic behaviour. Merleau-Ponty furthers the idea that the psychic and the physiological are intimate to each other in every action, co-existing in what he calls "existence" (1964, p. 88). *Existence* is what gives value to both body and consciousness and makes it possible for us to experience them together as an indistinguishable existential process which operates in every human activity.

Merleau-Ponty's project is to overcome metaphysics by overcoming the metaphysical misunderstanding of the being of the human body. He urges us to retrieve the ontological body by surrendering adherence to a dualistic, propositional way of thinking about the body. Rather than the ontical body of *common sense* or the ontical body of science, Merleau-Ponty argues that the ontological body is *always already* inherent in *Being* (Heidegger, 1962) as a whole.

In his implication of the body in perception, Merleau-Ponty provides an ontology of the body. Freud struggled to form an ontology of the body because of his partial adherence to Descartian dualism. Merleau-Ponty attempts to recollect, for depth psychology, the primordial body of feeling and perception. For Merleau-Ponty, the psychological and the physiological are integrated in existence, directed towards an intention. Existence, as defined by Merleau-Ponty, is the movement in *depth* between the body (impersonal existence), and personal acts, which would not be possible if they were separated from their physiological grounds. He grounds perception in the dialectics of these two dimensions. He calls this dialectical tension the essential *ambiguity of existence*. In the *Phenomenology of Perception* (1962) he describes it as such:

> My act of perception ... takes advantage of work already done, of a general synthesis constituted once and for all, and this is what I mean when I say that I perceive with my body and my senses, since my body and my senses are precisely that familiarity with the world born of habit, that implicit or sedimentary body of knowledge. (p.238)

Merleau-Ponty (1968) argues further that there is no good dialectic except what one might call a *hyperdialectic*. The hyperdialectic does not reject the ambiguity of existence and result in a new position, or a *consciousness of*, the latter being what Merleau-Ponty considered an idealist error. Rather, the hyperdialectic of consciousness is centred on a being "lying before the cleavage operated by reflection", "not outside us and not in us, but where the two movements cross, there where there is something" (p. 270).

Merleau-Ponty (1968) calls this ambiguity of existence the *hyperdialectic of flesh*. This term embraces a philosophy of consciousness which gives expression to the ambiguity of existence in so far as we, as humans, are both active and passive, seer and seen, mass in itself and gesture. Incarnate being, thus understood, is not just a seer or a toucher, it is also something seen and something touched. It has a certain *reflexivity*; the body sensed and the body sentient are the obverse and the reverse (Merleau-Ponty, 1968). To touch one's own hand is to make it lose contact with the world it touches, but then it becomes an object, part of the world touched by the other hand. This means that there is always a distance between the two experiences which is spanned by the experience of our body. This gestalt is what Merleau-Ponty calls *flesh*.

Merleau-Ponty's notion of flesh essentially deconstructs the dualism of subject-object and

> the entire complex of metaphysical representations within which the human body has been held captive ... It is this notion of an elemental flesh which serves to liberate the metaphysically delimited body; for it enables for us for

> the first time to think 'carnal being' as 'a being of depths ... a being in latency (Merleau-Ponty, 67)'. It is a notion which *releases* the body from restrictive representations and reifications and *opens it out*, a 'primordial' body unfolding, like the bud of a flower in the morning sun, opening out into the expansive field of worldly being. (Levin, 1985, pp. 65-67)

According to Merleau-Ponty, out of the hyperdialectic of the impersonal and the personal, the body-ego gradually emerges from its encompassing field, taking over from the primordial body the various organizing functions which once took place without any ego at their centre. But the body itself begins to get increasingly restricted to boundaries defined and imposed by the ego. Thus, for Merleau-Ponty, the ego-subject and its correlative objects emerge from within the depths of a more primordial ontological situation. The dialectic of existence, he argues, is that we thematize impersonal and personal existence whilst our actual lived experience of events is ambiguous; present yet hidden, visible yet invisible and ultimately a mystery for consciousness. As such, we cannot ever polarize body and world because they both have the same flesh.

In his conceptualization of the hyperdialectics of flesh, Merleau-Ponty revisions the idealistic nature of Freud's partitioning of conscious and unconscious. He considers consciousness and unconsciousness as dimensions of lived experience which overlap with one another. They are simultaneously embraced by the ambiguity of existence which is inherent in flesh. What Merleau-Ponty is arguing then, is that the essence of the human condition is a *quasi-reflective* reciprocity between the person and the world. One's flesh literally *encroaches* upon the world but so too does the flesh of the world encroach upon the individual's flesh. This *fleshy insertion* into each other is grounded in the bodily basis of perception but is not only bodily. It is a unity of projective exploration that reaches out beyond itself.

What Merleau-Ponty repeatedly stresses is that the *common* nature of the sensible world is anchored in the reflexivity of living flesh, and that our bodies are *entwined* together with other bodies and other things across a surface of separation that lends itself to projective exploration. In virtue of this projective exploration, a bond of coexistence *arcs* across the surface, establishing a *kinship*. By virtue of this kinship one's interrogative movements come to be anchored in a bodily point of view and simultaneously embedded within the common sensible world.

Merleau-Ponty takes this further, intimating that the *quasi-reflective* nature of bodily reversibility is a *bodily anticipation* of the reflexive nature of human thought. This leads him to conclude that reflexive thought is a founded mode of intentional access which is grounded in the perceptual orientation of the living body (Tuedio, 1985). That is, reflexive thought is only possible by virtue of the indivisibility of body and mind.

For Merleau-Ponty (1968), it is the openness of the body that forms our deepest relational intertwining with the flesh of the world. He regards this openness as *ek-static*. The ek-static nature of bodiliness is asserted as disclosiveness, as openness onto the world. "The body is a movement of the heart, reaching out to touch, to embrace - as ecstacy" (Aanstoos, 1991, p. 95). The notion of shared flesh is evoked by Roll's (1987) use of the term *skinship* to describe our relations with each other and the world. The body has *carnal knowledge* of the flesh of the world because: "All sense perception involves something like a carnal embrace" (Lingis, 1985, p.52). Similarly

> every perception is a ... communion ... the complete expression outside ourselves of our perceptual powers and a coition [an intercourse], so to speak, of our body with things. (Merleau-Ponty, 1962, p. 320)

Merleau-Ponty is not implying that body and world are the same. They are distinguishable but not separable. The body-world boundary is a porous one, permitting unceasing interpenetrability. His argument is that my body and the other are so expressive of each other that there can be no reduction to an extrinsic, causal relationship. It is my body that inhabits the gestures of the other and so discovers in the other "a miraculous prolongation of my own intentions" (Merleau-Ponty, 1962, p. 354).

Aanstoos (1991) notes that this embodied disclosure of intersubjectivity is nowhere more evident than in our embodied relationships with our most intimate others. He notes many examples of parents' ecstatic intertwining with their children; breast-feeding mothers will begin lactating upon merely hearing their infant cry out for food and parents will wince with pain at their infant's distress.

> That empathic embodiment is the miracle of being a parent. That is the miracle of any loving embrace, and the disclosive presencing of our fundamental openness. (Aanstoos, 1991, p. 107)

Merleau-Ponty (1964) predates Aanstoos' implication of esctatic intertwined embodiment to the nursling couple in an essay *The Child's Relations with Others* wherein he speaks of the intercorporeal *original ecstacy* shared by mother and infant. It is an original openness-to-others which is manifested in the warm *radiance* of the shared flesh.

Merleau-Ponty does not directly address the phenomenology of the skin in flesh. However, one can assume that one's bodily interrogation of the world happens via the sensory surface of the skin and that the skin is a central component of our ontological intercorporeality.

Merleau-Ponty only cursorily extends his ontological understanding to psychopathological syndromes. Indeed, virtually no authors have extended their understandings of psychopathological presentations by an inclusion of Merleau-Ponty's idea of flesh. This has left a gap in the literature, when one considers the implications of his understandings for the formation of bodily boundaries and borders in early development. To apply his thinking to the phenomenology of the borderline personality would be very fruitful. In the discussion, the results of the study will be dialogued with Merleau-Ponty's concept of *flesh consciousness* in an attempt to understand more comprehensively the phenomenology of self-mutilation; the borderline's fracturing of her own flesh.

Concluding Comment

In this chapter the specific role of the skin in psychic development is examined. The authors discussed have variously proposed that psychic life is predicated on the formation of an early *mental skin*, or *skin container* that serves as a sensory template for ongoing ego consolidation and differentiation. In particular, the capacity for symbolization and language is contingent upon the sufficiency of such a skin container. The following chapter looks at what pathologies ensue when this background is not consolidated or is skewed in one of several directions. In particular, the literature will be reviewed with a view towards how it can inform an understanding of self-mutilatory incisions into the skin.

Chapter Five

PATHOLOGIES OF THE SKIN CONTAINER

Frances Tustin and the Autistic Envelope

Frances Tustin has produced a very innovative discourse on the pathologies that beset the psychic container in her trilogy on autistic states; namely *Autistic States in Children* (1981), *Autistic Barriers in Neurotic Patients* (1986), and *The Protective Shell in Children and Adults* (1990). The sequence of her book titles reflects her extrapolation of ideas originally developed about autism to other softer pathologies such as personality disturbances and neuroses. Unfortunately though, she does not extend her thinking directly to the specific personality disorders or to self-mutilation. Nevertheless, her ideas can be used to throw light onto the types of container configurations of the self-mutilator. It must be borne in mind that autistic children, although preoccupied with sensory surfaces, also commonly mutilate their own bodies.

Tustin draws upon the works of Klein (1946), Bion (1962, 1967, 1970, 1977), Winnicott (1965, 1971), Bowlby (1969, 1973, 1975), Meltzer (1967, 1975), and Mahler et al. (1975) in describing the shell-like structures that are mobilized by autistic individuals as protective encasements against a sadly traumatic environment. Her primary focus has been psychogenically autistic children whom she labels *encapsulated children.* Later, she extrapolates this concept of encapsulation to include a form of sub-clinical autism in neurotic adults and children. This latter group overlap considerably in their clinical phenomenology with borderline personalities. Given this overlap, Tustin's ideas on the psychic container are

worth considering in attempting to understand borderline self-mutilation.

For Tustin, encapsulated autistic children develop, as infants, a massive formation of avoidance reactions in order to deal with a traumatic awareness of bodily separateness from the mother. These infants are beset by an elemental dread of falling apart, falling infinitely, falling with a bruising bump, spilling away, exploding away, and losing the thread of continuity which guarantees their existence. These anxieties are akin to what Winnicott (1958) calls *failure to go-on-being*, Spitz (1965) calls *anaclitic depression*, Balint (1968) calls the *basic fault*, Bion (1962) terms a *psychological catastrophe*, and Meltzer (1967) calls the *black hole*.

Tustin sees autism as a massive *not-knowing* and *not-hearing* which is provoked by the awareness of bodily separateness. It is a form of survival mechanism which the autistically encapsulated child uses to protect herself in the face of this cataclysmic separateness. She develops an imaginary hard shell to shield her hypersensitive surfaces from the hostile impingements of all *not-me* experiences, primary among which is that of the *stranger/mother*.

Tustin proposes that the disturbance for these children occurs at a stage more primitive than bonding which she calls *autosensuousness*; a phase prior to autoeroticism and autosadism and their sequel, narcissism. This stage is similar to Ogden's (1989) proposed autistic-contiguous position, Anzieu's Skin Ego (1989) and Bion's (1977) mental skin. Tustin's encapsulated child demonstrates a pathologically abrupt rupture of autosensuousness, causing the expected development into sensual differentiation and integration linked to object bonds to break down.

The early ego is an auto-sensuous ego which matures under the persuasion of a facilitative environment. However, the ego of the traumatized autistic child

> ... is morbidly fixated at an uncouth, crude bodily level of precocious, overconcretized and hypertrophied reactions. This leads to the sense of having a swollen empty shell fabricated from the subject's own bodily activities. This is a barrier to intercourse with the outside world ... This 'impenetrable cystic encapsulation' is the expression of a hypertrophied, crude body 'ego' which had been startled into precocious development along an aberrant path by the impingement of unbuffered awareness of bodily separateness from the mother. (Tustin, 1989, p. 44)

Bollas (1993) makes a similar point when he suggests that children who contain anguishing traumatic complexes do not usually seek to elaborate them symbolically. The trauma is usually represented in acting-out within human relations. The effect of trauma is to sponsor symbolic repetition rather than symbolic elaboration.

The autistic child's primary fear is of the body falling apart and consequently, her main preoccupation is with surfaces to which she can adhere, in order to acquire some sense of bodily definition. She turns to *autistic objects* for the sensations they engender and for reassurance that the skin is still a containing membrane or, more accurately, can be rendered so by the addition of an adhesive autistic object. The autistic child uses sensation-dominated objects in a frantic attempt to seal the phantasized holes and ruptures in the tunic of the ego.

> 'Hardness' is a characteristic feature of most autistic objects. This gives the child the feeling that they keep him safe. Autistic children, because they lack the experience of civilizing relationships with other human beings, feel constantly threatened with being attacked and hurt. They feel that their helpless bodies are a target for savage and brutal attacks. They particularly feel that the projecting parts of their bodies will be bitten off in very barbarous ways. The castration anxiety of neurotic children is mild as compared with the perils that autistic children feel they have to face. The main purpose of autistic objects is to shut out menaces which threaten bodily attack and ultimate annihilation. Hardness helps the soft and vulnerable child to feel safe in a world which seems fraught with unspeakable dangers, and

> about which he feels unutterable terror. These objects help prevent the realization of bodily separateness, and to promote the delusion that impingements from the outside world are obstructed. (Tustin, 1987, p. 107)

These material autistic objects become unduly important because they stimulate soothing bodily sensations. Autistic objects stand in to deal with unbearable frustration, but they also prevent the development of thoughts, memories and imaginations which, in normal development, compensate in some measure for the inevitable lack of complete satisfaction which being a separate human entails.

Bick (1968) and Meltzer (1975) have also described the way in which unintegrated children need to adhere their skin surfaces to other surfaces in order to offset their terror of falling apart or spilling. For Tustin, autistic objects meet this need. Tustin makes the distinction between an autistic object and Winnicott's *transitional object*. The latter has attained the status of an object in the child's mind, and as a blend of *me* and *not-me* it can facilitate continued separation, symbol-formation, and ongoing psychological development. In contrast, the autistic object becomes an adhesive appendage to the fragmented skin boundary, and serves as a kind of glue, thereby forestalling differentiation into a separate skin and sense of body boundary.

In addition to autistic objects, Tustin (1986, 1990) speaks of *autistic shapes*. These are tactile traces of sensation which are experienced in a tangible way as diffuse swirls of fluid or soft bodily substances. These shapeless shapes have no shared meaning and are pathological manifestations that are part of the child's undifferentiated sense of being.

> Such shapes are inchoate tactile manifestations ... that are experienced on internal and external bodily surfaces which are not differentiated as outside or inside. They are also experienced on the surfaces of non-bodily objects which may not be clearly distinguished from bodily ones. (Tustin, 1986, p. 142)

The autistic child's constant resort to these autistic objects and shapes means that autistic children, instead of having creative internalized experiences with the mother's breast (and all that this implies), have object-like and shape-like tactile sensations on body surfaces. These superficial and unreal securities do not provide fundamental help in times of stress. They merely prevent the child from experiencing and learning from these times.

Tustin argues that the psychogenic autistic state has origins in the mother being depressed to the degree that she cannot engage in nursing the child with *maternal reverie* (Bion, 1962), *primary maternal preoccupation* (Winnicott, 1958), or as a *protective shield* (Kahn, 1963). The mother's depression has interfered with her container function for her infant. Lacking an adequate container, the fiery passions of the autistic child have been covered by an icy protective coating of autism (Tustin, 1986).

Tustin (1990) extends the concept of pathologies of the sensuous boundary from the extreme configurations of autistic children to more subtle forms which are discerned in neurotic adults and children. In neurotic patients, a voluntary narrowing-down of awareness can preserve sanity by shutting out perceived threats of bodily damage and hurt. Borderline derealization and splitting can arguably be understood as such a narrowing-down of sensory awareness as a protection against phantasies of catastrophic separation from the maternal skin.

Sydney Klein (1980) claims that the traumatic situation is a hidden part of the neurotic patient, lying unassimilated, suspended, and unchanged. Since the trauma was originally experienced before the acquisition of language, it remains beyond the realm of the talking cure of psychoanalysis, but does get re-enacted in the analytic relationship via projective identification and splitting.

The traumatic discontinuity of these patients' separation experiences leaves them without a *background of safety* (Grotstein, 1981) or a *protective maternal skin* (Anzieu, 1990a) to fall back on in times of stress. They feel wounded bodily by separation; a wound which, unless coated with an impervious protective shell, is reopened at every subsequent separation experience. Tustin (1990) poignantly spells out this experience:

> We are coming to realize that this 'core' originates from the fact that human beings are shy and timid animals who need to engender some form of protection for their naked vulnerability when awareness of bodily separateness from the (m)other becomes a fact of existence. For various reasons associated with the suckling situation of infancy and the degree of reciprocity stimulated there, some people have needed more of this type of protection than others. In extreme forms, such protective strategies become a serious handicap to psychological development. (p. 189)

The cover of Tustin's most recent book, *The Protective Shell in Children and Adults* (1990), depicts a photograph of Henry Moore's great sculpture titled *Mother and Child: Block Seat.* Mother and child are both swathed and enveloped and thus, are out of contact with each other's body. The mother's unswathed left breast has a black hole where the nipple should be. The infant, although sitting on her lap, is cut off from touching her by the swathes which cover its body. Instead of a mouth it has a cork-like protuberance. This mouth would block the flow of milk from the breast instead of being a means of sucking at it, occluding the

realistic function of both breast and mouth. For Tustin, this represents the kind of perversion that lies at the root of autistic states, even in those otherwise normal individuals who have a pocket of autism.

Within the latter group, Tustin does not directly address the nature of the protective formations encountered in character pathologies such as borderline personality organization. Nevertheless, her ideas on protective surfaces will be used in the discussion section to deepen the understanding of the self-mutilator's attacks upon her own bodily container, and the hitherto puzzling relief that action brings.

Thomas Ogden and Autistic-Contiguous Pathology

Each of the three basic psychological organizations proposed by Ogden (1989), the autistic-contiguous, the paranoid-schizoid and the depressive, has its own distinctive form of anxiety. In each instance, the nature of the anxiety is related to the experience of disconnectedness (dis-integration) within that mode of experience, whether it be disruption of whole object relations in the depressive position, the fragmentation of parts of the self and object in the paranoid-schizoid position, or the disruption of sensory cohesion and bodily boundedness in the autistic-contiguous position (Ogden, 1989).

> Common manifestations of autistic-contiguous anxiety include terrifying feelings that one is rotting; the sensation that one's sphincters and other means of containing bodily contents are failing and that one's saliva tears, urine, faeces, blood, menstrual fluids, and so forth are leaking. (Ogden, 1989, p. 68)

These autistic-contiguous anxieties are similar to the flayed skin phantasies that accompany Anzieu's (1989) *Colander Skin Ego*, which develops in the wake of a ruptured intersensoriality. Similarly, in keeping with Bick's (1968) *crustacean* and *amoeboid second skin formations*, Rosenfeld's (1987) *thin-* and *thick-skinned narcissistic formations*, and Meltzer's (1975) *adhesive identifications*, Ogden also proposes that defenses which are generated in the autistic-contiguous mode are directed at re-establishing the continuity of the bounded sensory surface and the ordered rhythmicity upon which the early integrity of the self rests. In Grotstein's (1980) terms, patients attempt to reconstitute a sensory *floor* to their threatened *going-on-being* (Winnicott, 1956).

In an autistic-contiguous mode, one attempts to defend against the anxiety of disintegration by sticking bits of the surface of the object to one's own failing surface. Ogden illustrates this with the case of a chronic hospitalized schizophrenic patient:

> Phil seemed psychologically dead as he lay on the floor of my office or was escorted from one hospital "activity" to another. The initial form of contact that he made with me in the therapy was by imitating my posture, my tone of voice, my every gesture, every word I spoke, and every facial expression I made. Rather than celebrating this as his entry into the land of the living, I experienced it at the time as an attack on my ability to feel alive. I felt as if my spontaneity was being tyrannically drained out of me. Nothing I did felt natural.
>
> At that time I understood this as a form of projective identification (Ogden, 1979, 1982, 1983), in which the patient was engendering in me (communicating to me) his own feelings of lifelessness and incapacity for spontaneity as well as his inability to feel alive in any way. However, I did not at the time sufficiently understand the phenomena that I am referring to here as autistic-contiguous to appreciate the nature of the affection in the patient's imitation of me. He was using me as a second skin or container within which he was experimenting in a primitive way with what it might feel like to be alive. He was paying me a very great compliment indeed by indicating that it was to be my skin in which he would conduct this experiment. (Ogden, 1989, p. 75)

Psychopathology can be thought of as a collapse of the generative dialectical interplay of modes of experience (Ogden, 1986, 1989). A collapse of the dialectic of the autistic-contiguous and paranoid-schizoid modes of generating experience in the direction of the former, ushers in a primary anxiety that has been variously described as the experience of one's skin becoming a sieve through which one's insides leak out and fall into endless, shapeless space; a formless black hole devoid of an etched and textured surface or definition of any sort (Bick 1968; Anzieu 1989; Meltzer 1975; Rosenfeld, 1987). The term a *formless dread*, Ogden suggests, might well accurately reflect the anxiety of the autistic-contiguous mode, since the experience of shapes, rhythms, and patterns are the only *names* that exist in this mode (Ogden, 1989).

The dialectic of the autistic-contiguous and the depressive modes of generating experience may also collapse in the direction of the autistic-contiguous, leading to a feeling of entrapment in a world of sensation that is almost completely unmediated and undefined by symbols. To the extent that the latter self-envelopment occurs, there is no room for *potential space* (Ogden, 1986) and consequently for symbolization and the creation of transitional phenomena (Winnicott, 1951). This closed bodily world is a world without room in which to create a distinction between symbol and symbolized, and therefore a world in which there is no possibility for the coming into being of an interpreting subject. It is a world in which there is no psychological space between the infant and mother in which transitional phenomena might be created or discovered.

There is no doubt that Ogden's diachronic model goes a long way towards integrating the psychic and somatic poles that are present in psychopathology. However, he does not directly

extend his formulations to the unique phenomenology of the borderline personality and that group who enact their psychopathology on the very sensory 'ground' of the ego, namely the skin. Therefore, it is the intention of this thesis to use Ogden's ideas to deconstruct, phenomenologically, the highly specific yet meaning-laden symptom complex of self-mutilation.

Joyce McDougall and Psychosomatic Archaic Hysteria

Joyce McDougall examines the psychic life of psychosomatic patients in her books (1980, 1986, 1989). She attempts to address the relationship between the body and the psyche, and the pathologies of that relational balance as evidenced in various psychosomatic conditions. She comes to conceive of these bodily expressions as disturbances in the formation of the psychic container or skin container.

McDougall understands psychosomatic disorders as having their origins in the mother's failure to act as a protective shield against overwhelming stimuli from without and within, and as a source of primary sensory stimulation. This failure results in either over or understimulation, giving rise to an archaic body representation, in which body limits, the investment of erogenous zones, and the distinction between the mother's and the baby's body remain confused. Under such circumstances, separation and difference are feared as destructive to the sense of self, preventing the child from revelling in the experience of separation. This, claims McDougall,

> Results in a variety of psychic "solutions": sexualization of the conflict; the construction of narcissistic or borderline personality patterns; addictive solutions such as drug or medication dependency, alcoholism, or bulimia; or

> a profound split between the psyche and soma. The latter offers two different kinds of solution: The first leads to autistic pathology, in which case the body and its somatic functioning frequently remain intact while the mind closes itself to the external world; the second keeps the relation to external reality intact, with the risk that the soma will begin to act in what we might call an "autistic" fashion, that is, detached from the psyche's affective messages in terms of word-presentations, leaving powerful thing-presentations to seek non-verbal expression. Thus, in later life, psychic pain and mental conflict arising from inner or outer stress are not recognized at the level of verbal thought and discharged through psychic expressions such as dreaming, day-dreaming, thinking, or other forms of mental activity, rather, they find discharge in ... psychosomatic manifestations, as in early infancy. (1989, p.43)

McDougall calls these *somatic explosions* a form of *archaic hysteria* which is fuelled by anxieties aroused when the sense of individual identity, or life itself, is felt to be threatened with obliteration. She defines it as follows:

> In archaic hysteria, therefore, these phenomena do have a psychological meaning but of a presymbolic order, in that they are the result of a primitive attempt to deal with what we might well term psychotic anxieties, were they to be consciously recognized and believed to be imminent. But neither psychotic nor neurotic symptoms have been created to compensate for what has been ejected from consciousness, because the anxieties aroused have been unable to achieve a mental representation in a symbolic, verbal (i.e. thinkable) form. (1989, p. 55)

The overinvolved, impinging mother does not allow the child to hew out its own psychic container from the mother-child matrix. Later, rather than develop the capacity for transitional phenomena (Winnicott, 1951), the child develops and resorts to what McDougall (1982) terms *transitory objects*. These objects are attempts to seal over the rupture in the envelope of self left by maternal unavailability, and may take the form of addictive substances, addictive relationships, and perverse or addictive sexual behaviour. The borderline personality's characteristic engagement in such addictive-like sensory experiences is noteworthy.

These addictive-prone patients develop an envelope that guards against the pain of intense affective states; a form of *disaffected armour-plating* (McDougall, 1989, p. 107). This protective envelope is of a pre-verbal, pre-neurotic order that manifests as a psychosomatic rather than an ideational response to conflict and psychic pain. There is an inability to enter the realm of language and to represent affective experiences in words.

McDougall argues that the skin operates as both a physical and psychological perimeter or envelope to the self. It is the psychosomatic patient's inability to place painful experience into word-presentation, remaining caught in thing-presentation, that is substrate to their psychosomatic explosions. The preverbal signifiers of the early relationship, as yet incapable of verbal symbolization, have given rise to *symbolic equations* which Segal (1957) equates with a psychotic mechanism which could be said to be equivalent to a *pictogram* (Castoriadis-Aulagnier, 1975), or in Bion's language, *beta elements* (1963). The psyche, in by-passing word-presentations through regression to infantile ways of experiencing mental pain, is left with destructive thing-presentations. Since these are not contained in words, the thing-presentations mobilize powerful and uncontrollable unconscious forces whenever the psyche detects a menacing situation, such as separation experiences. These find their expression in and on the surface of the lived-body. The body becomes the inscribing surface for these unspoken thing-presentations. This begs the question as to whether this is what is being enacted in self-mutilation. Is self-mutilation a self-enacted somatic inscription as opposed to a psychosomatic one? Is cutting a way of etching out a painful *somatic narrative* that cannot be brought to word-presentation? These questions will be addressed in this study.

Dinora Pines and the Psychopathology of Skin Disorders

Dinora Pines (1980) has studied psychosomatic skin eruptions, particularly the effects of early skin disorders on the establishment of a psychological skin boundary. She draws upon material taken from observation of women with histories of infantile eczema. She concludes:

> ... the preverbal trauma of infantile eczema results not only in a fundamental disturbance of the mother-infant relationship, but also in repeated unconscious attempts to regain contact with the archaic object, which had provided a primitive experience of being bodily soothed. The longing appears to persist throughout the life cycle, and is interwoven with every new relationship. The patient's hope of integrating that object, and its comforting role with the self, is repeatedly revived, but then withdrawn. Primitive fear of loss of the self is a powerful threat to individuation. (p. 321)

Pines' thesis is that these eczematous patients had, as a consequence of their illness, a prolonged period of attempted bodily soothing that inadvertently interfered with the growth of a separate containing psychic skin. Thus,

> infants who experience extended periods of bodily soothing learn to translate psychic pain into visible bodily suffering and so arouse concern and care. (Pines, 1980, p. 322)

Pines' findings are of possible relevance to this study in so far as borderline patients report a high incidence of illness and skin disorders in their developmental histories (Doctors, 1979) and arguably, may have had an early traumatization to the formation of the early mental skin.

Hirsch and the Digestive Skin

Hirsch (1993) presents the argument that we can mistakenly see the eating disorder as the enactment of an unconscious dynamic, instead of emanating from a lack of a sense of

containment in both the sufferer's psychological and physical self. She argues that the lining of the digestive system can be understood to operate in a similar way to the skin, as a containing boundary between the internal and the external.

In the case of the eating disordered patient however, the idea of a permeable yet containing lining is absent. Feeling unable to sustain an independent psychological and physical life, these patients live in a world in which they are either *inside or outside* rather than *attached to* and *separate from*; *inside* being associated with both a refuge and a claustrophobia, *outside* with the danger of fragmentation and annihilation or death.

Klein (1947) and Bion (1967) argue that the precursor to processing psychic experience is the baby's experience of taking in milk. The experience of ingestion and digestion paves the way for *digesting* internal and external perceptions. In both psychic and physical digestion there is a process of taking something in and making it one's own. Hirsch extends Bion's idea of the skin as a membrane keeping *the internal in and the external out* to include the internal lining of the digestive system. For her patient Anita, she suggests:

> In Anita's mind ... there existed no such lining, food was not contained by the digestive system but poured into the whole of her body and stayed there. (1993, p. 31)

Hirsch concludes that, in the case of Anita and other cases commented on, there is not so much a physical enactment of a psychological problem as a failure of containment. This failure happens at a level of development that predates any clear differentiation of the psychic and the somatic.

Hirsch's ideas are worth noting, given the reported high co-morbidity of self-mutilation, borderline personality disorder and bulimia nervosa. Gartner et al. (1989) report that 57% of their sample of 35 eating disordered patients met the criteria for at least one DSM-III-R axis II diagnosis; borderline, self-defeating, and avoidant being the most frequently assigned personality disorders. Similarly Piran et al. (1988) found that the rates of personality disorders among subjects with restricting anorexia nervosa and subjects with bulimia were 86.7% and 97.4% respectively. The most common diagnosis in the group with bulimia was borderline personality disorder, which occurred in 55.3% of the patients. In the limited sample of 5 patients in the current study, 3 reported a history of bulimia and/ or anorexia.

Allied to the above findings is the series of studies which have found evidence of childhood sexual abuse in patients with eating disorders (McClelland et al., 1991). McClelland et al. report that in their sample, within the abused group all patients subjected to repeated severe abuse had a mixed anorexic-bulimic psychopathology. These patients all fell into the borderline/antisocial personality diagnostic category.

Boris (1984) similarly examines the skin as a transitional space marker in anorexia nervosa. Making use of Winnicott's (1971) idea of the transitional object he says

> the transitional space is like a buffer, a neutral zone, between two bodies (as if a demilitarized zone) which makes room for the play of imagination and the apprehension of reality - both. (p.319)

Boris argues that the anorexic has failed to maintain those elemental body boundaries and hence failed to maintain that space.

Winnicott and Psycho-somatic Pathologies

Winnicott (1960, 1962, 1963) accounts for all forms of psychopathology, including character disorders, as eventual outcomes of a derailment in the integration of the psychosomatic unity of the self; an arrest of the process of personalization: " ... a word that can be used to describe the achievement of a close relationship between the psyche and the body" (Winnicott, 1963, p. 223). The process of personalization is accompanied by attendant anxieties that threaten to arrest the process of integration.

> The establishment of a state of *I AM*, along with the achievement of psycho-somatic indwelling or cohesion, constitutes a state of affairs which is accompanied by a specific anxiety affect that has an expectation of persecution. This persecutory reaction is inherent in the idea of the 'not-me', which goes with the limitation of the unit self in the body, with the skin as the limiting membrane. (Winnicott, 1962, p. 62).

Winnicott (1962, 1963) argues that psycho-somatic illness is often little more than the stressing of the psycho-somatic link in the face of a danger of breaking the link. This, he says, results in various clinical states which are called *depersonalization*. This is a psychosomatic defense relied upon by borderline and self-mutilatory patients (Miller & Bashkior, 1974).

In his concept of the *false self*, Winnicott (1960) indicates an understanding of the borderline patient's defensive ego boundaries that are mobilized in the face of depersonalization and a severance of the psycho-somatic linking. The false self is built on the compliance to the mother's image rather than on the child's real psychosomatic experiences. As such, the false self becomes a prosthetic structure of the self that serves as a hypertrophied crust to the personality; a kind of defensively organized boundary or border.

Esther Bick and Second-Skin Formations

Bick (1968) describes ways in which disturbance in forming a sense of skin containment gives rise to various *second skin* formations, such as pseudo-independence or pronounced mental or muscular development as a substitute. She argues that, in their most primitive form, the parts of the psyche are not yet differentiated from the parts of the body and are felt to lack a *binding force* amongst themselves. They must therefore be held together passively by the skin's functioning as a boundary. This gives way to an internalized containing object. The infant experiences this containing object concretely as a skin.

If the containing function is introjected, the baby may acquire the concept of a *space within the self* and accede to a differentiation; via splitting and projective identification, of self and object, each contained in its respective skin. If the containing function is not adequately fulfilled by the mother, or if it is impaired by the baby's destructive phantasy attacks, it is not introjected by the infant; a pathological projective identification continually takes the place of a normal projection, and confusions of insides/outsides arise. States of confusional unintegration persist.

The failure of this primal skin to function may lead the baby to form a second skin, a substitutive prosthesis which replaces the normal dependence upon the containing object with pseudo-independence. Bick argues that when an infant is faced with the catastrophe of absence of the maternal envelope, she can feel that part of her body has been lopped off, leaving a wound or black hole which she has to plug in some form. She can react in one of two ways. Either she can form a barrier from the mother, instead of a boundary of give and

take that both links and separates them. Or child, mother, and physical objects can stay merged in a confused and chaotic way. Of the two types of protective manoeuvre, she finds confusion the most difficult. Consequently, even a rigid and pathological barrier is more manageable. In either event, no transitional area develops (Winnicott), and no three dimensional sense (Ogden, 1986). The infant, protected thus from input, meets little new experience and digests little or no sense of process or time. These infants are stuck in a forever world with a deep need to keep things the same.

Bick, writing of a neurotic adult patient, describes two alternate and complementary types of experience of the second muscular skin. The patient describes himself as being either in a *hippopotamus* state (the second skin as seen from the outside: he is aggressive, tyrannical and relentless in following his own way), or a *sack of apples* state (these fruit with their thin, bruisable skins commonly symbolize the breast). The sack represents the inner space of the Self protected and concealed by the second skin. It contains the parts of the psyche bruised by the early period of feeding difficulties. In this state, the patient is touchy and in need of constant attention and praise, easily bruised and constantly expecting catastrophe (Bick, 1968). This latter description is concordant with Anzieu's (1989) Colander Skin Ego and Rosenfeld's (1987) thin-skinned narcissist.

It is Bick's thesis that if the stimulation from a hypertonic mother and/or from the earliest environment have been incoherent, overly intense, or unpredictable, then the psychical apparatus, instead of seeking to filter the stimuli qualitatively, seeks to protect itself against them quantitatively. If the stimuli are too weak because they have come from a depressed or withdrawn mother, then there is almost nothing to filter and the search for further

stimulation becomes necessary (Tustin's description of the development of psychogenic autism). In both cases, the second skin serves a useful purpose, either to reinforce protection against the outside, or to activate the body internally to reach out in search of a stimulating object (Tustin's autistic object).

Bick's ideas concur with Yariv's (1989) view that maternal depression smudges the infant's attempts to form a boundary. The deeply depressed mother becomes an *infiltrating object* that the infant is unable to keep out.

John Kafka and Transitional Object Skin

Kafka (1969), in attempting to understand self-wounding, appeals to Winnicott's concept of transitional objects. In describing the reaction of a self-injuring patient, Kafka notes the relief of the patient, who experienced the flow of blood resulting from her self-cutting as a pleasant, warm, voluptuous bath that enclosed her like a security blanket. Kafka suggests that the blood was linked to the patient's internalized representation of her mother, which she sought to externalize into a soothing transitional object in times of crisis. Kafka suggests that it is necessary for a patient to experience transiently his or her own skin as a *not-me object* so that automutilation can be carried out. Kafka offers the tentative hypothesis that:

> Although less dramatically, early traumatic fixation points, relating particularly to the formation of the membrane of the body scheme, may play a part in the developmental history of other patients with the cutting syndrome. (Kafka, 1969, p. 211)

In a wider framework, Kafka argues that the dynamic, semi-permeable membrane which helps to define the individual yet permits two-way passage to and from the social environment, is gradually formed by sequences of parental communications or meta-communications appropriate to the age of the offspring, to the effect that ambiguities and contradictions are tolerable. This tolerance of ambiguity permits the gradual formation of a membrane which is ego syntonic, to the extent to which it was not prematurely and externally imposed, but individually established through much active exploratory crossing and recrossing of the ambiguously defined border territory. He closes his brief paper:

> But let us return for a moment to the membrane which particularly concerns us here, the cutter's skin. While sadism and masochism, are generally considered two sides of the same coin, it remains a fact that one or the other side of that coin dominates a particular clinical picture. The study of how one's own body can be a 'not-me' object may illuminate the general question of the sadistic or masochistic preference. In a sense the cutter's choice is a transitional one between the sadistic and masochistic object, his own *not-me* skin. It is his skin which, however, he experiences as *not* his own. (Kafka, 1969, p. 212)

Kafka, by suggesting that the skin becomes a transitional object, is the only psychoanalytic writer to comment directly upon the cutter's actions on the skin. However, he only hints as to its implication in the psychic idiom of the cutter. It is this paucity in the understanding of the self-mutilatory skin that the phenomenological inquiry of this study addresses.

Analytical Psychology and the Wounded Puer Skin

Analytical psychology contributes an archetypal discourse to the question of pathologies of the skin container. Randolph Severson (1977) and Mara Sidoli (1993) argue that the skin is both a dwelling place and a container of archetypal psychic life. The puer skin becomes a

dwelling for anger, desire, sexuality, grief, depression, pain, pleasure and ecstasy (Severson, 1977). This echoes Jung's understanding of the archetypes as the foundation of psychic life, where archetypal organs are alive with imagery. As Severson comments,

> Were it not for the promptings of the spirit in skin disease the doors of the somatic soul might remain locked and bolted. (Severson, 1977, p.148)

Hillman (1977) is unique amongst psychoanalytic writers in highlighting the significance of blood and bleeding. He takes up the symbolic importance of the blood seeping from the puer's wound.

> ... bleeding is primary, as if before the wound, as if the wound releases and reveals essence ... It is said that the bleeding of Christ tells of love, of compassion, of suffering and of the endless flow of the divine essence into the human world, and of the bond through blood kinship and blood mystery of the human world with the divine. The bleeding of Jesus is a transfiguration of a basic puer motif onto a theological plane. The bleeding reveals an archetypal structure in several ways. First, it is an image for vulnerability in general, the skin too thin for real life, the sensitivity to every pointed instrument of attack, the defencelessness of youngly naive and open truth. The bleeding tells of the puer propensity for victimization, for the constellation around him of the psychopathic attackers ... a hero-in-reverse, noble for his martyrdom ... He has no tourniquet partly because his bleeding is so beauteous. Why stay such blood, a blood that is latent with flowers? Myths tell us again and again that from slain puer spring wondrous blooms. The puer is transfigured by his wounds into glory. It is as if he does not sense his broken vessels, cannot smell blood, only flowers.
>
> Second, puer's bleeding is a 'multiplicato', an infectious giving out of essence for the sake of transforming the world around ... A superhuman power emanates through the open wound and through being wounded. (Hillman, 1977, p. 109-111)

Puer wounding and bleeding, as described by Hillman, also raises the question of the state of the puer vessel or psychic container.

> The open wound may here refer to the 'unbuilt psychic body' which originally, in Plato, is the guard and keeper (not imprisoner) of the soul. Then the rush

> of life energy bursts the thin bag of psychic skin and the reddening comes too fast which, as the alchemists said, showed that the work was spoilt. Thus, what is fundamentally missing in the puer structure is the 'psychic container' for holding in, keeping back, stopping short, the moment of reflection that keeps events within so that they can be realized as psychic facts. (Hillman, 1977, p.112)

The suggestion that the wound is an opening insinuates that the wounded is one who is afflicted by openness; an innocence without rupture. The wound then, initiates the puer out of innocence into a new state of being; a state of suffering from openness, bringing to a close the world of painlessness and seamlessness. Now the puer hurts from the lack of innocence. It is as if the soul can find no path out of innocence other than physical hurt.

The building of the psychic vessel of containment then, requires bleeding and leaking as its precondition. It reflects the unstoppered condition of the puer, who has yet to contain his woundedness with imaginal depth. The wound, and the bleeding, is the point of development of soul. For Hillman, the wound is the opening up, or entry into, archetypal consciousness. The wound reflects one's mortality, one's limitations, and begs for an integration of the archetypal and the personal of one's life.

> Each complex has its symptom, its Achilles heel, its opening into humanity, through a vulnerable and excruciatingly painful spot. (Hillman, 1977, p. 116)

The memory of a wound is also carried in the scar which is left by it. The scar is the mark in flesh of soul. It is the seal of the anima, the somaticized psyche. The open wound belongs to the puer structure, but the scarred-over wound suggests the person whose soul can care for her, the person whose life blood courses through the complexes, feeding and vitalizing them. Healing emerges from within the very wound itself and leaves a scar, a scar that is

always visible to one's own nursings.

> Healing and wounding alternate, or, as healed wound, tender scar, they present the complex image of weak-strength, of soft-hardness. The scar remaining is the remainder, the soft spot recalling the body to its tenderness. The scar acts as a 'memento mori'... The scar reminds consciousness of its wobbling uncertainty, the dark vulnerability in the heart of its light. (Hillman, 1977, p.121)

The analytical literature reviewed above considers different forms of psychosomatic puer woundedness, such as neurodermatitis. Although not addressing self-inflicted woundedness, the understanding of the wound and bleeding in this literature is significant for self-mutilation. What is the puer quality of these young self-wounders? And what is the significance of their bleeding from this self-wounding? These are questions the present study will address.

The Sado-Masochistic Skin

Self-mutilation is commonly labelled masochistically self-destructive. Indeed, in most masochistic perversions the eroticized skin often plays a predominant role. Anzieu (1989) notes that often the entire surface of the body becomes the site of pain, the epidermis being both the surface for attachment and clinging, as well as the limiting membrane that defines and delineates the self. Bonding and beating rituals, argues Jones (1989), join both the instinct to separate (the flaying of the skin) and the instinct to cling (to be bonded and tied).

Anzieu (1989) views masochism as the result of traumatic overstimulation and/or deprivation of physical contact and the wish for attachment. The skin represents the dual union between mother and child, and the process of separation represents the rupture and tearing of that

common skin. In the stage of primary masochism and primary narcissism, masochistic suffering is accounted for by the repetitious, quasi-traumatic alternations between full-bodied stimulation by the mother and deprivation of physical contact. Tension between the satisfaction of, and frustration of the need for attachment is thus set up. The constitution of the Skin Ego or the skin container is a precondition for the transition from primary to secondary narcissism, and from primary to secondary masochism. For Anzieu, the consolidation of secondary masochism presupposes the interiorization of a functional Skin Ego.

Anzieu (1989) points out that masochistically fixated patients often speak of an episode of actual physical injury to their skin in early childhood; an episode which provided decisive material for the organization of their phantasies. This may have been a superficial surgical operation, i.e. one principally affecting the surface of the body, or it may have been dermatitis or alopecia, or an accidental fall in which a substantial area of the skin was damaged. The damage may well have been of a direct physical nature that brought to prominence the unconscious phantasy of a *flayed* body. Anzieu notes in his observations of masochistic patients:

> The unconscious phantasy which these various observations have failed to bring to light is not one of a 'fragmented' body, as certain psychoanalysts have hypothesized: that phantasy seems to me to be typical of psychotic organizations. In my view, it is a phantasy of a 'flayed' body which underlies the behaviour of the perverse masochist ... The masochist's 'jouissance' reaches the maximum degree of horror when corporeal punishment applied to the surface of the skin (spanking, flagellation, pricking) is pushed to a point where pieces of skin are ripped, pierced or torn away. To obtain masochistic pleasure, the subject needs, as we know, to be able to represent the blows as having left a mark on the surface of his body. (1989, p. 41)

Further evidence to this effect is provided by Doctors (1979) and Kafka (1969), who respectively report self-mutilatory histories significant for the presence of harsh physical discipline, skin disorders, and skin injuries. Not to mention the histories of painful sexual abuse visited upon the surface of the bodies of self-mutilators.

Glickauf-Hughes and Wells (1991) argue that masochism can be viewed as a preoedipal child's attempt to get skin contact and love needs met by a nonloving or painful parent figure. This sets the template for subsequent object relational patterns. The hostile, intrusive and unpredictable environment in which masochists grow up however, leads them to develop rigid defenses or thick boundaries to protect themselves from negative stimulation and intrusion. However,

> the rigid defenses developed by these clients have a paradoxical effect. As painful sensations are more impelling than pleasurable ones, pain is more likely to permeate the masochist's thick boundaries than pleasure is ... Furthermore, as pain is one way that a person establishes self-definition and separation-individuation, painful relationships serve two functions for masochists: (1) helping them to feel emotions and to feel connected with others; and (2) helping them to feel separate and individuated. The latter is particularly important in view of Johnson's hypothesis that masochism is primarily a pathology of individuation. (Glickhauf-Hughes & Wells, 1991, p. 60)

Anzieu (1989) makes the point that in the event of insufficiency of maternal care, an infant may learn to invite pain as a way of recalling the maternal embrace. In extreme cases, inflicting a real envelope of suffering on oneself can be an attempt to restore the skin's containing function which was not performed by the mother. It is through this suffering that the body acquires its status as a real object.

The subsequent marks of masochistic violence become a means of procuring a certain pleasure and of owning one's self. The masochist can only enjoy mastery of her own body by posing as a victim. By leaving visible scars she is able to appropriate the pain in the markings and turn them into narcissistic emblems. In Anzieu's words, such a borderline person is trapped in a *body of sufferance*, unable to experience the self as a *body of suffering*, the latter being a body that suffers the painfulness of separation and comes to have a facility for symbolization and language which transforms that separateness into a liveable experience.

Anna Antonovsky (1978) further articulates the masochist's inability to endure an unbearable loss or rupture despite her immersion in suffering. She is unlike the fetishist, who denies the irrevocable loss of her narcissistic oneness by filling up the *empty space* with the fetishistic object. Antonovsky concludes that thinking, and thereby memory of loss, is only possible if there is a capacity to bear pain. She claims that the whole realm of symbolization, encompassed within the axis of metaphor, allows the child to move away from the original object and bear the inevitable dissolution of the mother-child dual unity. The masochist struggles to relinquish this unity and clings to what Antonovsky has described as "the thereness of the given" (p.399).

Biven (1982) notes how a perverse masochistic wish to inflict the maximum degree of pain by stripping the body of skin has been recorded from the time of Ancient Greece to the present day. Specifically, artists have variously represented the skin in sadomasochistic images and themes; artist Jean Valverde's flayed model holds his skin at arm's length, Joachim Remmelini's engravings show the skin knotted around the belly like a sarong,

Berretini's model is blindfolded by shreds of skin and Bidloo portrays a woman with her wrists tied in skin shredded from her back.

Narcissistic and Borderline Skins

Anzieu (1989) is the one theorist who has attempted a specific articulation of the skin container configuration of the borderline personality disorder. The borderline skin contains elements of the masochistic skin as described above, but is not consonant with it. As commented on before, the Skin Ego has two faces, one internal and one external, with an intermediary space that allows for the creation of phantasy and ideational life. In narcissistic personalities, Anzieu (1989, 1990a) argues, the space between disappears or is compressed into a single *double-walled* skin. In the face of surrendering the shared skin that dependence entails, the narcissist reinforces her skin to a point of invulnerability in two ways.

First, she abolishes the space between the inward and outward looking faces of the Skin Ego; between external stimuli and internal excitation, between the image she gives of herself and that which is reflected back to her. Her surface envelope becomes solidified by becoming a double centre of interest. Solidified and extended in this way she has a sense of security. However, this solidification comes at a price. The Skin Ego is rendered inflexible by this *vulcanization* and is accordingly prone to rupture.

The second fortifying action aims at doubling the outside of the Skin Ego wall with a symbolic maternal skin that confirms her narcissistic invulnerability.

> In the narcissistic phantasy, the mother does not share a common skin with her child, but gives her skin to him and he dresses himself in it triumphantly; this generous maternal gift (she divests herself of her skin to guarantee him protection and strength in life) has a beneficient potential: the child imagines he is called on to fulfil a heroic destiny. This double covering (his own joined with that of his mother) is brilliant, ideal; it provides the narcissistic personality with an illusion of invulnerability and immortality. (Anzieu, 1989, p. 124)

The above description of the narcissistic double-walled Skin Ego reminds this author of a patient he treated in psychotherapy during his internship training. This young man, when feeling depressed, unmasculine, and heavily burdened by the responsibility of being a young father, would secretively wear his wife's underwear and instantaneously transform into a relaxed, sexually eroticized, and contented person. The underwear needed to have been worn and preferably unwashed so that his wife's smells permeated it. This behaviour began with his mother's underwear when he was a 14 year-old adolescent Whilst it lies outside the scope of this thesis it poses the interesting question whether transvestism is about coating oneself in the maternal skin, a sensorial enactment of what Anzieu suggests the narcissist enacts symbolically.

Anzieu (1989) argues further that, in contradistinction to narcissistic phantasy, in borderline masochistic phantasy the duplicitous mother only pretends to offer her skin to her child, the covert intention being to reclaim the child's own newly hatched Skin Ego which has become stuck to the proffered maternal skin. The mother wants to strip it painfully from the child in order to re-establish the phantasy of having a skin in common with her, causing renewed dependence and wounding of the child's nascent Skin Ego (Anzieu, 1989).

In the case of the narcissist, thanks to the double-walled skin organization, the Skin Ego is retained as an unruptured container, thereby making symbolization and thinking possible. The borderline personality is less fortunate in that the Skin Ego is ruptured and prone to the confusional leakage and seepage of psychic contents. The borderline is left with a twisted psychic container that centrifugally ejects powerful affects and images to the surface of the self and beyond, whilst also desperately seeking alternative skins to merge with.

Herbert Rosenfeld (1987) classifies narcissistic patients in terms of the type of psychological skin they are encased in. He describes two types of narcissists; the *thick-skinned* and the *thin-skinned*. The thick-skinned have developed such an impenetrable narcissistic structure that they are insensitive to deeper feelings and have lost the capacity for empathic exchange with the outside world. The thin-skinned, by contrast, are described as hypersensitive and easily hurt, in analysis and everyday life.

This description of narcissistic thin-skinnedness is congruent with a psychic skin that is wafer-like and infiltrated with negative narcissism. However, here the narcissistic self is more sensorially consolidated than in Ogden's formulation of psychopathology of the autistic-contiguous position, where the self is felt to be a porous sieve and where adaptive responses are attempts to seal over cracks in the container. In contradistinction, Rosenfeld implies that the narcissistic patient has a sufficient, albeit vulnerable, sense of bodily going-on-being, and that her defensiveness is in order to ward off a rupture to her fragile self. Her fragility lies more in the territory of an assaulted self-concept rather than the injury being etched into the bodily surfaces of the self. Rosenfeld's thin-skinned narcissist is phenomenologically similar to Anzieu's Colander Skin Ego.

Concluding Comment

This chapter delineates those writers who have looked at various psychopathological presentations as manifestations of fractures in the containing psychic skin envelope. Although using different heuristic tools, all the theorists presented in this chapter speak of a skewed development of the skin container and of the sequelae of various forms of skewedness. The paucity of literature on the phenomenology of the skin container of the borderline personality is notable. The present study will attempt to fill this gap in the literature by exploring the phenomenology of self-mutilatory behaviour.

Chapter Six

METHOD

The aim of the research is to describe the self-mutilator's lived experience of cutting of the skin. The nature of this symptom is that it is a behaviourally-enacted symptom rather than a primarily cognitively-mediated experience. As such, the self-mutilator often has difficulty in placing the context of the action into words. Melvin Lansky (1989) notes of impulsive action that

> In the patient's recollections of his conscious experience, it is often unlocatable, indescribable, obscured so much by what precedes and what follows, and so foreign to the usual capacities of language that all or part of it may not be conceptualized or even registered in conscious experience ... Our language deals more easily with presences or behaviours than it does with absences. Our conscious awareness and recollections of senses of absence are very much coloured by our language or lack of it. (p. 16)

Self-mutilation often occurs without the person languaging the experience parallel to the action. It is this very silent nature of the symptom that has rendered it inaccessible to a comprehensive understanding when investigated from a purely empiricist tradition. In fact, of all the studies reviewed that cover the area of self-mutilation, not one offers up an in-depth description of the symptomatic action of self-mutilation. This hiatus in the literature can be partly bridged by a phenomenological description that aims at a full articulation of the self-mutilatory experience. The complex pre-reflective ground of this symptom calls for nothing less than a full explication of the phenomenon. As such this research aims to exhume the associated feelings, thoughts and fantasies that are antecedent to, concurrent with, and sequelae to the act of cutting.

The very failure of language to fully capture this experience presents some unique methodological considerations. Reviewing the literature on the subject Roumasset (1991) concludes: "Future research is encouraged investigating the link between self-mutilation ... and unconscious mental functioning." (p. 1)

The unique pre-reflective nature of self-cutting demands a research methodology that brings "the pre-reflective life-world ... to the level of reflective awareness where it manifests itself as psychological meaning" (Valle & King, 1978, p. 17). What is called for is a methodology that concurs with Romanyshyn (1971) that

> it is the unique demands of the problem which indicate the method rather than the method which limits the problem... When the problem changes, then the method must also change, or at least its appropriateness for the problem as it then presents itself must be recognized. (p. 107)

The methodology chosen by the researcher to attain a fuller description of the phenomenon of self-mutilation is one informed by a phenomenological attitude. Such a phenomenological praxis is consistent with a phenomenological attitude with a primary mandate "to listen to what the incidents, the phenomena, tell him" (Van den Berg, 1972, p.77), and hence to remain faithful to the concrete dimensions of "the phenomenon as it appears" (Giorgi, 1976, p.331).

This researcher's experience was that the interview situation, though constructed neutrally, became highly evocative of affective experience in all of the subjects as they narrated their respective experiences of self-cutting. After the interviews the subjects spontaneously commented that the retelling had transported them into the affective state experienced when cutting. They were all visibly stirred up and needed to talk about their respective experiences of being interviewed. The interview process, because of its innovative mode of engagement

with the phenomenon, brought much of the pre-reflective ground of the cutting to the surface in the presence of the researcher.

This presencing of the experience in the room necessitated that the researcher offer a debriefing period to each of the respondents after their respective interviews. Most notably, one telephoned the researcher several hours later in a disturbed state of mind saying that the interview had stirred up a strong desire to start cutting again. She was very desperate, stating: "If I start cutting again I will cut deeply to kill myself ... because I thought I was over this. The interview has just shown me that I am not!" The researcher responded by immediately arranging for the subject to be booked into the Johannesburg Hospital overnight. The researcher spent time that evening counselling her out of her desperate state of mind. She did not want to be hospitalized for the whole weekend and was sufficiently calm to be discharged later that evening. One of the other respondents was similarly disturbed and felt an urge to cut. She telephoned asking for an urgent follow-up debriefing session because "the interview stirred up a whole lot of feelings and thoughts and has brought up some important insights that I need to talk with you about".

This latter information is not represented in the interview data. Nevertheless, what it does highlight is that, with troubled interviewees, the method can be a very powerful catalyst that needs to be dealt with ethically and responsibly. Nowhere in the researcher's reading of the literature has anybody subjected self-mutilatory patients to such sustained, in-depth interviews. The consequence of doing so presented the researcher with important ethical dilemmas wherein the welfare of the patients became an important post-interview consideration. The researcher had to offer crisis-type counselling to prevent the possibility of these patients

regressing into symptomatic spirals of cutting.

Access to data emergent from the post-interview debriefing sessions render this study a form of case study inquiry, in addition to being a phenomenological one. As such, the study could be described as a form of phenomenologically informed descriptive-dialogic case study method wherein

> the emphasis is on faithful description and portrayal of a phenomenon. However the case is not regarded as unique, but one which can be expected to embody general principles articulated in the literature ... (where) there is still an emphasis on description and development of an initial conceptual framework where current theory lacks rigour and exactness and is not satisfactorily operationalized. (Edwards, 1990, p.19)

Levey (1973) notes that subjects pre-eminently suitable for phenomenological research are those who are verbally fluent and able to communicate their feelings, thoughts and perceptions in relation to the researched phenomenon. However, the very nature of self-mutilation mitigates against a fluidity of communication of thoughts and feelings surrounding the phenomenon. In sympathy with this, Van Kaam (1969) warns that it is inevitable that many, if not all, of the descriptions by the subjects will be incomplete or imperfect: forgetfulness, poor vocabulary, and the inability to express oneself clearly could all be contributing factors. These imperfect descriptions do not invalidate the subject's experience but may fail to reflect an essential part of it.

> This problem can be overcome largely by the use of more than one subject. By making use of a variety of subjects, the possibility of finding underlying constants or themes in the many forms of expression the experience takes is greatly increased. Similarly, a subject may concentrate on one particular area and fail to describe other aspects of personal experience. This does not necessarily imply that this is all there is to that experience - it merely indicates that the person has not explicitly described other aspects. The explicit areas of concern mentioned by other subjects may be implicit in this individual's

> descriptive expressions. At least, they should be compatible. If not, it is incumbent upon the researcher to take these incompatibilities into account when elaborating the structure of the phenomenon. (Kruger, 1988, p. 152)

In light of this, it was decided to elicit protocols from five self-cutting subjects rather than to be reliant solely on one case account.

Subjects

Five young women who were admitted to Tara, The H. Moross Centre were used as subjects in this study. By the time the interviews were conducted all five had been discharged and were attending the Tara outpatient facility. One of the respondents was eventually dropped from the study after reviewing her interview tape. She had great difficulty in disclosing her experience, pulling the interviewer into overdirecting the interview with prompting questions that, on retrospective appraisal, broke with the parameters of a bracketed mode of inquiry. That is, the interviewer became intrusive in the face of the respondent's reticence in responding.

Collection of Data

1) Research Questions

An examination of the literature on self-mutilation, coupled with inquiries to clinicians working with self-cutting patients, revealed that no research existed wherein these patients had been systematically asked for a thorough description of their experience of cutting. It appears

that when the symptom was encountered, it was side-stepped by talking of the type of precipitant factors that were precursory to the mutilation rather than a deeper inquiry into the lived experience of the symptom itself.

Preliminary interviews were accordingly conducted with two self-mutilating patients from the Adult Psychotherapy Unit, Tara Hospital. Both these respondents commented that, in all their dealings with mental health professionals, none of the clinicians had specifically asked them about their cutting and what motivated it. They noted that when faced with an incident of cutting, the clinicians would tend to redirect the patient to discussion of other areas of their interpersonal lives. This report further convinced the researcher of the necessity of a phenomenological inquiry into this oft-misunderstood symptom.

The preliminary inquiries also helped the researcher to formulate a hierarchy of questions that would elicit a fuller explication of the phenomenon. The primary question used in the study was as follows :

Could you describe as fully as possible your experience of cutting yourself? You can recall a specific incident of cutting to help you in this task. In your description comment on as many aspects of the experience as you wish. The purpose is to obtain as full as a description as is possible.

On the basis of the information gleaned from the preliminary interviews, certain follow-up questions were formulated to facilitate a deepening of the inquiry in specific focal areas. These questions were as follows :

A. Could you describe your experience leading up to the actual act of cutting?

B. Could you describe your experience of the actual cutting of your skin?

C. Could you tell me more about how you experienced your skin in the act of cutting?

D. Describe your experience of pain during and after cutting?

E. What was your immediate experience after cutting?

F. What effect did the experience of cutting have upon you?

G. Is the experience of cutting comparable with any other experience you have had in your life?

H. Could you describe any fantasies you may have had of how you would ideally like to cut yourself.

In the preliminary interviews, the researcher noted the difficulty the self-mutilators had in responding to a totally open-ended interview process. As a result, the study utilized the above-mentioned follow-up questions to facilitate a more deliberate and sustained reflection upon the experience. Surprisingly, the researcher found that when the preliminary respondents were granted permission to talk directly about the symptom, and were contained by the above series of questions, they became unexpectedly disclosive and descriptive of their experiences. This

convinced the researcher that an interview method would indeed serve as an appropriate method of inquiry into the phenomenon of self-mutilation.

The questions were presented in a flexibly interchanged manner, so as to intersect the respondent's narrative appropriately without interrupting the thematic flow. That is, at the start of the interview the researcher read the main research question to the subject, who was then allowed to speak as uninterruptedly as possible. When the subject finished the spontaneous narrative, the researcher asked the follow-up questions in an appropriate sequence.

2) Interviews

The researcher contacted each respondent personally whilst she was an out-patient at Tara, The H. Moross Centre, following an in-patient stay. Subjects were told that the research topic concerned self-cutting and that they would be interviewed specifically around this. Subjects were guaranteed complete anonymity. If, after hearing of the purpose of the study, they agreed to act as respondents, an interview was set up in the researcher's office at Tara, The H. Moross Centre.

At the start of the interview, the researcher placed the respondent at ease by confirming the anonymity of the occasion and reassuring her that there was unlimited time available for the conducting of the interview, taking special care to create a non-judgemental and accepting attitude which the respondents could take up as an invitation to explore their lived experience of cutting. This was particularly important in light of the respondents' consistent comments in the preliminary inquiry that they felt their self-mutilation to be covertly disapproved of by

the clinicians they had encountered, and that the latter had placed overt pressure on them to surrender this behaviour for more mature forms of handling their feelings.

Analysis of the data

Four of the five interviews were selected for inclusion in the study. The four selected protocols were then individually explicated using the following steps:

Stage 1 : Initial Reading of the protocol.

Each transcribed description was read several times to constellate an holistic grasp of the data. The researcher also listened to the original tape-recorded interviews so as to stay as close to the lived experience of the description whose richness is somewhat lost in the transcribing. All of the respondents became highly emotional during the interviews and this fluctuating cadence of their affective state is not captured in the one-dimensionality of the transcription.

Stage 2 : Delineation of meaning units.

The researcher read through each protocol with the aim of dissecting the text into manageable units or discriminated natural meaning units (referred to as NMUs henceforth). NMUs are a psychological intersection of the text wherein the researcher discerns units of psychological meaning in the respondent's description. Each unit may be defined as

> a statement made by [the subject] which is self-definable and self-delimiting in the expression of a single, recognizable aspect of [the subject's] experience. (Cloonan, 1971, p. 117)

Each description is accordingly broken up into manageable, psychologically discernible units, in keeping with Fischer's comment that the task of this methodological phase is an "articulation of the central themes that characterize the respective unfolding scenes of each protocol" (1974, p. 414). The NMUs for all four protocols are delineated in the analyses which appear in the appendix.

Stage 3 : Re-articulation of meaning units from a psychological perspective.

Modelled on Thorpe (1989), Hoek (1988), Parker, M.A. (1985) and Parker, P.B. (1986), the NMUs were altered to a form in which they were expressed in the neutral third person. The reason for effecting this transformation in phenomenological research is to remind the researcher that the task at hand is to understand the protocol from the perspective of the author of the text and not the interpreting researcher (Parker, 1985).

Following the process of reflection and imaginative variation (Giorgi, 1985), the researcher re-articulated each of the discerned meaning units into psychological language. Thus, each transformed meaning unit reflects the essential psychological meaning of that unit with respect to the phenomenon of cutting of the skin as a self-mutilatory act.

Crucial to the conversion into NMUs is for the researcher

> to note that each meaning unit exists in the context of the other inter-related meanings of the protocol so that, regardless of how clearly meanings are conceptually differentiated from each other, there is nevertheless an inseparable relatedness of all these meaning units in their lived sense. (Kruger, 1988, p. 153)

The transformed meaning units arising from this procedure follow immediately on from the NMUs in the appendix. This step does not appear for all four protocols. Following the example of Thorpe (1989) and Kelly (1994) this step is only presented for two protocols as an example.

Stage 4 : Clinical situated structure.

This step entailed the regrouping of the transformed meaning units according to their thematically intertwined meanings, and placing of the transformed meaning units so that they accurately reflect the sequential pattern of the respondents' experience of cutting. The researcher then synthesized and integrated the regrouped and transformed meaning units into a coherent description of the psychological structure of self-mutilatory cutting of the skin. This structure of meaning is labelled 'situated', as it remains faithful to the concrete, individual subject and her specific situation.

An attempt was made to construct each structure into a coherent narrative. Thus, though the researcher excluded irrelevant and repetitive data, the situated structures retain a narrative line. Information relevant to the particular case, but non-revelatory for construction of the extended description and the general structure, was later eliminated in Stage 5.

The reason for this alteration in the construction of the situated structure was to incorporate some of the advantages of the case study method, in addition to those of the phenomenological method. Although the researcher did not solicit case study material in the actual interviewing process, the respondents did provide some biographical information. In

addition, the researcher was aware of aspects of the respondents' case histories by virtue of attending ward rounds on the unit from which the sample of respondents was drawn. The emergent situated structures could thus be seen as four case studies in self-mutilatory cutting, and are therefore referred to as clinical situated structures. Insights obtained from this stage were integrated with the general structure. Precedent for this has been set by Thorpe (1989).

Stage 5 . Central themes

The transformed meaning units were then expressed more directly, in terms of self-cutting, as central themes. Each central theme expressed more generally the essence of a number of transformed meaning units and was arrived at with a view to formulating the general structure (Thorpe, 1989; Parker, 1985).

Stage 6. Construction of extended description

The extended description of the structure of engaging in self-cutting of the skin was then constructed by the researcher. This was accomplished by reading and re-reading the clinical situated structures and central themes of the four protocols until common themes emerged. Themes which occurred only once were also included in the extended description, if they were considered to be revelatory of the experience of self-mutilation of the skin by cutting.

Stage 7 : Construction of a general structure

The general or essential structure, which embodies the necessary and sufficient conditions, constituents, and structural relations which constitute the phenomenon of self-mutilatory cutting, was then constructed. According to Thorpe (1989) the aim of this stage is to establish what is typical of the phenomenon rather than what is universal. The construction of the general structure requires a hermeneutic dialogue between each protocol's situated structure and central themes, in order to elucidate common themes and structures. Imaginative variation (Husserl, 1970) was engaged in to move the hermeneutic reading of the text beyond the generality provided by the four respondents in this study. As articulated by Wertz (1987), the common features were sometimes highly implicit. Each of the general statements isolated were related back to the individual clinical situated structures and the central themes, in order to confirm their generality as evidenced by the broader base of data. To cite Kruger (1988) on this point:

> a general description is one which communicates the meaning-structure of a phenomenon in general and which attempts to overcome the limitations imposed by any specific context. There is an obvious tension between the expressed specifics of a concrete situation and the more general description based on psychological insights derived from the explication. (p.154)

Chapter Seven

RESULTS

In this chapter the results of the explication process are presented. The *clinical situated structures* and *central themes* of the four protocols are extracted and presented. These are followed by the *extended description* and finally the *general structure*. A presentation of each protocol with the accompanying analysis in full would unnecessarily lengthen this thesis. Thus, the full protocols are included in the appendix section. A full qualitative analysis of protocols one and two are appended. The discriminated natural meaning units are presented first, based upon the viewpoint that the description was an example of self-mutilatory cutting. Following the discriminated natural meaning units they are then expressed more directly in psychological language and with respect to relevance for the phenomenon of self-mutilation. Protocols three and four are presented according to their NMUs but not according to transformed natural meaning units. This procedure is modelled on Thorpe (1989) and Kelly (1994).

Clinical Situated Structures

The clinical situated structures from the four fully explicated protocols are presented below. Each situated structure is a combination of a case history and the traditional specific situated structure of the phenomenon of self-mutilatory cutting.

Protocol One: Clinical Situated Structure

Background Information

The patient was recruited whilst an in-patient at Tara, The H. Moross Centre. The interview was conducted post-discharge. She was not receiving any out-patient follow-up at the time of the interview. Prior to her admission she had been in out-patient psychotherapy. Her admission diagnosis was that of Borderline Personality Disorder, with associated self-mutilatory features.

The patient comes from a well-to-do family with no overt psychopathology. She spent school holidays with her grandparents in another town from the age of four. The patient recounts that from as early as age four her grandfather perpetrated severe forms of sexual abuse on her, invariably when he was drunk. This entailed her having to submit to painful vaginal and anal intercourse, cunnilingus, and fellatio, where she was regularly forced to swallow her grandfather's semen. When she refused to submit he forcibly pinned her down and pinched her viciously on her arms, and between her legs.

The patient recounts how, between sexual assaults, her grandfather was extremely supplicatory; buying her gifts, and overtly stating to others that she was his favourite granddaughter. Privately, he had threatened her that he would kill her should she ever divulge their 'secret' .

Most poignantly, on history-taking, the patient reported that she could somehow tolerate all the painful sexual assaults. The worst for her was when her grandfather became slobbery, telling her

he loved her, and forcing her to engage in prolonged French kissing. She recounts with revulsion the smell of his alcohol and tobacco pungent breath and how she used to invite him to penetrate her anally so as to avoid the kissing and the face-to-face contact.

Interview Data

The patient recounts a cutting incident after returning from her mother's house. She felt upset, angry, and hurt. She describes an urgency to take some action to free her of these feelings. She cuts, and when cutting all her prior physical tenseness and emotional turmoil dissipate. Time and place lose their meaning as she becomes completely absorbed in the experience of the blade cutting through her skin.

Prior to cutting the patient feels a range of emotional states described as ugly, dirty, cross, sad, angry. She feels that these dysphoric affects are all stuck inside of her. She takes these in as a result of her interactions with others, finding herself passively absorbing others' negativity without the ability to refuse that process. She gets to feel that all the negative things in her life are all stuffed inside her with no release. She begins to feel that she will literally burst from the accumulation of all this "bad stuff" unless a release can be found. By cutting, an incision is made through which the patient feels all the negative emotions can escape. She exclaims "It's not the cut that opens, it's me that opens".

Cutting is the only way the patient knows to relieve her of all the bad things building up inside.

Further, the patient experiences the cut as opening up her whole being, her total psyche, her soul.

The patient feels it is her duty to absorb other people's negativity towards her. She feels unable to protect herself from hurtful and/or upsetting experiences. She feels obligated to keep all the feelings aroused inside of herself and not to express her feelings verbally or tearfully in the context within which they emerge. Instead, she reassures herself that she can cut later in order to alleviate the distress such experiences incur in her self-experience.

The patient equates her inability to say no to hurtful experiences with the running of a bath. The bath will overflow unless the plug is pulled. Cutting is like emptying by pulling the plug, or like squeezing a saturated sponge.

Despite its relieving action, cutting cannot rid the patient entirely of all pain. She is aware of a continual residue of pain that is deeply imbedded within her body and difficult to get to. This leads to further, future cuttings. It is her hope that the next episode of cutting will get to the deeply-imbedded pain. The patient fantasizes about getting to this pain by cutting her stomach wide open and leaving a gaping wound that will serve as a perennial point of excision of this distress.

Cutting has to be carried out alone in order for it to be satisfying. It is her self-made opening. Nobody else has forced it open. This gives the patient a sense of personal mastery and pride in her self-creation. The cut is felt to be a perfect creation that cannot be spoilt or interfered with

by anybody else. When interrupted in her cutting she becomes rageful, in that she perceives it to be a private pleasure that nobody has a right to attempt to curtail. Similarly, when the blade is blunted and does not cut through the skin easily, the patient becomes enraged as if somebody had purposefully blunted the blade in order to thwart her private pleasure.

The blood is vitally important to the patient in her cutting. She experiences it as clean and pure. The cleanliness of the blood ensures that she is rid of the bad stuff that has accumulated inside her. The patient is often entranced by the appearance of the blood in small red beads on the surface of the cut skin. Further, she sees the blood as a unique, incomparable red. Its uniqueness confirms the creative nature of cutting.

The patient also loves to smear the blood on her skin and to pay particular notice to the smell of it. The clean, fresh blood has a unique smell to her which is lost when the blood dries on her skin surface. The smell of fresh blood eclipses all other smells around the patient. She becomes captivated by the smell of her own blood.

The patient does not experience cutting as painful. It is felt to be sore, particularly when cutting deep, but not painful. The stomach cuts are the site of the most pain in that the patient cuts deeper there in order to draw blood. The pain however, is always tolerable in that she knows it will come to an end. Further, she never cries with pain when making deeper incisions. These deeper cuts are seen as punishing rather than pleasing cuts, with many interlaced cuts as opposed to a series of carefully-inflicted incisions. When punishing herself thus the patient does not allow

herself the pleasure of looking upon her blood.

Cutting has never been a suicidal gesture for the patient. She gets enraged when others misinterpret her cutting as suicidal and attempt to prevent her from doing it.

The patient likes the scars and turns to them for reassurance. In running her fingers over old scars she recalls the circumstances of that prior cutting and how it alleviated her felt pain and discomfort. The scars remind the patient of the satisfaction of a painter on looking upon a completed canvas. She regrets that the scars fade with time and cannot remain as memories of the pleasurable effects of cutting.

The cutting evokes a feeling described to be similar to being drugged, or alternately, to meditation. In this, all negative affective states dissipate immediately upon cutting.

The patient describes normally hating her skin and her body. The only time she purposefully touches her skin is to run her fingers over the scars. Normally her skin is ugly to her but at times of cutting she perceives it as beautiful. The patient comments that the only time she feels that she owns her skin is when she is cutting it. She normally cannot touch her skin with her naked hands and can only do so via the medium of an inanimate object such as a blade.

The patient describes her skin as very thin like ricepaper, particularly in the places she is accustomed to cutting. It is conceived of as composed of layers of thinness rather than a

thickness. It is perceived akin to a thin fabric like cotton rather than a robust fabric like wool.

The patient has little sense of, or appreciation of, the flesh beneath her skin. She thinks of herself as composed of skin and blood and a skeleton, but not of flesh. Normally she has a feeling of not being substantial in the world. When she cuts she feels much more substantial and her body is experienced as more present to her. Whilst cutting, her skin and her body feel as if they belong to her more than at any other time of her lived experience.

The patient describes cutting as an ecstatic experience. That ecstasy is like the moment before an orgasm but more exquisite and indescribable. It surpasses sex in so far as it makes her feel totally alive. Whereas in sex she has to consider her sexual partner, cutting is a purely self-satisfying experience. There is no mix-up with another in the act such as in sex. She describes it as a timeless feeling that can always be recaptured in a subsequent cutting incident. Even giving birth was not as ecstatic an experience as cutting for the patient.

Protocol Two: Clinical situated structure

Background Information

The patient was recruited whilst an in-patient at Tara, The H. Moross Centre where she had been admitted following a para-suicidal overdose. The interview was conducted after her discharge whilst she was attending out-patient psychotherapy at Tara, The H. Moross Centre. It was her

first psychiatric hospitalization. The patient grew up in a coastal town. When she was two, her mother absconded with a lover to Canada without warning or preparation. The patient remembers finding a chocolate bar and a two Rand note on her pillow as a farewell gift from her mother. She never heard from her mother again. Her father was an alcoholic who left the children in the care of his parents and found work in another town. He visited and stayed for periods of time erraticly, usually when he was in the throes of an alcoholic binge. The grandparents were extremely strict and controlling and reportedly never missed an opportunity to tell the patient that her mother was a 'whore'. Throughout her latency and adolescent years they kept an extremely tight rein on the patient. She did not recount any sexual abuse during her childhood. Her psychotherapist noted in her clinical intake notes that this seemed to be an area of extreme anxiety for the patient. The therapist entertained the hypothesis that parts of her relationship with her grandfather may have been repressed.

Interview Data

The patient commenced self-mutilatory cutting at age 17. Her first cutting incident occurred soon after moving away from her grandparents home into a flat on her own. She was sitting with friends and was overcome by a deep sense of loneliness. She is unable to articulate exactly what the prodromal precipitants to cutting are other than a diffusely-felt mounting affective state that she describes as "anxiousness". This anxiety is felt bodily and is felt to lie outside of her control. It is felt as being on edge. The edginess builds up without warning, and rapidly. The patient then believes that the only way open to her to relieve this feeling is to cut her skin. She knows, from

past experience, that cutting will bring an instantaneous relief from the bodily discomfort she feels.

The build-up of edgy anxiousness and the desire to cut are unpremeditated. Both well up rapidly. Once the desire to cut wells up nothing else will suffice as a palliative and the patient's whole consciousness narrows down to thinking of cutting. The build-up is further described as if her feelings are jumping around inside of her and are all jumbled up and intermingled with each other in a state of disorder. She feels that she wants to escape the escalation of this jumbling-up of affects. Then she begins to feel that the jumbling-up is going to escalate to a point where she will literally burst unless she cuts and empties herself of this internal imminent crescendo.

The patient notes that the build-up to the cutting is preceded by feeling hurt, of hurting emotionally, in some unarticulated and ill-defined way. She knows that cutting will remove her from that hurtfulness and render her invulnerable to any further hurting.

The cutting itself is not painful, despite the patient sometimes cutting frantically and almost hacking away at her skin. It is felt to be like a light scraping over the surface of the skin or, in cases of extreme cutting, a dull sensation not described as painful. It is only later that a sensation of pain emerges in relation to the severed skin.

The cutting brings an instantaneous relief, described as "tranquillizing", which is felt throughout the body. She also feels "warm" after cutting. The total emotional release is also felt to be

exhausting such that immediately after cutting the patient describes being in a state where nothing could touch or rouse her emotionally.

She describes this state as one wherein anything that has emotionally hurt her previously is now neutralized in that she cannot be touched by it. She feels out of reach of those hurtful influences. On one occasion the patient felt guilty as she emerged from this state in that she fantasized that if her grandmother (who had brought her up from age two and had been her primary caretaker) was lying bleeding profusely at her feet, she would be neither moved by that nor would she take any action. Such is the degree of removedness she feels immediately after cutting.

The immediate feeling after cutting is also described by the patient as one of a becalmed emptiness, as if she were "sitting behind a glass wall at a lofty distance". That emptiness is felt from her stomach to the top of her head. There is a distinct sense of having been emptied of something by cutting and being left unburdened of those contents.

The experience of relief is also described by the patient as a state of near-euphoria. The feeling is so satisfying that the patient comments that if she could find a pill that offered up the same effect then she would undoubtedly be addicted to such a pill. Alas, she has never found any other experience that provides the same utter relief and euphoria that cutting does. The euphoria is not an excitable or agitated mental and affective state. On the contrary, it is a unique mix of deep satisfaction and euphoria; as the patient describes it, "a becalmed euphoria" wherein there is no longing, desire, arousal, or affective agitation.

This post-cutting state lasts either approximately half an hour if left uninterrupted, or else is broken if somebody intrudes on the scene. At either of those points the patient becomes aware of her surrounds and of her own self. She also then becomes aware of pain beginning to settle in around the cut(s).

The patient normally elects to cut on her arms and her inner thighs in so far as they are described as readily available. She does not feel she purposefully or unconsciously selects certain spots other than that in her state of resolution to cut, she selects the most immediately available place on her arms. She reports having cut her stomach on occasion but not with the regularity she did so to her arms. The patient also cuts her arms and legs because they can be concealed from others and their reactions.

The patient is not ashamed of her scars; the residues of her cuts. Rather, she is more troubled by others' responses to her scars when they do see them. She personally has a certain pride in her scars, feeling no shame about her cutting. However, she is not perpetually conscious of her scars and overlooks their presence most of the time.

The significance of the scars are less important to the patient than the act of cutting to attain relief. She is ambivalent about the scars in that she sometimes wishes the cutting left no scarring, but on the other hand they do serve as a reassurance for her that there is always recourse to cutting if in need of doing so.

The patient normally takes her scars for granted but does periodically find herself diverting her attention onto the scars, noticing them as ugly. They appear ugly to her when she looks upon them through the eyes of another. Her private perception is not one of disgust. Rather, she is comfortable with the scars and only hides them to avoid having to defend herself against others' reactions and associations to her scars. She notes them as traces of memory of her cutting incidents.

Only on one occasion did she feel embarrassed about a particular cut she made on her face. On that occasion she had been rejected by a male in whom she had some romantic interest. She felt terribly rejected and ugly. She then, in a state of self-loathing, made a deep incision into her face that required suturing. This scared her a lot and she had a lot of difficulty accepting that she had cut her own face. She could not articulate exactly why, but she claims retrospectively that her face is not a negotiable territory for cutting. She felt so ashamed of the facial cut that when she went to the hospital for stitches she fabricated a story about having been mugged. She persisted with that story, and believed it herself, right up to her admission to Tara.

The patient notes that the scar on her face is far too exposing and that it leaves her little room to reveal or conceal it. As such, she is out of control of other people's access to that scar.

The blood that emerges from the cutting is important in so far as relief is felt the moment the blood oozes up to the surface of the skin. The moment the patient sees the blood she feels the onset of euphoric calmness. In addition, the blood also features in the experience in so far as it

is also the feeling of the blood presencing at the skin surface that is implicated in the relief.

To a much lesser extent the smell of the blood is an element of the cutting that the patient registers as part of the satisfaction. Nevertheless, it is predominantly the sight of the blood that reassures the patient that the cut has been effected and that ushers in the relaxation of prior tension.

Most noteworthy is the absolute immediacy of the change from a state of anxious agitation to utter becalmedness the moment the cut is effected and the blood is seen. Sometimes, when the agitation is particularly intense, it will take several attempted incisions before the state of calm is attained.

The patient is angered if her cutting experience is intruded on by another. She feels she has a right to do it and is angered by others' misinterpretation of the cutting as an attempt to end her life. She does not see it as a sign of pathology or a weakness, as it is labelled by others. On the contrary, she sees it as a very effective way of inviting a unique state of body and mind. In this regard, she dislikes having to go for stitches intensely in that it involves the hospital staff and their critical opinions. The stitches represent the wrongness of the act to her and tend to make her feel guilty about the cutting. Thus, she pulls the stitches out of the cuts because that returns her to being in control of the cutting.

The patient states emphatically that the cuts have to be self-inflicted. Were somebody else to

inflict the cuts she would feel out of control and they would consequently be both painful and not satisfying. For somebody else to be implicated in the cutting would spoil the enjoyment of the cutting.

The patient is unable to articulate why she specifically cuts her skin but does say that the emptying process occurs via the incision in the skin and the blood which seeps out of that cut. She describes the cut as a form of aperture into the body that allows that which is building up inside her to escape. The emptying occurs via the bleeding. Whatever is inside comes out with the blood. When particularly agitated, she makes more and deeper incisions so as to hasten the process. In this sense the blood is cleansing to the patient.

For these aforementioned reasons of letting the "bad stuff" out it is very important to the patient that she make the cutting an effective exercise. Thus, she prefers to always have razor blades at hand that can make clean, precise, surgical incisions. The purpose is not to angrily damage herself but to execute an emptying as swiftly and efficiently as possible.

In cutting, the patient is pleased when the skin slices open easily. She is aware of how thin her skin is, particularly where there is scarring over of prior cuts. She is pleased when her skin yields easily to the blade and "falls apart" so readily rather than resisting her efforts. She recalls an incident where she used a blunt blade and had difficulty in making the incisions.

Cutting protects the patient from the cumulative effects of a hurtful or series of hurtful

experiences. She describes this as the cutting helping her traverse a boundary. Once on the other side she is protected and invulnerable to the continuation of hurt. It is an escape from the hurts that she has hitherto been unable to stop or defend herself against. Once she has cut it is as if she has thrown a cordon around herself that cannot be permeated or traversed by the hurtful other.

Another feature of the cutting is that the patient gains pleasure from the feel of the metal blade against her skin. Unlike a broken bottle, a metal blade is surgical, cold, effective. The sensory surface of the metal blade is a reassuring one.

Protocol Three : Clinical Situated Structure

Background Information

The patient was referred to the study by a colleague of the researcher who had been her psychotherapist during an admission to Tara, The H. Moross Centre the previous year. The patient comes from an upper-middle class home. There is a history of unspecified ongoing sexual abuse at the hands of her grandfather.

Interview Data

The patient commenced by describing a specific incident of cutting that stands out in her memory. It was a full moon and she was in a very emotional state in which she fantasized being a Sioux Indian. She accordingly went up to the top of a koppie with her horse and made incisions into her face. She had a feeling that no-one had initiated her into life or given her any life direction. She was alone with her animals but felt alienated in that she could not share her experience of being human with them. She desired some kind of human contact. The following day she went to the races with her grandmother and sat at the chairman's table with her facial markings. She had a strong desire to stay that way forever and was impervious to others' reactions at the table.

The patient recollects having a preoccupation with her own blood from as early as age five. She cannot explain it rationally but she gets a tremendous reassurance of being physically alive from her blood. She states that to draw blood is the only way of reassuring herself of her tangible being when she gets to feel either very emotional or removed. She describes a vague feeling that something is missing from her and the only thing that can substitute for that undefinable absence is her blood.

The patient experiences her own blood as clean, fresh, and uncontaminated. It also has a life of its own. She describes it as a miracle. Part of the "sacredness" for the patient is the fluidity of the blood that momentarily defies solidification when it comes out into the external world.

The patient gets to feel surrounded by others' indifference to life. She sees nature as full of miracles and finds that her cutting reminds her of the miracle of human life. She sees the blood as a bridge between humanity and nature. The blood reminds her that there is something special in being human.

The taste of blood is also an important ingredient in the patient's cutting. It tastes similarly clean and unique in a way that the patient has difficulty putting into words.

In similar vein the smell of the blood features prominently in the patient's cutting experience. It is a unique musty smell that she pictures as a mixture of a wild horse's blood and a deep forest soil smell. She experiences it as a unique essence.

The patient comments that her intellect and rational faculties are powerless in the face of the sight and smell of her own blood. The combination of the feel, taste, and smell is described as spiritual in a way that bypasses intellectuality.

Once she attempted to share her experience with her aunt by offering her a glass of blood. Her aunt's revulsion confirmed for her the solitary nature of the experience.

The patient can only enjoy the experience of cutting and of her blood when she is alone. There are no words or explanation for the experience of cutting. The cutting takes away all self-

consciousness and takes her into a completely internal experience that cannot be shared with another.

She is unconcerned about harming her skin in that she does not see it as something living. She experiences her skin as a cloth that restrains something. Without scars her skin is inconsequential to her. In fact she was upset when a drawing of a horse she etched into her skin disappeared approximately a year later.

The scars are described as being like "friends". They remind her of the peace of being with herself. She becomes preoccupied with the healing process of the scar, equating it with a process of artistic creation. The scars are also mementos of her life experiences and there is no danger of ever losing them. She has a total reassuring guarantee that they are there and they are a memory of her lived experiences.

Pleasure is not attainable for the patient without pain. If there is no pain imbedded in it then it feels to her like it is not happening. Deep cutting does not bring her closer to herself whereas smaller, precise incisions in the skin bring her closer to her own feelings. The patient describes how the intermingling of pain with pleasure gives her a feeling of being on edge which is neither sexual nor sensual in pleasure.

The being on edge is a very delicate balance that can only be attained by cutting herself. It is described as a kind of peak experience that cannot be attained in relation to another person.

Indeed, the privacy makes it a more extreme experience.

Cutting is described as a creative act. There is a sense in the bleeding of flowing from one form into another. Unlike other creative acts, cutting and bleeding has smell and taste that give it a much deeper dimensionality than writing or sculpting.

The skin of animals and humans are described as containing of a whole living world. She equates cutting to an experience of watching a foal being born. The similarity lies in the absolute newness of the birth, the freshness of the blood, and the untarnished nature of something newly-born.

The patient describes the cutting as changing her in that it takes away the irrational, the loneliness, which is felt to be too overwhelming for her to contemplate. The cutting is like pulling a plug that releases a knot of confusion and ill-defined emotions. She says it takes care of a subjective sense of being physically scattered. When feeling that way it is as if her whole body is confused and distorted and her soul is flipping out all over the place. The cutting redresses this sense of disjointedness and brings her back together again. The pain on cutting automatically brings her back into her body and her mind becomes clear. Then she feels cool and collected and can think calmly about what it is that is missing that broke her into so many little pieces.

The patient reflects upon a recent cutting experience where she became aware that she was

ashamed of being a caring and sensitive person and that she needs to take responsibility for that. She became aware that she had been denying that she is caring, and that the more she did so the more her anger would mount and the more she would have to hurt herself. She comments that if she had not cut she would not have reached this awareness.

Cutting alerted her to the fact that she harboured little respect for herself and for other humans, but had harboured an intense respect for life. She was not motivated to care for individuals as individuals. Further, she professes to have battled to express herself femininely with others, adopting a masculine approach for her protection. The cutting and bleeding puts her more fully in touch with the feminine dimension of herself.

Masculine cutting is associated with killing but her cutting is a form of creating and bringing together. It gives a sense of renewal and beginning. When depressed the cutting reawakens a passion for life.

The patient is also bulimic and the cutting, she claims, accomplishes what the bulimia attempts to do. Bulimia is only a release and is felt to be destructive. Cutting, however, is done with more passion, for the love of it, and is not essentially destructive as is the bulimia.

The cutting reconfirms for the patient that she is a vital human with blood coursing through her body. It does not allow her to take her body for granted nor to be forgetful of the fact that she is a flesh and blood human being.

Protocol Four : Clinical situated structure

Background Information

The patient was recruited for the study whilst an in-patient in the Adult Psychotherapy Unit at Tara, The H. Moross Centre. She was admitted to Tara following an overdose of Ritalin tablets. She was 22 years of age at time of admission and 23 at time of the current interview. It was her first psychiatric hospitalization. The interview was conducted post-discharge. The patient was receiving out-patient psychotherapy. The patient had a history of self-multilatory cutting from age 18. She was inappropriately diagnosed as suffering from Gilles De Tourette's Syndrome and placed on heavy dosages of Ritalin and minor tranquillizers. On admission to Tara she was taken off all medication and given a tentative diagnosis of Borderline Personality Disorder.

Her developmental history reveals some salient information. Her father was an academic and her mother an artist. She herself has artistic talents. From age four to twelve her considerably older cousins sexually abused her. There was no forced intercourse and the predominant mode was to fondle her and to simulate sexual intercourse between her buttocks. She was also forced to engage in fellatio and to observe her cousins masturbate to the stimulus of her body. This occurred secretly in her parental home.

At age five the patient's mother had a severe accident in which she suffered third degree burns to her face, arms, and upper body. She spent two years in hospital (according to the patient's

recall) with her face, hands, arms, and chest swathed in bandages. Even on her return home she kept herself covered in bandages for at least an another year. The result was that the patient could never look upon her mother's face, nor offer or receive physical comfort from her during this time. She describes having forgotten what her mother actually looked like. Even after her recuperation period, the patient's mother, whom had previously been a flawlessly beautiful woman, was so ashamed of her terrible disfigurement that she would turn away from her children and husband and never look at them directly.

She also resorted to covering her face with scarves and shawls. Reportedly, she could never look at herself in a mirror for several years thereafter. The patient recalls that when her mother did eventually look upon her own reflection she wept bitterly and lapsed into a period of profound depression. It is noteworthy that the patient was described by the ward staff as an extremely beautiful young woman with a particularly clear, unblemished skin. In her matriculation year in Stellenbosch the patient was chosen as the local beauty queen.

Interview Data

The patient recalled an incident of cutting before which there had been no cutting for approximately a year. She had moved from her parents' home to another city to study and had moved into a flat. She was alone in the flat, sewing (the course she was studying), and had drunk a few glasses of wine, when she became aware of herself descending into a state of depression. She suddenly scratched her arm with a sewing needle and saw blood come out. That stimulated

her to cut more. Her boyfriend then entered and attempted to stop her. She locked herself in the bathroom and made several moderately deep incisions in her arm.

The prodromal depression to the cutting was accompanied by a feeling of floating rather than sadness. On another occasion she felt profoundly depressed and cut deeply into her neck. In this instance it was not a suicide attempt.

The blood had an immediate effect on the patient. She experienced it as warm and dark, akin, she describes, to a baby getting a warm bottle of milk. The more it came out the more she wanted to empty herself of her blood. The more her blood was coming out, the more her life was coming out and the closer she felt herself to be losing her life.

The patient notes that as the blood seeped out it was also a seeping out of her hurt and anger. The cutting was emptying her of these emotions.

Prior to cutting she had a sense of tension building-up. The moment she cut the tension dissipated and she felt calm and assured that everything would be fine from then on.

The patient lets her blood drip and watches it drip from the cut onto a hard, impersonal surface such as the bath. She equates the reassurance derived from cutting with that of a small child who gets reassuring hugs from her mother after hurting herself.

The patient has always been worried about the scarring in that she did not want to inflict a big, obvious scar. However, when depressed she will often attend to her scars and that will provide her with a memory of how the cutting had previously reassured her. This will give the patient a sense of warm, reassuring comfort.

The cutting provides the patient with a sense of personal achievement. It is something she does for herself and does well. It makes her feel free in that if she is unable to accomplish anything else, she has recourse to cutting at any time without anybody else being able to prevent her.

The patient also cut in the incident described as a message to others that she was serious about being unhappy and that the cut was not just a fabrication. It was clear, tangible evidence of her felt sense of unhappiness.

The scars provide a sense of satisfaction for the patient. Prior to scarring her skin was unblemished like a baby's buttocks - beautiful. When she cut her skin open and the blood popped out she had a deep sense of satisfaction. A satisfaction at being able to get through the skin, and to penetrate that surface to access the veins, where she perceives all the problems to be located.

Cutting the skin is annoying if it does not yield easily. Once the skin is open she has the desire to go deeper and deeper. The smell of the blood incites her to cut further. She equates the feeling with dogs going crazy at the smell of blood. She enters a state of intense excitement that compels her to cut until she has got sufficient blood out.

Afterwards she is extremely calm. On one occasion her boyfriend intervened and prevented her from finishing. The moment he dropped his guard she continued cutting. It was only when the blood dripped through the makeshift bandage onto her shoes that she felt better and calmly awaited his return to take her to hospital for stitches.

The patient does not feel much pain on cutting. The only pain feels like an injection needle piercing her skin. Once through the skin there is no pain. It is never painful, as when stepping on a piece of glass, because there is no shock. The only pain on cutting is a brief burning at the beginning.

Rather than pain there is a feeling of all-enveloping numbness. It is experienced as being inside a cocoon that protects her from sound, heat or cold, and other sensory experiences.

The desire to cut is experienced as an all-consuming urge that has to be satisfied. The patient becomes increasingly tense and single-minded in her intent until she can consummate the act of cutting.

The patient has to cut deep enough to have stitches in the cut. In getting stitches she feels comforted. She has a tangible wound and she feels that if there was no tangible wound she would not elicit comfort from others.

The patient has only cried once during cutting. Normally, she has to drum up courage to cut, usually facilitated by drinking alcohol. Without alcohol she anticipates more pain and less motivation to go ahead with the act of cutting.

Compared with menstrual blood, the blood from self-mutilation is clean. Menstrual blood is not under her control but cutting means that she is completely in control as to when and how much blood appears. It is under her volition.

The patient describes cutting as an attempt to get away from the loneliness of not being understood for her hurting and her fear of life. These feelings cannot be shared with others so cutting becomes a way of escaping the painfulness of these feelings.

Central Themes

Protocol One: Central themes expressed more directly in terms of self-mutilatory cutting.

1) P is aware of an upwelling of intense emotional turmoil as in one occasion when returning from her mother's house. The emotions felt then were anger, hurt, and badness following an altercation with her mother.

2) This knot of negative emotions accumulates over a period of time to a point where P feels she is filled with them and her body will literally explode unless relief is sought.

3) P experiences the negative emotional mix-up inside herself as emanating from her interactions with others. She feels passive and unable to say no to their saying or doing hurtful things to her. She experiences herself as unable to protect or defend herself from "taking-in" such hurtful, painful experiences. She feels her only option is to stoically and passively absorb all the negativity from others. This results in a feeling of being stuffed to bursting-point with "bad stuff".

4) P sees cutting her skin and drawing blood as the only relief and release from the overflowing feeling. She feels that all the negative emotionality escapes via the incision made into the skin. It is all carried from her interior to the exterior by the blood which oozes from the wound(s).

5) P feels that the wound is more than an incision into her body. Rather, the wound is experienced as an opening up of her whole being, her total selfhood, and a ridding of noxious emotions.

6) P equates the accumulation of negative emotions with the running of a bath. It will overflow unless the plug is pulled. Cutting is her equivalent of pulling the plug and allowing all the unwanted contents to swirl away and leave her replete. Or alternatively it is the equivalent to the squeezing of a saturated sponge.

7) P never experiences cutting as painful. It is temporarily sore but not painful. Sometimes she cuts deeply to punish herself. These cuts are more sore.

8) Cutting has never been a suicidal gesture. P gets enraged when it is misunderstood as such.

9) P only cuts when alone, becoming rageful if intruded on or if attempt is made to stop her completing her cutting experience. Done alone, cutting provides P with a sense of personal mastery. The cuts are felt to be perfect creations that cannot be spoiled or sullied by another. Cutting is immensely satisfying in that it is entirely self-done.

10) Cutting provides P with a deep sense of relief which she describes as ecstatic. P struggles to put that experience into words, commenting on its indescribability. P notes it to be like the moment before an orgasm but more exquisite. It surpasses sex in so far as it makes her feel totally alive. It is felt to be a timeless feeling with no beginning and no end. The purely self-satisfying nature of cutting sets it apart from any experience that implicates another. Cutting is for her, whereas in sex she has to consider the sexual partner.

11) P feels more substantial and alive in her body with cutting. It is the one time when P feels she owns her skin and her body. Normally she experiences her body in an amorphous way. Also, P hates her body, never purposefully touches it, and looks upon her skin as ugly. In cutting she both touches her body and looks upon her skin, her body, and its contents of blood as beautiful.

12) The blood is crucial to cutting for P. It is experienced as pure, clean, new, uncontaminated, and unique in its coloration. P is entranced by the beads of blood that appear on the skin surface after making an incision. The cleanness of the blood also reassures P that all the negative

emotionality has escaped from the interior to the exterior.

13) P pays particular notice to the unique smell of the blood. The smell contributes considerably to the ecstasy experienced at cutting.

14) P hates her skin and avoids looking at herself in the mirror. The only time she intentionally touches her skin is to cut with a blade or in running her fingers over her scars. In cutting, P perceives of her skin as beautiful, it being the only time that she feels she owns her skin and that it is truly part of her. Cutting becomes like a mirror for P. It is the one time that she can look at herself with satisfaction and enjoyment.

15) P experiences her skin as extremely thin, like ricepaper. It is composited of layers of thinness that can easily be sliced open. She equates her skin with a thin fabric like delicate cotton rather than a robust woollen fabric.

16) P feels drugged and/or in a state of deep meditation immediately after cutting.

17) P rubs her fingers over her scars for reassurance that she can always resort to cutting if feeling distressed.

Protocol Two: Central themes expressed more directly in terms of self-mutilatory cutting.

1) P is aware of an unexpected build-up of anxiousness described as being on edge. It is felt diffusely throughout the body.

2) P notes the build-up usually follows in the wake of feeling hurt by another or feeling isolated whilst in the company of others.

3) P feels that the anxiousness will build to a point where she will literally burst. She feels the urge to flee and escape the felt experience of edginess.

4) P knows she can gain immediate relief from the edginess by cutting her skin and drawing blood.

5) P is unable to put the experience of edginess into words nor fully articulate the precipitant experiences in any detail.

6) P becomes very resolute in her desire to cut, perceiving it to be the only way to alleviate the felt discomfort. Her only mental imagery at that point is her telling herself repeatedly that she must find a way to cut.

7) P removes herself from company as her cutting must be done alone. She normally cuts into

her forearms with a razor blade, although she has cut her stomach and her inner thighs with less frequency.

8) The moment the incision is made and blood wells up at the surface of her skin P is overwhelmed with a deep sense of relief. The relief is felt all the way from her stomach to the top of her head.

9) The relief is experienced as being drugged, as a profoundly becalmed euphoria, and as a sense of being tranquillized. She also feels a warmth envelop her whole body.

10) The relief also entails a feeling of being removed and invulnerable to any further hurt. She feels protected as if behind a glass wall.

11) Immediately after cutting P feels emotionally unmoved and untouchable. This experience lasts approximately thirty minutes if uninterrupted. Any interruption angers her in that it takes away the ecstasy and the pleasure of cutting and introduces an element of moral judgment.

12) It is important for P to draw blood. She has a sense that the cut is an opening for the 'jumbled-upness' that is building up inside to escape and to seep out with the blood. In this sense the blood is cleansing.

13) The blood is also experienced as emptying in that all the jumbled-up stuff is allowed to

escape and she is left with a sense of peaceful emptiness.

14) P is aware of her skin being wafer-thin and gains satisfaction at seeing it slice open easily under the blade. It is gratifying when the skin yields under the pressure of the metal blade.

15) P feels ambivalent about the residual scarring. She accepts her scars and is reminded of the reassuring availability of cutting by her scars. However, she does conceal them to avoid others' reactions to her scars.

16) P gets angered when others try to stop her cutting or when they misinterpret her cutting as a suicidal action or intent. She resents their misunderstanding of the pleasure cutting entails and of what she experiences as the enlivening nature of cutting.

17) P describes the cutting as a crossing of a boundary. She describes taking accumulated hurts to a point where she feels she will burst from them. She then cuts to place all those hurts outside herself and to cross an imaginary boundary. Behind that boundary she cannot be hurt either emotionally or physically.

18) P describes never being able to substitute the experience of cutting with any other action or activity. She notes that if there were a pill that produced an equivalent effect she would be addicted to it.

19) P notes that she goes through cycles of cutting approximately every two years.

20) P once angrily cut her face after a rejection from a romantic interest. She was filled with self-loathing at the time.

Protocol Three : Central themes expressed more directly in terms of self-mutilatory cutting.

1) P is aware of a diffuse, intense emotionality, prodromal to her cutting herself. P recalls a significant cutting event where she had felt uninitiated into life. She felt alienated from shared human experience and strongly desired a form of shared human contact. She accordingly made incisions into her face reminiscent of the Sioux Indians.

2) P describes a vague sense of something being missing from her existence. She cannot articulate a form or definition to that thing. She just feels removed, intangible, or very emotional, as if she is scattered all over the place. She is unable to explain it rationally but, when in such a state, she gets tremendous reassurance of being a tangible physical being from cutting and experiencing her blood intersensorially.

3) When feeling physically scattered, P feels as if her whole body is confused and distorted and as if her soul is flipping out all over the place.

4) P describes blood as the only substitute for her vague feeling of missing something. Blood

is the only substitute for the indefinable absence she feels.

5) Since age five P has been fascinated with her blood, although she only commenced cutting at age 16.

6) P gets to feel surrounded and troubled by others' indifference to life. She observes nature as full of miracles and finds that cutting and drawing blood confirms for her that human life is also a miracle. Blood is described as a bridge between humanity and nature, in that it reconfirms for P that there is something special in being human. Cutting reconfirms for P that she is a vital human with blood coursing through her body, thus not allowing her to take her body for granted nor be forgetful of the fact that she is a flesh and blood human being.

7) P describes cutting as transforming the irrational loneliness which feels too overwhelming to contemplate. It takes care of the subjective sense of feeling physically scattered. Cutting redresses the sense of disjointedness and brings her back together again. The pain on cutting immediately brings her back into her body and her mind becomes clear. Then she becomes collected and is able to think calmly about what it is that is missing that has evoked a subjective sense of being broken into so many little pieces.

8) Cutting is also described by P as akin to pulling a plug in a fast-filling bath, pulling a plug on an accumulation of confusion and ill-defined emotions. She feels emptied of these diffuse, uncomfortable feelings by cutting.

9) For P there are no words to explain the experience of cutting. It takes away all self-consciousness and takes her into a completely private, internal experience unshareable by others.

10) Blood is a central feature of P's cutting. Blood is experienced as clean, fresh, and uncontaminated. It flows with a life of its own, its fluidity defying solidification on its contact with the external world. The uncontaminated nature of blood revives a passion for life in P when she feels depressed and disoriented.

11) Other aspects of the blood that feature in the cutting experience for P are the taste and the smell of the blood. Blood tastes clean. In addition, P describes it as having a unique taste that is incomparable and which she cannot put into words.

12) The smell is described as uniquely musty. It is an admixture of a wild horse's blood and a deep forest soil. P describes it as a unique essence.

13) In the face of the sight and smell of her own blood, P's intellect and rational faculties are powerless. The combined sensory experience of the feel, taste, and smell, is experienced as spiritual in a way that bypasses intellectuality.

14) P does not concern herself with the damage inflicted on her skin in cutting. Skin is merely a restraining cloth that, when cut, releases her essential blood and the knot of confused feelings. Skin is seen as containing a whole living world beneath its surface.

15) Scars residual to cutting give some meaning to P's skin. The scars are comforting memories of the peace that cutting brings to her. They are like reassuring, reliable friends to P. They are a reassuring memory of her lived experiences that are not lost forever. P was deeply upset when a drawing of a horse she had etched into her thigh disappeared after approximately a year. She felt the experience of pleasure she attained in that etching was similarly erased with the fading of the markings.

16) The healing of the scars is important for P. She monitors the regenerative nature of the skin tissue and perceives it to be a creative act.

17) The pleasure attained from cutting is only attainable by virtue of it being intermingled with pain. It is important that it be just the right amount of pain and must not obliterate the pleasurable edge. Deep cutting into the flesh is experienced as dulling whereas smaller, sharper incisions in the skin bring P closer to herself, her sense of her body, and her feelings.

18) The juxtaposition of the correct quantities of pain and pleasure provides P with an exhilarating feeling of being on edge. This is neither sexual nor sensual. It is a delicate balance attainable only through cutting and in no other way, nor in relation to another person. Thus, sexual pleasure could not supplant the experience of cutting alone.

19) Cutting is experienced as creative. It provides a sense of transmuting from one form into another, of a fluidity to the self. Because of the implication of the taste and smell of blood,

cutting provides a much deeper dimensionality than other creative endeavours such as painting, writing, or sculpting.

20) Cutting helps P recollect what is missing from her. She recently became aware of her shame of being a caring, sensitive person. Though she had an intense interest in life she excluded humans from this care. She adopted a masculine approach in relation to others for her own protection, eschewing her femininity. The cutting and bleeding puts her more in touch with her femininity.

21) Whilst masculine cutting is equated with killing, P considers her form of delicate cutting as having feminine qualities of renewal, beginning, and creation.

22) P is also bulimic. This she considers a destructive release. Cutting, however, is passionate and done for the love of it. It is uplifting, unlike bulimia which is experienced as degrading.

Protocol Four : Central themes expressed more directly in terms of self-mutilatory cutting.

1) P experiences a mounting prodromal depression prior to cutting. The depression is accompanied by a feeling of floating rather than sadness. This is also accompanied by a build-up of diffuse tension. On one occasion when she cut almost suicidally into her neck it was preceded by a profound depressive mood.

2) The immediate moment that P cuts she feels the tension and depression dissipate and she is left with a deep sense of becalmed satisfaction.

3) The sight and smell of the blood seeping up out of the wound has an immediate effect upon P. She experiences it as reassuring in its strong smell, its dark colour, and its warmth on the surface of her skin. P equates the reassurance of the blood with the reassurance a small child receives from a mother's hugs after hurting herself.

4) Cutting provides P with a sense of personal accomplishment. It liberates her in that it is an accomplishment that is arrived at without eliciting the assistance of another, or that is inhibited by the actions of another.

5) Cutting also leads to an emptying out of troublesome emotions such as anger and hurt that are implicated in the depressive mood that is prodromal to cutting.

6) P is worried about scarring badly and of this becoming obvious to others. However, her scars serve as reassuring memories of how cutting provided prior satisfaction and calm. She resorts to looking at and touching her scars in times of emotional discomfort, in order to revive a semblance of the satisfaction that cutting those cuts provided. In addition, the scars remind P that she still has the courage to cut should she feel the urge to do so.

7) Her scarred skin reminds P that she can transcend pain and get to the painful emotions

perceived to be imbedded beneath her skin in the veins and arteries.

8) Cutting also serves as a communication to others to take seriously her complaint of feeling unhappy seriously. P sees the visible wound to be evidence of her distress and hopes that others will be less dismissive of the wound than of her verbal communication of distress.

9) Cutting does not invoke much pain for P. She equates it with an injection needle piercing the skin. Once the skin barrier is traversed there is no pain. Rather than pain, there is a feeling of an all-enveloping cocoon that insulates her from outside stimuli such as thermal variations and sounds. This she describes as an all-encompassing numbness.

10) P has to cut deep enough to need stitches. In needing to be taken to hospital and receive stitches she feels both comforted and taken seriously. There is a substantial and tangible wound that cannot be overlooked by concerned others.

11) Compared with menstrual blood, the self-mutilatory blood is clean and makes it appearance due to P's actions. It is under her control and volition.

12) Cutting is an attempt to escape feeling lonely and misunderstood. P feels scared of life and death and does not feel she can share these anxieties with anybody, even those who have been close to her. Cutting is thus a temporary escape from the panic and anxiety that thoughts about living evoke in her.

Extended Description

The self-mutilator is aware of a rapidly-escalating build-up of tension and discomfort felt diffusely throughout the body. This state of bodiliness is experienced variously as anxiousness, being on edge, being scattered into bits, floating and a knot of negative emotionality. This sense of embodied distress gathers momentum to the point where the self-mutilator entertains the fantasy that she is going to burst from the accumulation of this distressed emotionality inside of her.

The build-up of this distressed bodily felt-sense happens rapidly and unexpectedly although it usually occurs in the wake of an experience or series of experiences of feeling hurt, rejected, misunderstood by another, or alienated and disconnected in the presence of others. The self-mutilator feels unable to protect herself from the intrusion of such hurtful experiences, feeling them to lodge in her very bodily being.

She accordingly perceives the only relief from this distressed felt-sense is to cut incisions into her body so as to allow the accumulating "bad stuff" to seep out through the wound(s). This perceived solution comes to dominate her consciousness such that she feels compelled to cut at all costs, irrespective of where she is. She feels nothing else will alleviate the feeling of emotional "jumbled-upness".

Under these circumstances her preoccupation with cutting is so intense she will do everything

possible to remove herself from company and seek the most available means of cutting herself. The cutting must be conducted alone, uninterrupted by others' misperceptions of it as suicidal, misguided, and distasteful. The presence of another is perceived as a similar intrusion into the very privacy of her self.

Cutting is preferably executed with a sharp razor blade so as to effectively inflict a series of precise cuts into the forearms or thighs. When excessively angry the self-mutilator may make deeper, more disorganized cuts into other body parts such as the stomach, neck, and unusually, the face.

The moment the blood wells up to the surface of the wound(s) the patient is characteristically flooded by a unique sense of utter relief from the previous felt-sense of emotional turmoil. She feels variously a becalmed euphoria, tranquillized, uniquely ecstatic and exhausted with relief.

The 'bad stuff' that has built-up is felt to flow out through the wound(s) and empty the mutilator much like the squeezing of a saturated sponge or the plug being pulled on a rapidly-filling bath. The emptying effect, the attainment of peaceful emptiness, is immediately felt although it is appreciated that all the bad stuff cannot ever totally escape via the self-inflicted wound(s), no matter how many or how deep.

The blood cleanses in so far as it carries the bad stuff with it from the interior of the self, across the boundary of the skin, to the exterior of the self. In flowing and dripping the blood ensures

this noxious stuff is exteriorized.

In the relief, the self-mutilator feels 'untouchable' by all actual and potential sources of hurt. She feels removed, safely encased in a cocoon, impenetrable to any hurtful interpersonal influence or intention. She feels she can be in a world of people (mitwelt) but invulnerable for a while to their hurtful intrusions.

The blood is crucial to her cutting. It is experienced as pure, clean, uncontaminated, and uniquely coloured such that it reassures her of the spilling of the negative emotionality. The uncontaminated nature of the blood revives a passion for life in the self-mutilator when she feels depressed, disembodied, and scattered. She feels the sight, smell, and taste of the blood recollects a sense of her bodiliness from a prior sense of being scattered and lacking.

Another feature of the blood that is integrally linked to the cutting is the smell. It has a unique musty smell that is unlike anything else. The smell is experienced as soothing and adds to the ecstatic response.

The blood from cutting is completely different to menstrual blood. The latter is perceived to be dirty, uncontrollable, and unwelcome. It is not self-made.

The self-mutilator experiences cutting as a felt-sense that is indescribable in that words and intellect cannot capture the essential nature of the experience. It is a timeless ecstasy that has no

equivalent in her experience and thus she cannot capture and convey the subjective experience with words or images. It constitutes an embodied pre-reflective experience that escapes languaged description.

The ecstatic exhilaration of cutting is different to any sexual experience. Indeed, the self-mutilator feels it to be a sense of self that is unattainable through any other form of human activity.

Cutting is the only time the mutilator has a positive experience of her body; a body she normally loathes, refuses to touch, or look at in a mirror. Normally she feels half-alive in her disowned and hated body. Cutting is the one time she feels alive in her body, aware of her physical humanness, and able to look upon her skin and body as beautiful. It is a time when she can feel substantially alive within her body.

Cutting provides a sense of personal accomplishment that does not implicate others. The cuts are experienced as an opening up of the self, of the psyche, that is not attributable to another's efforts or intrusions. At this point in time, all of the self-mutilator's experience is under her volition.

The self-mutilator is conscious of the ricepaper-like or wafer-like thinness of her skin, gaining immense satisfaction from the way she is able to slice it open effortlessly with a blade. It is seen as a restraining cloth to be pierced to release the blood contained beneath it.

She is ambivalent about the residual scarring of her skin. She hides the scars from others to ward

off their judgemental comments. Privately, they are reassuring signs of the ability to cut. They are comforting memories of the peace that cutting brings to her. In stressful times she resorts to touching them in order to evoke memories of the satisfaction experienced at previous cuttings. They are reminders of her capacity to transcend the painful emotions imbedded beneath her skin.

However, she does gain some satisfaction in her cuts and scars being noticed by others. She will, at times, cut deep enough to require sutures so that the cuts can be tangible wounds that cannot be dismissed like emotional wounds can.

She does not experience undue pain whilst cutting. Rather, it is pain intermingled with pleasure and ecstatic relief. Even the deeper slashes are accompanied by a dull pain. It is only later, when she has been roused out of the reverie that accompanies cutting, that the pain sets in.

The self-mutilator may be bulimic. The latter she considers a destructive, degrading attempt at release. Cutting, on the other hand, is passionate, an act of self-love rather than self-loathing.

General Structure

The self-mutilator finds herself embodying a distressed felt-sense in the wake of hurtful experience(s) in the *mitwelt.* This bodiliness is characterized by emotional jumbled-upness, edginess, feeling scattered, and as if a part of the self is missing. It feels as if others in the mitwelt have placed this distressing 'stuff' into her and that it is accumulating to a point where

she feels she will literally become distended and burst.

Under the sway of this felt-sense the self-mutilator perceives the only relief to lie in cutting incisions into her skin, thereby allowing the bad stuff to flow from inside her to outside, across the boundary of her body, via the severed skin with the blood that oozes out of the wound(s). The flow of blood cleanses her of these unwanted, distressing contents, transforming her felt-sense into one of peaceful emptiness.

The cut and the flow of blood ushers in a feeling of ecstatic relief, calm euphoria, and a sense of being encased in an invulnerable, warm cocoon that renders her 'untouchable' by further potentially hurtful interpersonal experiences. Her prior defencelessness and thin-skinnedness is replaced by a protective cocoon.

The sight, the uniquely musty smell, and the warm flow of the blood on her skin recollects in the self-mutilator a sense of her vitality and humanness. In this she feels the blood is testimony to connectedness to the human lived-world and to her being possessed of a feminine sensitivity within that lived-world.

The cuts and residual scars are a testimony to others of her invisible pain that courses beneath the surface of her skin as well as a tangible reassurance to herself of her capacity to externalize and transcend that pain felt to be so deeply imbedded in her and that accumulates as a result of her defenceless interactions in the interpersonal world.

The self-mutilator's experience of her body is transformed in the act of cutting. A loathesomeness for her skin, her sexuality and her body is replaced by an appreciation of the vitality and beauty of her bodily existence. The only time she can touch her skin caringly is when cutting. She notices how delicate the skin is and how easily she can exact precise incisions into the envelope of skin that covers her. This recognition fills her with a sense of her own creative capability.

Cutting gives her a sense of personal accomplishment, of euphoric aliveness, and leaves her with a perception of mastery over any past or future emotional pain she may have encountered or anticipates encountering. She recognizes that the cutting cannot eradicate all the imbedded painfulness and thus she touches her scars for the reassurance that she can indeed transcend the build-up of distress when it does reoccur.

Chapter Eight

DISCUSSION AND CONCLUSION

The aim of this research is to address the hiatus in the literature on self-mutilation by attempting to describe, in specific detail, the self-mutilator's lived experience of cutting herself. The findings, consisting of explications of the self-mutilator's experience, are presented in the *clinical situated structures*, *central themes*, *extended description* and *general structure*. This chapter discusses these results in the light of the literature review. By way of conclusion, a model of self-mutilation which goes beyond existing formulations is presented. The limitations of this study and recommendations for further research are also discussed.

Discussion of the results

This section looks at some important theoretical and therapeutic implications which arise from the findings of this research. Using the *extended description* as a point of reference, the findings are dialogued with the literature on self-mutilation, the skin as psychic container, and other salient theoretical ideas. The discussion tracks the sequence in which self-mutilatory behaviour occurs and the existential themes around which it pivots. These themes of bodiliness, spatiality, temporality, scarring and markings, blood and bleeding, language and symbolization, and that of Mitwelt (Heidegger, 1962) are fleshed out in the following page.

Bodiliness

The four protocols are replete with diverse references to the bodily dimensions of the self-mutilation experience. All of the respondents speak of their bodily felt-sense (Gendlin, 1978) instead of referring to thoughts or fantasies entertained whilst cutting. The felt-sense is described as an out of control "edginess", a "jumbled-upness" and a "scatteredness". Importantly, the respondents all report a conviction that these feelings will escalate to a point where their physical beings will fragment or explode as a result of this accumulation. The prevailing fantasy is that the body is unable to remain a container and will literally burst its boundaries or alternatively, will fragment into pieces. In both fantasies the body will lose its coherence and integrity unless intersected by cutting. For patient number three it is a matter of:

> When I really feel out of touch and I feel very, very emotional, and sort of when I'm in a dream world and not really here and that's (cutting) the only way of kind of reassuring myself that I am physical.

Patient number three talks of passion in describing the atmosphere necessary for her cutting:

> ... I can't be in a really bad depression to do it. I have to be feeling *passionately* (my italics) upset and *passionately* (my italics) hurt ....

The link between psychopathology and passion is addressed by Jager (1991), who sees the entry into the social realm, the realm of language, of mutual mirroring, as a transformation of the depths of passion. Whilst passion is the insurrection of the flesh, of the depths, *expressive interchange* is in the world of light. In expressive interchange, the surface dominates and speaks on behalf of the depths: the face dominates the body, and the gleam of the eye rules the dictates of the flesh (Jager, 1991). But:

> In the world of passion the depth no longer remains mere support for a brilliant surface: it wells up and destroys the charming play of light, the brilliant outer covering of things and beings. The body in the heat of passion loses the finely sculptured features, the elegant gestures of the hand or the delightful reticence of a smile. All surface drowns in the upheaval of the body, in the upwelling of matter, and of flesh. Even language loses here its brilliant outer covering, the finely shaded wording, the witty puns, and clever allusions. The witty meanings and the charming gestures are overrun by the sound of breath and the heartbeat of the body. In passion, language is overcome by the body, gives in to the urgency of the flesh. From the depth, the flesh rises to shatter the world of mirrors overhead. (Jager, 1991, p. 224)

The upwelling of passion then, presents a *crisis of passage*, a movement from the logical realm to the illogical, sensory-dominated world of experience. This upwelling presents a discontinuity in lived experience. Jager argues that passion breaks the surface of language and presences in primordial, bodily ways and that all passionate upwellings are similar in so far as;

> Whenever we look in the world of passion, we find a cycle in which a thickening, a stiffening, a growing fullness and mounting pressure gives way when the term is full and the limits are touched. When that point is reached and the shore is approached, the passionate, filled body contracts and collapses in orgasm, in birth giving, in ejaculation, in outbursts of anger, in joy, in defecation, in sleep, and in death. (Jager, 1991, p.227)

Arguably, the cycle of experience described by the self-mutilators in this study could be understood as such an upwelling of passion. Most importantly, the body thickens with psychic life to the point of explosion. Patient number one describes feeling like a sponge that has reached a point of saturation and is unable to mop up anymore. The respondents generally describe being saturated with anger and hurt. However, these emotions are felt as "bad stuff" (patient number one) rather than as personal emotions. This stuff is perceived as being placed inside their bodies by others, rather than being a personal affective response. Their bodily boundaries are felt to have been crossed when the "bad stuff" was placed inside them, filling the self-mutilator's bodily container to an unbearable point.

After the cut or cuts have been effected, the self-mutilator feels her body to be alive in a way it was not before, confirming her as a substantial human presence in her aliveness. Even her skin is felt to belong to her whereas before the cutting it was experienced as an impersonal *thing*. Patient number three describes this experience thus:

> ... it firstly takes care of the ... the whole physical sense of being scattered. It focuses me so immediately there's pain ... the cutting brings everything together, because the pain has to bring me back into my body to kind of deal with it ... And then I'm fine, because then I can consider.

The other respondents also speak of the peculiar admixture of pain/pleasure which is felt upon cutting. In this sense, one may argue that the two sides of a sado-masochistic object tie or a sado-masochistic skin formation (Anzieu, 1989) are being invoked and mastered in the painful cutting. Importantly, all four respondents comment that in successfully completed cutting there is more a numbing than a painful sensation. For cutting to be effective, the self-mutilator strives for exactly the correct balance of pain/pleasure. An insufficiency or an excess of pain spoils the cutting experience.

Hillman's (1977) unbuilt psychic container is analogous to Anzieu's (1989) *flayed skin* of the borderline personality. Hillman writes that the puer's wounds reflect the *unbuilt psychic body* which is the guard and keeper of the soul. The puer structure is missing the *psychic container* which makes possible holding the moment of reflection that keeps events in, so that they can be transmuted into symbolic facts (Hillman, 1977). The self-mutilator's engagement in an action of wounding in a pre-reflective, unpremeditated manner echoes Hillman's understanding, in that self-mutilators have, in common with the puer, an unbuilt psychic container.

> Building the psychic vessel of containment, which is another way of speaking of soul-making, seems to require bleeding and leaking as its precondition. Why

> else go through that work unless we are driven by the despair of our unstoppered condition? The shift from anima-mess to anima-vessel shows in various ways: as a shift from weakness and suffering to humility and sensitivity; from bitterness and complaint to a taste for salt and blood; from focus upon the emotional pain of a wound - to its imaginal depths. (Hillman, 1977, p. 115)

Following Hillman, it could be argued that self-mutilation is an attempt to transcend puer woundedness, an attempt at soul-making, an attempt to grant wounding experience an imaginal depth. Here we must recall patient number three's commentary that in cutting and bleeding " ... you want something that is always bleeding, that isn't always contained ... ".

The act of cutting ushers in a deeply satisfying embodied felt-sense, variously described by the respondents as euphoria, ecstacy, satisfaction, druggedness, and becalmedness. These are affective states, but are so intertwined with a bodily sense of well-being and aliveness that one can speak of these feeling states as *flesh consciousness* (Merleau-Ponty, 1968) experiential states. To call these states psycho-somatic does not capture the existential fullness described by the patients. They are more aptly described by the term *ecstatic embodiment* (Aanstoos, 1991). All four patients describe this post-cutting reverie as the most absolute state of personal satisfaction they ever attain. According to the self-mutilators in this study, no interpersonal process, not even "the very best sex" (patient number one) can equate with it.

Contrary to the popular conception of self-mutilation as a form of half-hearted suicidality, the self-mutilator experiences it as an enervating, liberating and revitalizing action. The act is described as recollecting a sense of alive bodiliness which the mutilator does not normally possess. Patient number one describes it as a feeling of "being in touch with me", whilst patient number three comments that "it confirms that I am tangible". But more so, the cutting confirms her aliveness in a joyful manner which she had no appreciation of before inflicting

the cuts. Prior to cutting, the body is experienced as a flimsy container of "stuff", devoid of sensual awareness and vitality. It cannot be dwelt within with any sensual pleasure. Cutting recollects a delight in the ownership of a substantial and alive body.

A further dimension in the theme of bodiliness is the reassurance afforded by the tactile sensations of the blade against the skin and of its ability to surgically pierce the skin membrane. The autistic child is reassured by placing hard surfaces against the body, feeling these to be extensions of the body which shore up the sense of having had the body wounded (Tustin, 1986). Analogously, the self-mutilator, in addition to her cutting, appears to be soothed by the ready availability of the blade and the sensation of it touching the skin. . Patient number two speaks of a preoccupation with blades and knives even when not involved in cutting. The accessibility and reliability of the blade is very important; two respondents report becoming rageful and frantic when their blades did not cut through the skin with immediacy.

The Skin

Generally, the self-mutilator predominantly has a perception of her skin as a lifeless barrier. Rather than a protective envelope (Anzieu, 1989), an invulnerable barrier (Tustin, 1989), or a benignly permeable surface of intersubjectivity (Merleau-Ponty, 1968), the self-mutilator perceives her skin as a lifeless parchment or cloth that both marks and hinders access to her troubled interiority. Patient number one perceives her skin to be wafer-thin, like "ricepaper" and easily severed by a blade. Patient three sees her skin in a similarly removed manner:

> I don't mind harming my skin, it's ... I don't really see it as something living. It's a ... it's a kind of false sense of security. You know, it's containing something or restraining it. It's keeping a shape to something which hasn't really got a shape. You see, it's just a sort of cloth. ... I mean I'd say that afterwards, if the scar wasn't there, after cutting, that it wouldn't be important.

Whereas prior to cutting the skin is lifeless, the act of cutting relocates it as a sensitive surface of the bodily self. In cutting, patients one, two, and three report becoming aware of their skin(s) as belonging to themselves.

All four respondents pride themselves on the ease with which their skins slice open, allowing what lies underneath to be revealed and to seep out. In the act of cutting, the previously alienated skin becomes vitalized and recognized as part of the self-mutilator's living existence. As patient number one succinctly states, "when I cut it becomes my skin ... cutting is like my mirror, then I can see my skin". Similarly, patient number four recalls " ... a deep satisfaction when I ... I was able to like open the skin, get through the skin, and come to the veins where the blood is, where ... where all the problems lay".

The skin is perceived as a casing that contains the negative substances that have welled up interior to the skin surface. The skin surface has to be perforated in order to access and alleviate the distress emanating from this troubling interiority. The skin is not perceived by the respondents as a protective barrier which wards off the infiltration process, nor is it seen as a vital perimeter of the bodily self. Rather, it is experienced as an alienated casing, an impediment rather than a protective surface. For patient number one it is a matter of "Generally, my skin is nothing. I don't even think about it. I hate it.", whilst for patient number three her skin is experienced in the following way:

> I don't mind harming my skin, it's ... I don't really see it as something living. It's a ... it's a kind of false sense of security. You know, it's containing something or restraining it. It's keeping a shape to something which hasn't really got a shape. You see, it's just a sort of cloth.

This is consistent with descriptions of a *mental skin* (Bion, 1967), a perforated Skin Ego (Anzieu, 1989) and fragile *thin-skinnedness* (Rosenfeld, 1987). These terms highlight the deficit in the psychic skin to contain psychic experience, as well as to demarcate interiority from exteriority, and to facilitate an interplay between the two.

Markings

The self-mutilator has an ambivalent relationship with the scars that are left on her skin surface from cutting. She keeps them hidden from public scrutiny, fearing the curiosity and misunderstanding of others. Privately, she vacillates between indifference to, and unspoken pride in, her scarred skin. The scars serve as icons of the satisfaction and accomplishment she achieves from cutting. Examining them or running her fingers over them, particularly in times of stress, recalls the experience of cutting, reminding her of its possibility and availability. The scars are comforting memories and reminders of her ability to transcend distress and attain a deep sense of personal satisfaction. Most importantly, they are her *own* (my italics) etchings and creations; nobody else was involved in their creation.

The comments of patient number three call into question whether cutting may serve as a form of initiation into the human realm. Patient number three describes missing this initiation:

> And I just had this weird feeling that I had ... I had ... no-one was gonna initiate me and life hadn't given me the opportunity to be initiated into, and there was nothing specific where I wanted to become part of. So it had to be my animals and my natural surroundings. And it was really quite traumatic

> because I didn't ... I didn't have anything really to share with them ... I still wanted to go and ... I wanted some kind of contact as well.

This comment or perception of lacking it is important given cutting and scarification have played an important role in initiation rites and *rites de passage* in various societies and cultures (Van Gennep, 1960).

Van Gennep analyses how bodily markings denote the entry into a differentiated cultural life. Universally, the rites at puberty begin with re-enactments of birth, in which the child is removed from the protective envelope of the family and taken under the tutelage and discipline of masters. Once so marked, there is no return to the naiveté of prior existence. This separation is further celebrated by enforced markings, woundings, or mutilations which are attendant to the rituals of emancipation. These inscriptions upon the body, these decorative and healed scars, connote the replacement of maternal enclosure by entry into the life of intricate social divisions and statuses. Van Gennep (1960) suggests that it is as if these ritual inscriptions proclaim that we can only enter into the new realm of cultural life by allowing the cleavage from maternal enclosure to be represented on the skin surface of the body. These lines of cultural division are thereby transformed into a kind of writing, with the body serving as a kind of cultural text upon whose textured skin surface that cultural inscription is written.

Psychoanthropolgist Mary Douglas (1966) takes Van Gennep's view further. Her thesis is that body and culture are intricately intertwined and both refer back to one another. Consequently, the body exists within a wider matrix of meaning-making and it is as much a mirror to social process as social processes are a mirror to concerns about bodily integrity, surfaces, and boundaries. Thus, claims Douglas, we find most societies enact rituals around the orifices and the passageways from interior to exterior, as well as on the surfaces of the individual body.

Geertz (1983) endorses this in his observations of the Yoruba:

> It is not just their statues, pots, and so on that the Yoruba incise with lines: they do the same with their faces. Lines of varying depth, direction and length, sliced into their cheeks and left to scar over, serve as a means of lineage identification, personal allure and status expression. (p. 98).

Bruce Chatwin (1987), in *The Songlines,* maps the intricate web of Aboriginal ancestral trails which criss-cross Australia. These trails of heritage are identified by the different songs used in the various tribes and are located in the physiognomy of the land. In a similar vein, cultures mark the body in intricate ways in order to delineate systems of kinship. One might call these markings lines of *(s)kinship* which are etched on the surface of the individual body to denote both the distinctiveness and the interconnectedness of all other bodies.

All four respondents report making patterns of cuts on their bodies, and they equate this with creating designs or writing. Patient number three's comments capture this most lucidly:

> But the scars, they're like carrying your life experiences around on you. Whereas even if I write, if I have my book and my words and my drawings or whatever, that can be lost. I can't guarantee that they actually are where I left them.

The scars appear to serve as a form of personal bodily text for the self-mutilator; an experiential diary written on the skin which is constantly locatable. The skin/text is a reference work, or a biography of pain, which is open to revision and reauthoring through every new incident of cutting. The markings on the skin become inscriptions that bear testimony to what this author terms their *somatic narratives.* These somatic narratives are the non-verbal experiences that are etched into the bodily experience of the cutter and represented in the scars.

Nevertheless, certain critical differences exist between the personal markings of the self-mutilator and cultural markings, as commented on by Van Gennep (1960) and Douglas (1966). Whereas cultural markings are texts which are communally created and approved and serve as a public point of reference, the self-mutilator's markings are individually created as a private, rather than a public point of reference, and are culturally disapproved. Favazza (1989) suggests that

> Psychologically troubled adolescents who mutilate themselves may be demonstrating behavior that has in other societies been elaborated into a culturally acceptable means of resolving the maturational issues faced by all adolescents. The pathological acts of troubled adolescents may thus be primitive, morbid attempts to overcome seemingly unsolvable problems. (1989, p. 143)

Although for the self-mutilator, the scars are by-products of cutting rather than its primary intention, they are reminders of her autonomy and competence in transcending the pain and distress encountered in the cultural world. In this sense, her markings are signs of her refusal to enter into the cultural world as she knows it. The scars remind her of her capacity to recollect a sense of her own essential humanity without recourse to the world of others. Her scars are trophies in that they are the only part of herself that she has created. They are inscriptions of triumph over the painful somatic narratives imposed on her by the cultural world. Patient number one describes this vividly:

> The only part of my body I touch is where the scars are. I don't touch any ... to me every part of me exists over the scars ... the rest of me does not belong to me, that's what people want to see. The scars on me are me, the rest of me doesn't ... I avoid it.

Nathan (1990) builds a conceptual bridge between personal mutilations and cultural markings. In reviewing Anzieu (1989), Nathan notes that early childhood trauma is represented in the psychic apparatus as a hole in the skin-ego, a hole from which the envelope came away in

shreds. This hole makes its appearance in the identificatory system by means of a tendency towards mimetic identification. He argues that rites of initiation in traditional societies seem to explicate this mimetic process of representation in their societal organization of psychic traumas which are associated with skin injuries; scarifications, tattoos or sexual mutilations, in order to obtain identity.

Blood and Bleeding

The intersensorial nature of blood plays a pivotal part in the self-mutilatory experience. The sight, feel, taste, and smell of the blood all contribute to the self-mutilator's experience of cutting as a self-satisfying experience. Initially, the feeling of the blood welling up to the cut at the skin surface, and then the first sight of it, ushers in the beginning of a deep relief. When the blood flows through the cut from inside to outside, the cutter's relief is further enhanced. All four respondents report feeling that the blood has a cleansing action in itself, as if the blood itself carries *bad stuff* across the threshold of the body. The blood flow cleanses the interiority of the self, ridding the body of noxious build-up. None of the respondents describe the blood as dirty. Rather, the blood is uniquely pure despite carrying impurities out with it and thereby cleansing the body. As patient number one puts it: "The blood is so clean and so pure ... The blood is me".

All four respondents comment on the soothing thermal dimension of the blood; it feels warm as it trickles or flows down the skin of the arm. Patient four describes it as having "the same effect as a baby getting a warm bottle of milk". This is reminiscent of Kafka's (1969) hypothesis that the self-mutilator relates to her blood as a reassuring transitional object.

The smell and taste of blood are also integral to the cutting experience. All the respondents comment upon the unique smell of their own blood. Patient number three describes it as

> ... a mixture of a wild animal and a kind of a forest species ... a musty sort of wet ... not a fresh outside smell ... it's an essence.

Patient number four likens the effect the smell blood has on her to a pack of dogs driven to frenzy by the smell of blood: "You go crazy, you just go crazy and you just want to get more and more, bigger and bigger".

The blood, with its unique smell and taste, its perfect formation and unique textural consistency and colouration, confirms for the cutter her humanness. The blood may offer the cutter a temporary channel into the world of kinship:

> I don't ... I don't ... think that humans really have a place in the world, but somehow the blood is the only bridge. At least it shows me that its not so bad to be human. There is still a part of us that needs to be recognized and respected as ... as human.

The smell permeates the cutter's whole existence at the time of cutting and in doing so, obliterates the badness that existed prior to the cut. Patient number one claims:

> That blood smell ... it goes into my brain and into my whole body. Blood actually fills you up so completely ... I could make perfume that smells like blood all over the world ... I take it to my nose and smell it. You get the best smell ... the blood takes away any other smell, or other smells around.

Blood thus serves a paradoxical function in that it empties the cutter of bad stuff by transporting it through the cut to the exterior, but at the same time fills her up with a sense of her own essential humanness. Kafka (1969), the only psychoanalytic writer to directly address self-mutilation, spoke of the cut, bleeding skin as a transitional object, with cutting being a reminder of its me and not-me status. However, he did not embrace the question of

whether the multisensorial blood was a form of transitional object.

Importantly, it is the blood's intersensorial resonance that facilitates the return of the mutilator to a "felt-sense" (Gendlin, 1978) of humanness. Patient number three captures this graphically: "It's a sense, it's a feeling of bleeding yourself, you're flowing from one form into another". Her comment captures the transformative power of bleeding for the cutter who moves from feeling diembodied to embodied, from dead to alive, from urgent to becalmed, from dissatisfied to satisfied. The blood seems to soothe the cutter much in the way that McDougall (1989) and Tustin (1986) describe the soothing function of transitory object. It would appear that blood is not fully a transitional object (Kafka, 1969) in that it is primarily a sensorially-based phenomenon with little symbolic significance, as in making possible the creation of a transitional space. (Ogden, 1989).

Didier Anzieu (1989) argues that the Skin Ego is comprised of overlapping psychic envelopes, of which two are the *olfactory envelope* and the *thermal envelope*. He argues that pathology ensues when the Skin Ego is predominated by the olfactory envelope.

> This predominantly olfactory Skin Ego constitutes an envelope that is neither continuous nor solid. It is riddled with a great number of holes, corresponding to the pores of the skin ... This envelope of smells is, moreover, fuzzy, vague and porous; it does not allow for the sensory differentiations which are at the root of the activity of thinking. (p. 183)

The importance of the smell to the self-mutilator suggests that the olfactory Skin Ego is present in the cutting experience. She finds that the blood smell reconstitutes a sense of being contained within herself, within the perimeter of a sufficiently delimiting and protective envelope. Her sense is of a sensorially-dominated container rather than an effect that can be attained and sustained in thought. It is not accomplished by the activity of thinking. In this

sense, blood sensations are autistic-contiguous phenomena (Ogden, 1989) which cannot inform the ongoing development of a symbolic space of thought.

The warmth of the blood felt by the self-mutilator evokes Anzieu's (1989, 1990a) ideas on the thermal envelope. The envelope of warmth provides evidence of a certain degree of narcissistic security, sufficient for the patient to enter (in therapy or otherwise) into a relationship of exchange with the other, on condition that the exchange is based on the respect of each for the individuality and autonomy of the other. This envelope of warmth marks out the boundaries of a peaceful territory, its frontier posts allowing the entry and exit of travellers who are checked to make sure they carry neither evil intentions nor weapons (Anzieu, 1989). The self-mutilator, in cutting, attempts to evoke a warmth that will reconstitute a protective thermal envelope. However, this warmth is not expected from outside of the self. In the face of an internalized cold, unforbidding other, or a physically and mentally traumatizing other, the self-mutilator, in cutting, turns to inside her own body to provide the thermal warmth. Thus, her blood reconstitutes the benign thermal Skin Ego that she has hitherto felt to be missing. Patient two's words reflect this recollection of warmth: "It makes me feel calm, I feel warm. And I just feel good afterwards".

Merleau-Ponty (1962, 1968) indirectly offers a similar understanding to Anzieu of the intersensorial phenomenology of self-mutilation. For Merleau-Ponty, our embodied disclosure of intersubjectivity, our ecstatic intertwining (Aanstoos, 1991) is lived multi-sensorially. The fleshness of our *ek-static* intersubjectivity is lived with the fullness of our sensorial capacities. Bleeding is a confirmation of the very rootedness of humanness in the body.

The cleanliness, the unstoppered flowing, the self-created flow of blood commented on by the respondents echoes Hillman's (1977) commentary on the puer's bleeding. Hillman states:

> His bleeding reveals his archetypal structure in several ways. First it is an image for vulnerability in general, the skin too thin for real life, the sensitivity to every pointed instrument of attack, the defencelessness of youngly naive and open truth. The bleeding tells of the puer propensity for victimization, for the constellation around him of the psychopathic attackers. (p. 112)

Blood is described as an essence by two of the respondents; self-made and pure. The respondents see it as a creation. The sight of it reminds the mutilator that she can create and is able to produce something that cannot be tarnished by the interference of anybody else. On the other hand, menstrual blood is perceived as something the body rejects, something dirty and out of the mutilator's control. Her rejection of her menstrual blood is a rejection of her sexual body as a place of pleasureable dwelling. It is as is the menstrual blood recalls her vulnerability as a creature of desire, of her potential for intercorporeality. That is too painful a possibility for the self-mutilator.

Spatiality

There is an intimate interlocking between a person's bodiliness and her spatiality. We speak of personal space or bodily space. Kruger (1988) extends the importance of the dimension of spatiality to the world as lived with others in noting:

> Part of our being in relationship with another human being is the extent to which we share the nearness and farness of things known or unknown, trusted or not trusted with such a person. (p. 52)

This echoes what Merleau-Ponty intends when he states "my body is wherever there is work to be done" (1962, p.250) and "the body is essentially an expressive space" (1968, p.147).

Merleau-Ponty and Kruger are articulating that spatial relations, such as closeness and distance, are grasped primordially in terms of the embodiment of things as near or far. Heidegger (1962) calls this a *primordial spatiality*. This primordial spatiality is carved out, not by objective measures of space, but by our involvement, our interest, our *circumspective concern*:

> Circumspective concern decides as to the closeness and farness of what is proximally ready-to-hand environmentally. Whatever this concern dwells alongside beforehand is what is closest. (Heidegger, 1962, p. 142)

The act of self-mutilation is characterized by changes in the expressive space of the self-mutilator. Prior to cutting, the expressive space extends itself to others in a way that leaves her feeling unable to ward off unwanted hurtful actions and comments in that space, her bodily space is not her own. She is bodily intertwined with what she perceives to be intrusions from which there is no safe distance. The act of cutting alters that "space of expressiveness" (Merleau-Ponty, 1962, pp. 145-146). The moment she cuts, the self-mutilator feels "encased in a cocoon" (patient number four), "distanced ... cut off ... untouchable ... behind a thick glass window" (patient number two). The cut effects a distanced expressive space which preserves the safety and security of her bodiliness. This distancing is often understood as a form of dissociation (Saunders and Arnold, 1993). However, it is in effect the creation of a safe embodied disclosure of intersubjectivity.

Temporality

Medard Boss (1979) and Kruger (1988) discuss the existential status of time. Kruger comments: "Man is not in time, we should rather say that time is in man; it characterizes his existence" (p.65). Both time and anxiety are considered as existential givens in that *having*

time or *having anxiety* refer to a Dasein being attuned in a particular way. However, Boss (1979) demonstrates that the having of time is a way of being human in a much more comprehensive sense than being anxious is. He argues that the having of time always shows us *that* and *how* a person *is* as a whole, namely that she exists in and as a fulfilment of one or other relationship to that which she encounters. Boss echoes Merleau-Ponty's idea of existence as a perpetual state of ecstatic intertwining. Our relationship to time, Boss continues (1969), carries our world-openness. Kruger takes this further:

> Time, which we have or do not have, is time of which we can dispose in a certain way, which we can partial out or arrange in one way or another but *only* as time. In this way we are always ordering the past, the present and that which we anticipate in one or other way and thus we are timing our dwelling and journeying in the world. In conclusion let us hold onto the idea that the three dimensions of time are equally originary so that we stand out towards all three ecstacies of time in the same way and contemporaneously. (Kruger, 1988, p. 66)

Kruger (1988) extrapolates this to the experience of psychopathology. He proposes that the tortured movement and lack of mobility of the catatonic schizophrenic is related to her experience of time no longer flowing. It is noteworthy that the act of self-mutilation is characterized by a sense of timelessness. The respondents describe it as: "There is no time and there is no place" (patient number one) and " ... it's like everything is in slow motion and no sounds ... " (patient number four). It appears that the temporal horizons of the past and the future are eliminated in the immediacy of the present by the self-mutilator, possibly because past and present are too painful to bear. Thus, cutting is relieving in that it seems to close down temporal horizons and focus the present on the sensations of the body. In this way cutting effectively delimits the temporality of Dasein, rendering it more bearable.

Mitwelt

The interviews reveal that self-mutilation occurs within a relational context that is fraught with conflict and ambivalence. Initially, all of the respondents had difficulty in locating any precipitating events to their cutting. As the interviews progressed however, each of the four respondents pinpointed a distressing interpersonal experience as precursory to the build-up of somatic distress described in the section on bodiliness. Nevertheless, there are some essential differences in the exact nature of those distressing *mitwelt* (Boss, 1979) experiences.

Patient number one highlights an argument with her mother after which she, feeling hurt, angry, and emotionally confused, returned home and cut herself. She notes a process of having to tolerate the intrusions of others, of not knowing how to say "no", of her own ensuing hurt which was followed by the desire to cut. She perceives herself to be unable to resist or protect herself from being filled up by others' bad feelings or their negative perceptions of her. Cutting then becomes a way of relieving herself of that noxious accumulation. This process of her helplessness in the face of personal assault from others is graphically portrayed in her words:

> I take in shit from people. I don't know why. I just take, take, take, take, take, it never stops ... if someone says something to me; if someone says "You are really bad" I can't tell her to be quiet. I don't. I don't tell people to stop being horrible to me. And if somebody hurts me, I don't say stop ... I take it all in visually and through my ears. I am not asking for it.

Patient number two recalls cutting after feeling interpersonally rejected. She notes that her cutting came in the wake of a hurtful experience with her father. She also recounts the desire to cut welling up in her after feeling singularly isolated and alienated whilst sitting in social company.

Patients three and four similarly report cutting in the wake of feeling desperately lonely, misunderstood and hurt by others. Both these patients report an infractible sense of existential loneliness that cannot be alleviated by the ministrations of others. Patient four's narrative line runs:

> I'm always misunderstood or misinterpreted, and on the other side I went out with Frikkie and nothing that I did was good enough, so ... and there was nobody else I could tell because nobody approved of the relationship, so I was still alone.

There are two strands to the respondents' narratives; firstly, cutting in the wake of a profound sense of hurt by others' comments, and secondly, cutting as a sequel to a profound sense of loneliness and alienation from human connectedness. These appear to be two distinct prodromal mitwelt scenarios. The former an intrusion into the integrity of the self and the latter a neglect or disavowal of the integrity of the self.

In the sample group, cutting occurs exclusively alone. All the respondents comment on the absolute importance of cutting without impediment, judgement, misunderstanding, and the intrusiveness of others. The success of a cutting episode rests upon its privacy. Consequently, the self-mutilator removes herself from any form of company, becoming intensely focused on the intention and act of cutting. The self-mutilator removes herself from that which has set her distress in motion, namely interpersonal contact. Her fantasy is that human contact is either profoundly invasive or profoundly alienating of her existence. In her schizoid-like isolation the cutter removes herself from the perceived destructiveness of the other. Should she be intruded on in the act of cutting, the *spell* is broken and she experiences murderous rage toward the intruder.

Importantly, all respondents describe the changes that occur in cutting to be unattainable in the presence of or with the collaboration of another human being, irrespective of who they are. In this sense the act of cutting could be understood as a withdrawal into an *autistic-like* state as described by Tustin (1986). As subject number one explains:

> ... it don't (sic) belong to anybody else and you don't have to please anybody else at the same time. You don't have to take anything from anybody, you can do it all on your own.

The fierce autonomy expressed by patient number one is echoed in the narratives of the other respondents. The references to a sense of personal power, of self-attainment, of self-competence, and of individual creation all reflect a phantasy that human interaction will deaden and disempower the self, rather than offer it something enlivening.

Anzieu (1989) comments upon the omnipotence experienced by the patient with a narcissistic Skin Ego configuration. It is a configuration that disavows the *fleshness* (Merleau-Ponty 1968) and the inevitability of the perpetual ecstatic embodiment of human existence. Cutting is a temporary refuge from shared embodiment which has been experienced as, and is feared to be, a disintegrating and annihilatory intercorporeality. The shared *skinship* (Roll, 1987) has been too painful and damaging to endure any longer. The act of cutting temporarily severs that painful intercorporeal thread and provides a mastery over the interiorized dimensions of that ecstatic intertwining (Aanstoos, 1991).

A central dimension of the cutting phenomenon is the cutter's inability to directly express anger at the person who is causing the hurtful feelings. All of the four respondents speak of their reluctance to ward off the hurtful experience verbally because they want to protect the

hurtful other from their wrath. Consequently they negotiate their feelings towards the other by cutting.

After cutting, the self-mutilator experiences one of two possible sequelae. In the first instance she feels *emptied* such that she can face others again and gain the psychosomatic *space* needed to tolerate their perceived violations of her flesh (Merleau-Ponty, 1968). She feels calmly fortified to endure further anticipated hurts. In the second instance, she feels protected from others continuing to hurt her. She feels invulnerably protected by an invisible barrier or cocoon, a form of *thick-skinnedness* (Rosenfeld, 1987) that is entirely different to her pre-cutting sense of porous *thin-skinnedness* (Rosenfeld, 1987). Patient number two describes it thus:

> I just feel that nothing can get to me and I am safe from things that want to hurt me ... It's like the wish is there of cutting myself and then (I) put some barrier between me and the hurtful incident.

Patients two, three, and four describe cutting as rendering themselves emotionally untouchable by anything or anyone, including the death or injury of a loved one. Cutting enables them to be in the human world without any emotional vulnerability or empathy. Paradoxically, it is only by cutting into their *own bodies (my italics)* that they can feel invulnerable and protected. The deep fear of vulnerability that the mitwelt invites is spoken of by patient number two:

> It's not actually a barrier. It's like I put things in little boxes and put them away. They're gone. They can't get out of the box and the only time they can is if I get close to people and start trusting somebody. Sometimes the things start coming out of the box, so what I do is if I ... if I get friendly with somebody and I find that I open up to him in any sort of way, I push them away at sort of twice the speed, because I'm scared that the box is gonna open up even more. So it's not really ... I actually pack them away.

Here the patient speaks of the terror that human dependence will threaten the very fabric of her existence. Cutting allows her a safe, removed distance from the mitwelt. This transition in interpersonal sensitivity effected by cutting can be understood as a change in the status of the psychic skin container or skin envelope of the self-mutilator.

The respondents appear to describe a transformation in the texture of the Skin Ego (Anzieu, 1989, 1990a) through cutting. Anzieu argues that the borderline personality disordered person has a form of sado-masochistic skin wherein there is a primary phantasy of a flayed skin and a flayed union with the maternal skin. For Anzieu, masochism is an attempt at a reconstitution of a whole maternal-self skin envelope. The self-mutilator certainly describes the mitwelt as so invasive as to suggest the unconscious phantasy of a skin flayed and tattered by the severance from the (m)other, as well as of the maternal skin being similarly ruptured. The self-mutilator's phantasy is one of lacking a sense of personal containment that is robust enough to exist separate to the other.

Self-cutting has been described as masochistic (Doctors, 1979). The respondents confirm this by talking of the role of pain in the success of cutting. The interesting point however, is the way the cut reconstitutes a sense of invulnerability.

It is possible that the cutting constitutes what Anzieu (1989) and Rosenfeld (1987) call a narcissistic skin of phantasied invulnerability. Transcending pain may well lead to a formation wherein, in phantasy, the self-mutilator collapses the space between the interiority and the exteriority of the Skin Ego (Anzieu, 1989), and develops a double-walled thickness which gives the self-mutilator the illusion of invulnerability and immortality. It is a defensive Skin

Ego structure which disavows the permeability of the self and the continued dependence on the other for some form of skin to skin contact.

This study argues that, in the act of cutting, there is indeed a period of narcissistic ecstacy where mitwelt relations are transcended and the flayed skin transmutes into an untainted, pure, narcissistic skin. However, when the self-mutilator enters back into the world of people, the narcissistic skin begins to dissolve and the flayed skin becomes reconstituted. There is only temporary respite from the defencelessness of the ripped and invaded Skin Ego. Support for this hypothesis comes from Anzieu (1989), who comments:

> And the need to overinvest the narcissistic envelope in this way certainly seems like the defensive counterpart of a phantasy of a stripped-off skin: faced with a permanent danger of internal/external attacks, he must restore the fortunes of an ego-skin that is very insecure in its functions of excitement-screen and psychic container. The topographical solution then consists in abolishing the difference between the two surfaces, external and internal, of the ego-skin, and imagining the interface as a double wall. (p. 129)

The recurring theme in the respondents' narratives of feeling protected and safe as a consequence of cutting supports Rosenfeld's (1987) idea of the constitution of narcissistic thick-skinnedness.

An important theme which emerges from the respondents' narratives is their experience of a shift in their capacity for empathy and personal care. Patient number two describes how cutting places her "behind a glass thick mirror", such that she would be emotionally unmoved even if her grandmother (whom she loves) were bleeding in front of her. Likewise, patient four feels that cutting places her in a "cocoon" where she is beyond concern for others. The experience of cutting, whilst rendering the cutter safe from impingement, also blunts her capacity for empathic identification.

In addition to lack of concern for the other, a notable theme to emerge is that of the self-mutilator's disavowal of a degree of empathy for herself. Patient number three narrates a long struggle towards empathy and concern:

> And the point I came up with was, that I had to take more responsibility for being sensitive and caring. And the more I denied myself caring for things the worse it would get.

Allied to the above two comments is the theme in all four protocols of an inability to cry, whilst cutting or otherwise. The subjects all express a tremendous difficulty in allowing themselves to be emotionally alive, caring and sensitive people in the world of others and a tremendous fear of being irreparably hurt in the process. It is noteworthy that patient number two considers one incident where she sobbed uncontrollably to be the nearest to the relief she attains from cutting. As with cutting, this sobbing occurred whilst she was alone.

Language and Symbolization

Favazza (1989) notes that self-mutilation is a most frustrating phenomenon for treaters because of the self-mutilator's difficulty in giving voice to the experiences that prompt her to cut. Cross (1993) similarly reports that self-mutilators are beset with a

> primitive inability to verbalize emotion, no matter how articulate the patient is otherwise ... as a result, these women attempt to translate psychological pain and vulnerability into physical wounds ... which, thus transformed, seem easier to assauge. (p. 55)

All four of the present research interviewees comment on how words fail to describe their experience of cutting; "I can't have this in a relationship, because it doesn't happen. It's so private. It's the privacy which makes it even more extreme. There are no words" (patient number three). This failure of language and symbol is central to the phenomenology of self-

mutilation. Although, the respondents give full verbal accounts of their experience of cutting, they labour in putting words to its affective dimensions.

The capacity to represent affective experience in language is a developmental accomplishment that has often been thwarted in psychopathological infant-mother exchanges. Ogden (1985, 1989) presents a developmental model that could account for the collapse of such a symbolic capability in the self-mutilator. Ogden puts forward the concept of a dialectical process as a paradigm for understanding the form and mode of the psychological activity used to generate meaningful symbol formation. He argues that meaning accrues from difference; difference that is generated by the interplay of different existential poles. These three poles are dynamic positions, called respectively, the autistic-contiguous, the paranoid-schizoid, and the depressive positions. It is within the triangularity of these three positions that what he calls *potential space* originates.

The term *potential space* was first used by Winnicott (1950) to denote an intermediate area of experiencing which lies between fantasy and reality; the area of transitional objects and transitional phenomena, creativity and symbolization, and the location of cultural experience. It is seen by Watts (1987) as a metaphor for the ground of experience that is *neither yours nor mine*. Potential space is analogous to the term *MUNDUS IMAGINALIS* used by the French philosopher Henry Corbin (1972) and deployed in the field of countertransference by Jungian analyst Andrew Samuels (1985). The *MUNDUS IMAGINALIS* or the imaginal world, is an in-between state, an intermediate dimension, which may have the meaning *neither one thing nor another.*

Borrowing this concept of potential space from Winnicott (1951), Ogden argues that it is the development of potential space which leads to the capacity for generating personal meanings which are represented in symbols. In describing what he calls the psychopathology of potential space, Ogden (1989) shows how a collapse of the dialectic in the direction of either one of two poles, or the unavailability of the subject to recognize the dialectic, thwarts the production of potential space. There is an inability to symbolize and the person's experience remains at a concrete, pre-reflective level. All psychological problems become physical ones and emotional experience is concretized (Cross, 1993).

The autistic-contiguous mode is the most primitive form of psychological organization; a sensory-dominated, presymbolic area of experience in which the most primitive form of meaning is generated on the basis of the organization of sensory impressions, "particularly at the skin surface" (Ogden, 1989, p. 4). When there is a collapse of the dialectic between the autistic-contiguous mode and either the paranoid-schizoid or the depressive modes, a particular brand of sensory-dominated psychopathology ensues. Thus:

> Collapse in the direction of an autistic-contiguous mode results in a tyrannizing imprisonment in a closed system of bodily sensations that precludes the development of 'potential space' (Winnicott, 1971a). (Ogden, 1979, p. 77)

Collapse in the direction of a paranoid-schizoid mode results in a sense of entrapment in a world of things-in-themselves, wherein one does not experience oneself as the author of one's own thoughts and feelings, rather thoughts, feelings, and sensations are experienced as objects or forces bombarding, entering into to, or propelled from oneself (Ogden, 1989).

It could be argued that the self-mutilator suffers from an oscillating collapse of experience in the direction of both the autistic-contiguous mode and the paranoid-schizoid mode of

generating experience. Thus, the self-mutilator's experience of the self and others is dominated by skin surface and sensory experience as well as the literal experience of being invaded, attacked, and colonized by the malevolence of others. This would explain the difficulty such patients have in representing their experiences in symbolic equivalents. They live in the shadow of the tyranny of the body.

Anzieu (1989) suggests that the appropriate censorship of physical touching promotes a re-structuring of the Ego but only if the primary Skin Ego has been adequately established. The latter subsists, after the re-structuring, as a background to the functioning of thought. So, like Ogden (1989), Anzieu understands thought to be continually informed by bodily experience.

> It is nevertheless the case that the repressed primary tactile communications are not destroyed (except in pathological cases), but are preserved as a backcloth upon which systems of intersensory correspondences come to be inscribed; they constitute a primary psychical space, into which other sensory and motor spaces may be fitted; they provide an imaginary surface upon which the products of later operations of thought may be set out. Communication at a distance through gestures and subsequently by the spoken word requires not only the acquisition of specific codes, but also the preservation of this original echotactile backcloth to communication, and its more or less frequent reactivation And re-use ... This echotactile communication remains the original source of semiosis. It is reactivated in empathy, creative work, allergies, love. (Anzieu, 1990a, p.152)

The integrity of the Skin Ego makes symbolic equivalents possible, with the sensory floor as its point of reference.

Merleau-Ponty (1968) addresses the question of the movement from flesh to languaging the experience of that *fleshness*. He argues that the body serves as a tactile backdrop to language.

> In a sense, if we were to make completely explicit the architectonics of the human body, its ontological framework, and how it sees itself and hears itself, we would see that the structure of its mute world is such that all the possibilities of language are already given in it. (Merleau-Ponty, 1968. p. 155)

Extrapolating Merleau-Ponty's thinking to psychopathology, one may argue that psychopathology is a mirror of the distortions in the developmental experiences of flesh such that there is a disruption of the open embodiment of the presence of the other. The porous body-world boundary has been fractured in a way that does not permit of a harmonious sense of skinship (Roll, 1987) which would set the ground for harmonious kinship. Aanstoos (1991) comments on Laing's (1965) understanding of the schizophrenic's experience of disembodiment as one wherein the other's invalidation of the self is embodied and is felt as a literal disembodiment. The borderline body is literally experienced as one that is violated and colonized by others with their negative emotionality. It belongs to the other without recourse to self-protection; without recourse to a filtering fleshness. The self-mutilator's language and embodied responsiveness will reflect that state of primordial fleshness, ie. an invaded one.

McDougall (1989) also offers an understanding of the symbolization constriction of the borderline. Her view, similar to Anzieu's, is that when separation and difference are feared as experiences that may destroy the sense of self, this may result in a variety of psychic solutions:

> sexualization of the conflict; the construction of narcissistic or borderline personality patterns; addictive solutions such as alcoholism or bulimia, or a profound split between psyche and soma. The latter offers two kinds of different solution. The first leads to autistic pathology, in which case the body and its somatic functioning frequently remain intact while the mind closes itself to the external world; the second keeps the relation to external reality intact, with the risk that the soma will begin to act in what we might call an "autistic" fashion, that is, detached from the psyche's affective messages in terms of word-presentations, leaving powerful thing-presentations to seek non-verbal expression. (p. 43)

The self-mutilator does not lack words to describe her experience retrospectively. However, at the time of cutting she does appear to enter into an autistic-like state where her bodily felt-sense overwhelms her faculties for thinking about experience. In Jager's (1991) terms, her faculties of language are overshadowed by the upwelling of primordial passion.

Final Conceptualizations: The Self-Mutilatory Skin Container

The self-mutilator can be understood as attempting to shore up a ruptured psychic container or psychic skin in her cutting. The findings of this study indicate that there are two prodromal experiences to cutting.

First, the cutter experiences being deeply hurt by others' actions or comments. She feels hurt, angry, and upset and feels as if the other has placed *bad stuff* inside her. She has passively absorbed it and it reaches a point where she phantasizes that she will literally distend and burst her boundaries if this negative mix-up of stuff is not expunged. She is unable to give greater definition or clarity to the bad stuff other than to experience it as palpably filling up her insides.

Second, she feels alienated and painfully alone amidst the indifference and misunderstandings of others. This leads to a welling up of bodily-felt affects and an anxiety that these will overwhelm her unless evacuated via a cut.

In both scenarios the cutter experiences her bodily integrity to be under assault from interior and exterior sources. It is argued here that both of these scenarios represent a particular status

of the psychic container. In the first form the skin container formation of the self-mutilator is what this researcher has called a *Traumatized skin container*. It is suggested that the self-mutilator has had, at significant developmental points, a life history of traumatic assaults on her psychosomatic integrity that have profoundly compromised the integrity of her Skin-Ego and its functions. It is fractured in such a way that she cannot keep out unwanted interpersonal experiences and feels invaded and colonized by them. Her Skin-Ego is so porous that she cannot protect herself from the infiltration of negative processes. The screening (Anzieu, 1989) functions are all but absent. The very fragility of her psychic skin container implies that she will needily seek out others to shore up the traumatized texture of her Skin-Ego. However, there is a risk that those interactions she seeks out will turn sour and disappoint her, leaving her feeling as if they are noxious assaults on her integrity. She may well interpret anything less than a soothing experience as persecutory.

The second form of compromised skin container formation is what Anzieu (1989) called the Colander Skin-Ego. Here the mutilator has similar ruptures in her excitatory-screen and protective functions such that she readily feels frighteningly alone and overwhelmed by a mixture of dysphoric affects. It is argued here that such a patient has a developmental life history that did not provide her with a sufficiently balanced mix of nurturance/separation experiences for her to develop a mature Skin-Ego with its excitatory-screen, containing, and protective functions intact.

An important aetiological fact is the presence of histories of severe sexual abuse in two of the study respondents and less severe sexual abuse in the backgrounds of two of the other three respondents (of the original five respondents). The fifth respondent may have had an

undisclosed sexual abuse history. This provides some evidence in support of Saunders and Arnold's (1993) assertion that:

> The 20-50% of patients with borderline diagnoses but without reported abuse histories warrant serious consideration and may require conceptual and treatment frameworks that are different from what we present here. It would be useful for researchers to investigate whether a distinct cluster of borderline symptoms might differentiate this subgroup from the one with childhood abuse and violence. (p.188)

This study submits that the sexually abused cohort, in addition to any pre-existing Skin Ego deficits from early developmental fractures, suffer from a secondarily constellated Traumatized Skin Ego which is a direct result of the intersensorial intrusion and breach of bodiliness that ongoing sexual abuse entails. It is this author's hypothesis that this is a very particular configuration of the Skin Ego, wherein previously consolidated Skin Ego functions are ruptured by the overwhelmingly traumatic effects of sexual abuse, particularly painful anal and vaginal sexual intercourse as described by patient number one in this study.

Following this argument, it is submitted that borderline personality disordered patients suffer from either a developmentally immature psychic skin such as the Colander Skin Ego (described by Anzieu, 1989) or a Traumatized psychic skin, or perhaps a combination of both (that is, a doubly traumatized psychic skin), in so far as sexual abuse often occurs co-morbidly with deficient parental practices. Recent research suggests a strong correlation between a history of early childhood abuse and ongoing or later self-destructive behaviour (Briere, 1989; Courtois, 1988), particularly where there is also the involvement of ongoing parental neglect (Van der Kolk et al., 1991). Further research and theory-building could tease out these distinctions and may throw some weight on the side of the argument that there is indeed a typology of borderline personality disorders with distinct phenomenologies.

The wounding of the psychic container is so severe in the case of the self-mutilator that even her resort to projective identification (Klein, 1946) as a mode of self-protection and communication is insufficient to ward off internal and external threats. The unconscious and non-verbal process of projective identification is a mode of ensuring the integrity of the boundaried psychic container. Bick (1968) states that when the mother fails to contain the infant's projective identifications, a psychic hole like a wound is made in her emotional skin and the infant fears her emotions will pour through this hole. There is a terror of herself pouring through it and suffering annihilation. In the case of the cutter, something different appears to transpire. She fears that the wound in her emotional skin will be overwhelmingly breached by others and she will be annihilated. She cannot evacuate this dread sufficiently via projective identification so she resorts to a more primary mode of evacuation, namely cutting incisions into her skin and blood-letting.

The cutting has to be done under solitary conditions for it to have the desired outcome. This is where the self-mutilator differs crucially from the sado-masochist, who invites another to inflict pain on the body. This pain is also invariably of a sexual nature. The act of cutting is not primarily a sexual one for the self-mutilator, who feels that the pleasure gained from cutting is far more satisfying than sexual pleasure. Her solitary withdrawal may thus be understood more as an autistic behaviour rather than a purely sado-masochistic behaviour.

Tustin (1986) describes how autistic or *shell-type* children withdraw from human relatedness and turn to autistic objects in order to shore up a terrifying sense of bodily disintegration. These objects have no fantasy associated with them and thus are resorted to in an extremely canalized and repetitive fashion. These autistic objects are characteristically hard surfaces

which, when felt against the surface of the body, give the child the feeling of being safe. Tustin notes:

> Autistic children, because they lack experience of civilizing relationships with other human beings, feel constantly threatened with being attacked and hurt. They feel that their helpless bodies are a target for savage and brutal attacks. (1990, p. 107)

In addition to autistic objects, shell-like children resort to autistic shapes which are tactile sensations on body surfaces. These sensations are invariably sticky, soft and slippery. Tustin notes:

> The fluid shapes seem to caress and stroke the child to calm him down after stressful happenings which have threatened to interrupt his sense of continuous existence. (1990, p. 147)

Importantly, Tustin argues that it is not only autistic children who resort to autistic objects and autistic shapes. Neurotic adults may have an autistic core which needs to be similarly placated under stressful conditions. McDougall (1989) also talks of how psychosomatic patients, who suffer from a form of presymbolic *archaic hysteria*, use external objects or substances to ward off a sense of bodily disintegration. These are described as pathological transitional objects or *transitory objects* (McDougall, 1982) which serve as soothing substances. This may well take the form of an addictive psychic economy. As is the case with Tustin's autistic objects and shapes, McDougall's transitory object is differentiated from Winnicott's *transitional object* which, having reached the status of an object as opposed to an extension of the bodily surface, and being a combination of me and not-me, can facilitate ongoing psychological development.

The addictive nature of self-mutilation, and its drug-like soothing effect, suggest that the body and the blood in those moments serve as *autistic* phenomena rather than as transitional

objects, as suggested by Kafka (1969). The intersensorial nature of the blood confirms for the self-mutilator her essential aliveness and going-on-being. Supportive of this argument is that, in the act of cutting, the mutilator does not speak, nor can she recall any fantasies attached to the act. This is supportive of Tustin's (1986) point that there is no fantasy attached to autistic shapes and objects. They are exclusively sensorial experiences. In addition, the respondents' preoccupation with blades suggests that these may well represent hard autistic objects to the self-mutilator, where the newness and sharpness of the steel against the skin is reassuring to the cutter even when she is not cutting.

The autistic-like dimensions of self-mutilation are also consistent with Ogden's (1989) idea of certain psychopathologies being indicative of a collapse of psychic space in the direction of the autistic-contiguous pole of generating experience. Within this collapse, there is a return to the need for sensorially-organized experience in the service of providing meaning to going-on-being. Or rather meaning becomes saturated with sensory experience. The experience is autistic in that the bodily system is closed off from mutually transforming experiences with human beings, and as such there is also a collapse of potential space (Winnicott, 1971; Ogden, 1986) between self-experience and sensory perception. Ogden elaborates this foreclosure:

> This closed bodily world is a world without room in which to create a distinction between symbol and symbolized, and therefore a world in which there is no possibility for the coming into being of an interpreting subject; it is a world in which there is no psychological space between the infant and the mother in which transitional phenomena might be created/discovered. (Ogden, 1989, p. 60)

The self-mutilator may well have had a degree of *potential space* generated in her psyche prior to the cutting. However, it appears to have become increasingly eroded and corrupted

such that, at the point of cutting, it has collapsed entirely. The overwhelming fear of annihilation and dissolution has resulted in the failure of other defense mechanisms such as splitting and projective identification. It could be argued that at this point there is a retreat to cutting as a mode of consolidating the autistic-contiguous basis of the psyche. Reassurance of existence is attained via the intersensorial quality of the cut. The smell, the taste, the sight, the feel, the temperature, the viscous flow, all remind the mutilator of the aliveness of her bodily self. It also tangibly represents the expulsion of stuff which has accumulated inside of her. She does not have a symbolic means of processing that *expulsion*; it is done at a literal level.

Tracey (1990) asserts that trauma is a psychic wound caused by a violent intrusion; "it is like a 'wound', an 'internal haemorrhage, a hole in the psychic sphere'" (Pontalis, 1981, p. 196). Tracey argues that such a wounding trauma creates a specific autistic-like space. This space is caused by an excess of psychic pain flooding the ego, the failure of projective identification to find a holding container, and the loss through rage of the good internal object. As a result there is a regression to unconscious functioning, including autistic-contiguous organization of meaning, with its concomitant loss of secondary processing in the form of thinking and symbolization.

> What is left is a non-living space. This space has an autistic, deadening quality. Its cause is demonstrably similar to that described by Tustin (1972, 1981, 1988) in autistic children. (Tracey, 1990, p. 29)

Alvarez (1992) concurs:

> Children whose minds as well as bodies have been damaged by the intrusions of sexual abuse, violence or neglect, and others, quite different, who are handicapped by their own mysterious sensitivities to more minor deprivations, may experience a type of black despair and cynicism far beyond that felt by neurotic patients. (p. 9)

The near-instantaneous and dramatic effects of cutting; namely emptying, ecstasy, euphoria and becalmedness all speak of a massive alteration in the cutter's felt-sense (Gendlin, 1978). Most importantly, she is left feeling safe, invulnerable, untouchable, as if behind a thick mirror, or at an unbroachable spatial distance. She also feels emotionally untouchable by others. In this, the cutting arguably reconstitutes a thick-skinnedness, a narcissistic envelope of invulnerability (Anzieu, 1989; Rosenfeld, 1987). This sense of consolidation of the self is clearly revealed in patient number two's exclamation:

> I think the fact that I've been driven to cutting. I've been driven past my boundary and once I get past that I'm safe. And everything that was a threat to me and did hurt me can't get me now because of - in a way I cut myself off.

Besides the invulnerability, cutting also paradoxically brings to presence a sense of vitality that can be understood as a dimension of narcissism. The problem with this vitality is that it is accompanied by a sense of interpersonal invulnerability and insensitivity. In that sense, it is highly resonant with Rosenfeld's (1987) idea of thick-skinned narcissism wherein there is a blunting of the capacity for empathic identification.

Ogden offers indirect support for the thesis that cutting constitutes a narcissistic Skin Ego or envelope (Anzieu, 1989):

> As experience is increasingly generated in paranoid-schizoid and depressive modes, words like 'armour', 'shell', 'crust', 'danger', 'attack', 'separateness', 'otherness', 'invasion', 'rigidity', 'impenetrability', and 'repulsion' are attached to the quality of sensory impressions created by autistic objects. (1989, p. 56)

The process of cutting, wherein the mutilator moves from feeling vulnerable and permeable to feeling invulnerable, suggests that cutting helps to recollect a narcissistic envelope which covers over the originally rent psychic skin.

As such, in Ogden's terms, the cutting makes accessible a different dimension of the paranoid-schizoid position that, in dialectic with the autistic-contiguous position, generates a sense of the self which is resilient. In this sense, self-mutilation is indeed self-protective rather than self-destructive. Phenomenologically, the act of cutting recollects a sense of bodiliness, spatiality, and temporality, but not one which is fully open to Dasein (Boss, 1979). Most importantly, the cutting readies and prepares the self-mutilator for engaging again with the mitwelt in the only way she can: that is, to be absorbent, unassertive, and unable to negotiate her boundaries through language which is the predominant currency of kinship.

The cut empties the cutter of unwanted "stuff". What exactly that stuff is is a source of speculation in that none of the respondents was able to specify it. It is this author's hypothesis that what is expunged is the (m)other that has left her with a painfully porous skin container. This is either a maternal envelope that has not facilitated appropriate separation or an other that has assaulted the integrity of the fabric of the skin container with various forms of assault, including sexual. The cut then becomes a symbol of severance from the interiorized painful object.

The self-mutilator lives in a phenomenological world where kinship has traumatized and denied her access to a hospitable world where language, symbol, and empathic imagination are the currencies. She has, by virtue of early parental failure and/or abusive intrusion, been caught in a world of traumatic (s)kinship. Her self-mutilation can be understood as a way of attempting to deal with that traumatic (s)kinship and to struggle, in the way she knows best, towards a state of compatible kinship. However, when that kinship again threatens to overwhelm her fragile selfhood she retreats into cutting, thus perpetuating the cycle of

vacillation between skin and kin. She remains painfully torn between skinship and kinship.

Treatment Implications

The literature on the treatment of borderline personality disorders has been marked by controversy (Aronson, 1989; Waldinger, 1987; Waldinger and Gunderson, 1987). Positions tend to be articulated in a polarized manner, with authors arguing for either a structured and supportive approach (Silver, 1985) or an expressive and insight-oriented approach (Adler, 1985; Buie and Adler, 1982; Chessick, 1977, 1982; Gunderson, 1984; Kernberg, 1975, 1976, 1984; Masterson, 1972, 1981).

The intention of this section is not to lay bare the debate about therapeutic appropriateness and efficacy with borderline personalities. Rather, it is to outline some guidelines emanating from the specific data of the present study that could refine understanding of the processes that culminate in self-mutilation.

The characteristic processes of projective identification, splitting, idealization, devaluation, acting-out, and precariousness of the therapeutic relationship with the borderline self-mutilator, may be understood as struggles to deal with the anxieties attendant on a phantasy of a unreliable psychic skin container, where therapy presents the danger of it being rent into bits.

The ultimate aim of therapy is to restore the fractured Skin Ego's grid of functions, most particularly the containing and excitation-screening functions (Anzieu, 1989). Paradoxically then, psychotherapy, with its prohibition on touching, attempts to reconstitute Skin Ego

functions that are absent because of violent touching or inconsistent touching, particularly so in the case of the self-mutilating patient.

In therapy such patients resort to non-verbal modes of communication, such as splitting and projective identification. The therapeutic task is to process those projections (Thorpe, 1989) in a way that renders the underlying phantasies more manageable and containable by the patient. According to Anzieu, such a containment rests first upon a greater consolidation of the Skin Ego container itself. The task is to facilitate the consolidation of the Skin Ego, such that the capacity for thought and languaging about the psychic pain that has kept the patient trapped in a sensory-dominated mode of generating experience develops (Ogden, 1989). Anzieu cautions that the psychoanalytic work in these cases rests not upon the interpretation of phantasies but on the reconstruction of traumas, on the exercise of the psychical functions that have suffered deprivation.

> These patients need to introject a Skin Ego that can play a sufficiently containing role, a total surface against the background of which the erogenous zones can emerge as figures. The psychoanalytic technique to which I have recourse in such circumstances consists in re-establishing the sound envelope which lines the primary tactile envelope; in showing the patient that he can 'touch' me emotionally; in achieving symbolic equivalents for the tactile contacts that are lacking, by 'touching' him with true, full words, or even by meaningful gestures of the order of simulcra. (Anzieu, 1989, p. 141)

Anzieu makes the point that psychoanalysis is only possible if the prohibition on touching is respected. The analyst has to engage in the construction of a *skin of words* (Anzieu, 1990b) that symbolize, replace and re-create tactile contact, without the actual contact being necessary. This therapeutic exchange becomes a meaningfully symbolic one. A skin of words is woven between the traumatized patient and the understanding interlocutor which begins to re-establish, symbolically, a containing psychical skin that is able to make the pain caused by the wounds to the patient's psychic skin more bearable.

Tracey (1990), considering severely traumatized patients such as the self-mutilator, cautions that to form such a skin of words is a delicate, timeous process. She argues that the patient's incapacity to store, retain and symbolize means that therapeutic efforts need to be repeated over and over. The therapist is viewed as a threatening persecutor until the traumatized patient begins to accept the therapist as a secure, holding therapeutic skin.

Bion (1977) says that the traumatized person experiences "pain but not the suffering" (p.19). She is the pain, overwhelmed by it, the pain is not in her. In order for this pain to become tolerable, it needs to be lived and experienced. The psychotherapeutic experience is a continuous movement from resistance, to acceptance of having pain, to daring to be in pain, and thence to experiencing and suffering one's own pain. In suffering pain, thought process is required to integrate it (Tracey, 1991).

Similarly, Anzieu (1989) speaks of the task of the borderline in therapy to transform from a *body on sufferance* to a *body of suffering*. He claims that the body invades the whole of the therapeutic space; it has no owner. It is the psychoanalyst's task to give that body life and hopefully, to give it back to the patient. Such a patient inflicts marks of violence on her own body to give her a sense of owning it:

> This suffering displayed for others to see, and which arouses their fascination and horror, allows her to detach herself from the maternal grasp, to create an untouchable envelope and acquire a basic sense of security in her own skin. It then becomes possible for that skin to be auto-erotically cathected and enjoy the pleasures of touching. (1989, p. 209)

Through therapy, the hermeneutic interchange, the self-mutilator may be able to surrender using her body as a writing surface of sensory experience and supplant it with a thinking and

languaging about the painful inscriptions on her mental skin.

Limitations of the present study and research suggestions

The primary research question was for each respondent to describe in detail the experience of self-mutilation. It was found, as was anticipated from the literature review, that the respondents had difficulty initially in describing the details of their lived experience of cutting, taking considerable time to settle into the task. It was notable that all of the respondents commented on this difficulty. They all felt ashamed to talk about it and had surprisingly, never been asked to talk directly about their cutting by any of the professionals they had previously had contact with. Contrarily, cutting had been a taboo topic in their previous clinical contacts. In light of this, it is suggested that two or three in-depth interviews with each respondent may well have deepened the quality of their articulations of the experience.

An ethical problem that occurred in the conducting of this research needs to be commented on. All of the respondents were no longer in-patients at the time of the interviews, with only one respondent in sporadic supportive psychotherapy. None of the respondents were on medication at the time of the interviews. The interview was evocative for all of the respondents, all commenting after the interviews on how talking of cutting had evoked an awareness of how much they enjoy cutting. On closing, they all responded affirmatively to the query as to whether the interview had evoked a desire to recommence their cutting. This was of considerable concern to the researcher, given that they had all been asymptomatic for a period of time prior to the interviews.

As a result the researcher, being a clinician, offered each of the respondents an immediate debriefing session in order to get the evoked effects of the interview to subside, also offering a twenty-four hour contact number lest any of the respondents enter into a post-interview crisis. Forty-eight hours post-interview one respondent's work colleague telephoned the researcher to say that the respondent was threatening to cut herself at work. The researcher immediately arranged for her to be brought to the Johannesburg Hospital and arranged an emergency bed, meeting her there and spending two hours talking her down and setting up contingency plans for her forthcoming weekend. This was an intensive psychotherapeutic process. The respondent later left the hospital, not wanting to be hospitalized over the week-end. Consequently, the researcher gave her a contact number for the following forty-eight hours and specified times for her to report in with a telephone call. This is an established technique used with suicidal patients known as a suicide watch. In this instance, it was a self-mutilation watch. The weekend passed without any incident of cutting. A continuous follow-up with this respondent revealed that for eighteen months post-interview there had not been further incidents of self-mutilation. A three-month follow-up for the other respondents similarly revealed a non-occurrence of the symptom.

The point to be made is that the phenomenological method is a very powerful method of inquiry. As such, when dealing with subjects with acting-out potential, particular clinical caution must be observed. In retrospect, it would have been safer to have booked the respondents into a small ward for the interviews so that they could be monitored afterwards by nursing staff. This researcher would go so far as to suggest that the phenomenological method is actually a very powerful clinical process and as such, should rest in the hands of clinically sensitive researchers who are trained to deal with the evocative potential and

sequelae of this mode of inquiry.

A limitation of this study is that it was confined to female self-mutilators. However, as noted by Favazza (1989), self-mutilation is not the exclusive preserve of females. A further study with male subjects may indeed reveal a distinctly different phenomenological topography.

Treaters often frustratedly report how self-mutilation can escalate during a patient's hospital admission and how such a patient will thwart the treatment team's attempts to help by cutting in the presence of her therapist and nurse-therapist (Bollas, 1993). As therapeutic phenomena are co-constituted (Barton, 1984), and take place in a bi-personal field (Langs, 1975), a fuller examination of the mitwelt or interpersonal context of self-mutilation would be extremely helpful to those working in therapeutic units. Perhaps an analysis of the processes at play in a particular therapeutic relationship where self-mutilation occurs would cast light on the precipitating and sustaining dynamics.

In the present study the subjects were asked to recall an incident of cutting and describe the experience in as full a detail as possible. Consequently, this proved to be a highly evocative process with the respondents regressing to that experience. A further study could equip self-mutilators with tape-recorders and allow them to verbalize their experience as they go through a cycle of cutting. This would respect the need for it to be a solitary activity but would gain entry to the lived-moment of the phenomenon. It would be of tremendous value to record whether verbalizing the experience alters it in any way. Also, if the thoughts at the precise time of cutting were known, they could well inform innovative therapeutic strategies.

None of the research subjects commented spontaneously on their dreams during a self-mutilatory phase. A possible study could be to investigate the nature of dreams prodromal to and during such a cycle of cutting. This would allow greater access to the fantasies and wishes that lie substrate to the self-mutilatory behaviour.

A further point of research inquiry could be to conduct a detailed analysis of self-mutilators' Rorschach protocols both during a cycle of cutting and during remission. The recent developments in Rorschach psychology (Exner, 1974; Marsh & Viglione, 1992; Willock, 1992) could enable a more specific and sensitive articulation of the perceptual, affective, and ideational organization of self-mutilators. In particular, it would be very informative to examine what changes occur between the pre-cutting distress and the post-cutting becalmedness. Is this subjective change also accompanied by changes in perceptual organization and self-perception? A controlled study in this regard would be highly illuminating and would complement this phenomenological inquiry.

Epilogue

By way of conclusion a brief section of prose submitted spontaneously by patient number three is included:

THE CUT

> The cut; my child; my voice of feeling for wordless storms that rage within, or calm and gentle dreams of sleep. It never heals, yet never sickens either. She is my pulse, sending messages of hurt or pain or love, passionful of living towards the surface, where I can see and touch and taste my self, at any given moment.

APPENDIX

The appendix consists of protocols one to four. These appear as the original transcribed interviews. Protocols one and two are presented with a full qualitative analysis. That is, a delineation of the natural meaning units (NMUs) followed by the transformed NMUs. Protocols three and four are presented with a delineation of the NMUs but not the transformed NMUs. The precedent for not presenting this final step for all the protocols is set by Kelly (1994) and Thorpe (1989). The reason offered for this exclusion is that it prevents unnecessarily long protocols. Their exclusion also does not detract from the explication process.

Protocol One: Qualitative analysis

Interviewer (I): The purpose of this interview is for you to describe your experience of cutting yourself. You can think of a particular incident when you cut yourself. The idea is for you to describe your experience of cutting in as full detail as possible.

Patient (P): 1) When I got home from my mother's place where I used to go to. I was angry, I was hurt, I was upset and I just thought, now do something to try to get rid of all this. My back was sore, my wrists were clenched, all tight, and I got my blade...I hide them...because it's like my secret. It's everything that really belongs to me. And I got the blade out and I cut on my arms and while I was cutting, it's like there's nothing else. It's like just me and this blade, and in the whole world nothing else is happening. There is no time and there is no place, it's ... it's nothing, it's just ... it's just this upset feeling of, you take the blade and you put it against you skin, and your skin just opens.

P was angry, upset, and hurt on returning from her mother's house. She was physically very tense with clenched fists and a sore back. Her thought was to cut to alter her sense of tension. She retrieved her hidden blades and cut into her arms. Whilst cutting there was nothing else she was aware of. Place and time disappear and her consciousness narrows down to the act of placing the blade against her skin and cutting it open.

2) And the blood comes, and it's so clean and so pure. I normally make that three or four little cuts, where the blood doesn't come straight away; it takes a little while and then it comes out like little drops, so it's like sort of perfect. I mean, just like catching and holding this thing, okay this is mine, I did it all on my own. My own cut and it's my blood and it's my feeling, and then I forget about being angry and upset and hating everybody and I just feel so ... I did a meditation once and it's the same feeling you get from meditation. It's the same feeling like ... like you've been taking drugs. Even if I talk about it, it just feels so nice. It's like taking a deep breath and just everything just goes shuuuu (sic).

P notes the blood to be clean and pure. She makes a series of small bloodless incisions. It takes a while for the blood to surface in little drops. P feels the blood and cut are perfect. She did it all alone and it belongs to her. She then forgets about the angry, upset, hating feelings she had prior to cutting.

P notes that cutting provides a similar feeling to meditation. Or like she has been drugging. Even talking about it partially recollects the feeling.

3) And afterwards, like the next day when I have to go to my son's school and I've got to wear a long-sleeved shirt, because you can see the blood, you know, I got scars and scars all over my body and people can see this. I think why should I have to get embarrassed about something that makes me happy? That makes me feel, you know, like a person, it makes me feel ... it makes me feel, full stop.

Cutting makes P feel like a person. It makes her feel alive and she resents having to cover up her bloodied and scarred arms in public and be embarrassed about something that makes her happy.

4) You know, it's the only thing that takes away ... protects you, whether you ... and most important is that it's so clean. It's like so ... the one cut in my arm, it's gone septic, and I hated - it was like - it was always like punishment for a cut. It's like my body said: look, I don't want you to do this any more. And I can understand the logic when I said to my husband: look, cutting doesn't hurt anybody, it just hurts me. The actual experience, the actual putting that blade to your skin and doing it yourself, the power, it's like ... it's like so cleansing, you know. So the blood ... the blood when you cut is so clean. It's just like ... like when I make a lot of cuts and I do it on my stomach, then I take each drop ... so it's perfect, it's like ... and I have made it. I have made this perfect thing and no-one can stop it up, no-one can come and close the cut or take away the blood.

P feels the cutting is the only thing that protects her. The cleanliness is vital to the act. She hated it once when a wound went septic. P experiences immense power in the act of cutting. The blood is perfect in its' cleanliness. P feels she has made something perfect in cutting and no-body can spoil or interfere with that.

5) I always do it on my own. You know, I don't do it with anybody, and the scariest thing about it when I did my first cutting was just when I had a bath, and it was fine. Once you start doing it, the more you do it, the more you want to do. It's like so ... it's addictive, but the addiction doesn't come from the mind.

P always cuts alone. Once she had cut for the first time, she knew it would become an increasing activity. P describes it as addictive but that the addiction is not mental.

6) Cutting even scars afterwards, you know. I like my scars. I don't want them to go. I want them to be as a ... that I look at them I can remember and by touching them I can remember the cut and remember why I cut, and I remember that the cut worked. I remember that it took everything away and then it's ... it's like it opened me; and afterwards I can go to sleep.

P likes her scars. She wants them to remain visible as a remembrance. Also by touching her scars P can recall the circumstances of the cutting: how it took everything away that preceded it and how it opened her up. These recollections relax her.

7) Sometimes I wish ... I used to carry a blade in my handbag and I always thought, I wish I was in a shop and I felt like cutting, it does, it solves, I mean I know ... but the feeling, part of me says: just speak to your cuts, that's all you need and then you're fine. And then I am fine. If I start my day going into the bathroom doing my little cuts, I'm fine. You know, like really cool and fine and rational, you know. It's like almost like prevention is better than cure. If I start my day with cutting, then ... it's a satisfying action.

P has the desire to cut herself in a public place to solve her felt tension. She cannot so speaks to her scars and that soothes her. If she commences the day with slight incisions she feels fine. It is a form of prevention that leaves her calm and satisfied in the day ahead.

8) I get frustrated when the blade is blunt, like somebody is plotting against me, you know. The company that makes the blades especially knew that I was gonna buy this stuff and they've given me a really crappy one and ... but when it's sharp, it's clean and it's ... you know, actually it looks so ugly and it looks such a ... I don't think it's exquisite. It's the only part that I like are my scars, because it's the only part of me that I've made. Apart from the blood ...

Blunt blades frustrate P. It feels as if somebody is trying to prevent her from cutting. Sometimes the cuts are not easy to do and this leaves P upset. Then the only appealing aspects are the blood and the scars.

I: Tell me more about the scars.

9) The scars are like a memory and it's nothing that you can forget. I don't really cut very deep, as if you know that I cut quite deep then I got to go away ... there's like four, five on my arm.

Sometimes I just look at the cut and then ... and I also get, if I go out somewhere and see people look at you and then they look away, you know ... and I think they're quite cute, this has nothing to do with your peace of mind, it's like my ... it's like drawing. Sometimes I write when I cut, like words and it's like ... it must be like an artist must feel after she painted and she looks at the picture. And it's different, on the first day, there will still gonna be scrapes on, by the fourth day they're just like a little, but a week later, if they gonna stay, they stay, then they get red lines, you know, and like brownish lines and just so ... the only thing I wish is that they were neat, that they were to heal people, that they were, you know, that there was more substance to it. And when I am cross, then someone can go away, they can take a train, you know, they should stay, they got to stay there, it's proof that I felt.

The scars are like a memory for P. They help her recollect the experience of cutting. The scars remain as a testimony to her that she felt. It is important that they remain as such proof.

I: Proof that you felt?

10) Ja, that I felt something when I did, when I had this feeling of being in touch with me, of this is me, this is my body. Because it also worked as, when you cut yourself, you actually ... there is actually a you, there is actually a me, there is actually a person who's got ... you know, flesh and blood. It reminds me that I am something, somehow. It just brings back to me that ... that I'm not just what everybody says I am. It's actually more, with blood inside my wrist and flesh ... I wish I was brave enough to go and - I don't know where to get one - but I'd like to get a scalpel and actually cut really, really deep and see what's actually in there, and you can see and say, this is me and I got skin and I got veins and I got blood and I got flesh and I got this and ... when I cut my stomach, I know it sounds ugly, but cut it wide open and take out everything that's in there. The scars on my stomach are a reminder that I hurt my stomach ... that I like blood on my stomach. I never ever used to touch my stomach at once. I hate my body.

Cutting helps P feel in touch with her body. She feels there really is a her when she cuts - a flesh and blood person. It reminds her she is not what others say she is. Rather the cutting confirms there is something more substantial to her than what others' say she is.

Sometimes P would like to cut much deeper into her flesh to see what is there. Then she could describe all the aspects that make her up from the skin through to the flesh.

Cutting is the only time that P is aware of her bodily self. She normally hates her body and never touches her stomach other than to cut it.

11) The only part of my body I touch is where the scars are. I don't touch any ... to me every part of me exists under the scars ... the rest of me doesn't belong to me, that's what people want to see. The scars on me are me, the rest of me doesn't ... I avoid it. And I don't want to show around my scars, don't want my scars to go away. I don't care if people think ... But I also get

cross when I have to hide them, you know. I think they're nice, I think that they're special and I think that ... and I wish they were nicer. I wish I had really nice clear scratchmarks, and I wish I had scars like scratchmarks, you know ... and I cut my scratchmarks and those ones scar really nice, because there's a scratchmark and there's a cut and a whole scar ... it's like a little pattern, you know, it's not a straight, it's not like elemental, it's not just a straight line that forms.

P only touches her body where there are scars. The rest of her bodily self lies beneath the scars. She avoids the rest of herself and only identifies herself via the scars. She feels the rest of her body does not belong to her and she avoids her body.

She hides her scars from others' but also gets cross that she has to. She likes to make up lasting patterns made of scratchmarks.

I: Describe to me a bit more the feelings that you have at the time of cutting.

13) To tell you the honest truth, when I cut really deep, like there ... a little bit sore, but I never feel like ... I don't think it's strong enough to be called pain, you know. It's just ... and it's not pain, because to me pain is ... it's like what people don't want. It's the difference between ... pain is like a horrible wound, you know what I mean. It's not pain, I mean obviously a dictionary would call it pain because it's sore, but it's not sore pain. It's a nice
pain. It's like ... it's like when you give birth, it's like that final push, it's like the most excruciating push but it's the best one, because it's over. And that's what I feel when it happens. It's a releasing and I feel ... I don't know, I felt so dirty and cross and angry and ... I didn't want to feel this and when I start feeling this, I'm - just wait, just wait, we sold it out now, now just wait wait wait wait wait, we get home soon now, soon now, soon now. And when I cut I feel ... the first one is a little bit sore and the way I make it sore is I pull them open, and suddenly I feel pain, a proper pain feeling, but it's more like ...pain when I cut, you know and I don't know why, I don't know why, I don't feel ... Why do I feel like ... because what I relate to pain is ... and my husband also always says that if I burn myself, I don't make a fuzz about burning my finger and I do, I don't feel pain as such. Especially when I do the ones on my stomach, it's ... those are the sorest ones, I don't know. They're more sore than those on my arms, because I got to cut deeper to get blood ... and I feel ... the best way I can put it, is calm and clean and ... and I think everything is okay, it's alright, it's alright and the blood will come up and it will all go away. It really is different when I'm cross with myself than I make it painless.

P can feel sore when cutting deep but it is not pain. It is not a sore pain but a nice pain. P equates the pain of cutting with giving birth - the final excruciating push that is the best one because it is the last one.

P does not normally feel acute pain so she attempts to make the cuts painful. The stomach cuts are the site of most pain in that she cuts there deeper to draw blood. When cross with herself she makes it painful, but the pain is tolerable because she knows it will go away.

I: Tell me a bit more about that pain.

14) If I've been really nasty and I have been really horrible and I have been a bad girl, then I cut myself to punish myself, and those are ... they can hurt like just ... it's not a ... it's not a satisfying cut, it's like slashing, slashing, slashing and stupid, foolish, revolting piece of shit. And that does hurt, those pains - that is really sore.

P sometimes cuts herself painfully so as to punish herself. That is after she feels she had been bad. These are not satisfying cuts. They are destructive, slashing cuts that really do hurt.

15) And I never cry, I never cry ... and that blood ... I wash that blood away. I don't look at that blood, because I'm too bad to deserve pleasure from the cut. There are two reasons why I cut. I cut to punish myself, and the punishing cut I generally do on my stomach. Those are really not nice cuts, they're just ... they're like lots and lots and lots and lots and hard and sore, and those are the ones that normally get septic. And I don't care where I do them and I don't ... there are no feelings when I do them, it's just ... it's just like punishing, it's like ... if I could hit myself with it, then ... I can't hit myself hard enough. And to me it's the same thing that gives ... it's like with kids. They love watching T.V. so the only way I can punish them is to take away the T.V. and it's like ... the way to punish myself is to spoil the experience. And spoiling means cutting and then don't see what happens, so that I don't get to see the blood and I don't get to see the essence.

P never cries even when cutting herself painfully. When she cuts that way she does not allow herself the pleasure of looking at the blood. These punishing cuts are inflicted on the stomach. There are then many, brutally inflicted incisions - carelessly administered. They are there to punish her. She would hit herself too, but cannot hit hard enough to inflict sufficient pain.

P spoils the experience of cutting when angry with herself. Here, she does not get to see the blood and thus it cannot be satisfying.

16) Oh, blood is everything, that smell, ohh.

I: Tell me more about the blood.

17) The blood is me. The blood is so ... you know, when you cut ... when you cut with a razor, okay, you get like just tiny little spaces, you get little beads, tiny little beads. It doesn't bleed ... you've seen a razor blade? Okay, you just get this little blood, little dots of blood, and if you just wait and you watch it, then it will ... they're like beads, they're like perfect little red beads and they are so ... they are so beautiful, they are like so ... I don't ... sometimes I don't want to ... I just want to stare like that and just I'm just watching, and that's what gives me even more of ...

the actual cutting is the actual looking at this perfect, perfect little drops of blood. And then I pick them up and I barely think at all and when I look at the blood, when I just hold it like this ... sometimes if I cut here, then I just ... just my arms that the blood runs down my arm, and it's so pretty, it's like ... there's no red like it, there's no pain, it's the most perfect reddish ... I can't even ... I mean, when I think - when I talk about it, I think I wanna go and do it, I mean, I want to do it, I want to cut myself.

P experiences the blood as very special. It is her. It appears to her as perfect red beads and she often feels entranced by their appearance on the surface of her skin.

Looking at the blood appear at the skin surface is as satisfying as the actual cutting.

The blood is a perfect, incomparable red to P. Even talking about it stirs P up into wanting to have the experience of cutting.

18) It's just so ... so beautiful. It's the most beautiful thing in the world, you know, it's like so ... and smelling it ... when I've used up the drops, when the drops are all messy and you can hardly see them anymore then I wipe it and I cover my whole arm with it, I rub it all in, I mean, you can really smell it, I can hardly believe it.

P describes the blood as the most beautiful thing in the world. She rubs the blood all over her arms and then loves to smell it.

I: What about that smell?

19) It's so ... it's sweet, it's so, so, so sweet. There's nothing like it. There's no other smell like it. You know, it's like ... and if I do it a lot, and then afterwards, when I go to the bathroom and that smell is still there then it gets like a dirty smell. I hate old blood, it must be clean, new, fresh blood. And what I sometimes do with the blood as well is, that when I've made lots of little cuts, then I take a blade and I just rub it along, so that it can mix the blood, and I hold my hands like this ... and the smell is like ... it takes away all the other smells, takes away the dirty smells and ... and I've got a very, very sensitive nose. I mean, I'm the type of person that would be ... I could find a milky lane by smelling it in a shopping centre. Seriously, I got the most ... I got a very bad eyesight, but I got the most acute sense of smell. And that blood - and the memory of the smell stays with me for a very long time.

The smell of the blood is sweet. There is nothing like it. When left in the bathroom the blood takes on a dirty smell. P hates old blood. It is clean, fresh blood. The fresh blood takes away all the dirty smells in her life.

I: What effect does this smell have on you?

20) It's like ... it makes real what I have done. It takes it away from just an empty,... like a feeling or an attitude, just done something. It's like the reality of itself. Whenever I remember an experience of anything, of going anywhere, the thing I remember most is always the smell. I don't know why, I just think that smell is most... And that blood smell is like ... it's not a smell which just comes into my nose and stops here, it goes into my brain and it goes into my whole body, and it's, like comes back ... it's like ... it's such a strong smell, it's kind of a smell you can't say: oh, that was a smell up my nose, because blood doesn't let you do that. Blood actually fills you up so completely ... that smell is just so ... in fact, if I could make perfume that smells like blood over the world, I mean, that but it's like so ... but I wouldn't, because it's not ... for example, I hate the smell of blood when I go the butcher, and I hate when I have to buy meat. I can't ... that smell makes me want to vomit. I only like my blood. I like my cut, my blood, you know, and I taste it and then ... smell and the taste is like - is like a whole treat. It's like if you go to dinner, and it's not just a piece of meat throwing on you plate or a salad that's made up with a slice of lettuce and half a tomato, it's the whole smell of it, first, you know, but like me, I smell first. It's the same when I cut, I ... smelling is just as important as the actual cutting and I ... if I hold my hand really, really still, so that drops ... I take it to my nose and I just smell it. You get the best smell ... just breathe, everything goes away. Everything ... it's like ... the blood takes away any other smell, or other smells around. If I could just keep my hands covered in that blood... but I can't, it's like a contradiction, because I can't, when it gets old but it's like, when I cut at night and I don't clean and I'm really tired, and then I just go to sleep, and if you don't wipe it out the blood just dries. I've had a lot of cuts and I've always been greedy and taken more than what I wanted, and I don't use the blood when I cut, they're just extra cuts, and the morning I wake up you can smell the dried blood. I like it a little bit, but I don't like it so much. Then I wash it when I don't want it. If I could get an old cut open with lots of blood then that is nice.

The smell of the blood makes the experience of cutting real for P. The blood smell permeates the whole of P's body. She wishes she could manufacture a perfume that smells like blood. Smelling the blood is as important as the cutting. The smell of the blood eclipses all other smells around her.

I: One thing you mentioned earlier - I'd like you to elaborate a little more in your own words. You come to a point that "it opens you up".

21) I feel in myself that I am closed, that everything is stuck inside me and I don't let it out. I don't talk about it - I take more in. I take in shit from people I really don't know why. I just take take take take take, it never stops. You know, in my ears, I can smell it, I can see it and I listen to it, and I just take all this stuff in. And it's like all this garbage and everything I have ever done is stuffed inside and it doesn't come out. You can't blow it out your nose. So, here it goes, and it's the same opening when you cut. It's like opening and you can say: okay, all the stuff you

don't want come out, out you come, out you come, out you come, and it's ... it opens me up. I know it's just a cut that's open, but I feel like ... when I do my stomach - phhh, it's like everything just ... I think of all the things that day have been really shit, and I just say, you can come out now. And they go out. It takes away all the shit. It's like just ... it's like it opens - it's not the cut that opens, it's me that opens. I open as ... and I think if I had to - if I could speak to someone while I was cutting that it would spoil the whole thing, you know. I think, I could more open, I think more clearly, I am more open to myself, I am more honest to myself when I am cutting. It's like I'd love to just walk around with great, big, open cuts on my stomach, so that everything that came in that I didn't want in, that I can immediately say: out you go, out you go. You know, the nice things I keep inside, and that's the blood, the nice stuff when I open ... it lets out the leaky stuff and the blood comes out, and those are the nice things. And the blood I can smell and you know, and I look and I can see it, the actual cut, when I open it up ... like it opens my insides, you know, and I'm not talking about my insides like my intestines. I am talking about me, my soul, my body, my mind, everything just goes.

Prior to cutting P feels closed. Everything is stuck inside her and she does not let it out. She feels she takes in "shit" from others and just continues to take. Then it gets to feel it is all stuffed inside her. She cannot blow it out her nose so when she cuts it has somewhere to pair out. Thus it feels the cut opens her up. Although she knows logically its' just a cut it is as if all this "stuff" can escape via the incision. She wishes she could walk around with big cuts on her stomach so that she could at will, let out all the bad stuff that comes in against her will.

The cut P says, opens up her soul, her body, her mind, everything of her psyche.

22) It's like someone says, okay, you can come out the whole lot, it's like I'm open, and it's so easy to open. It's so easy to just to take all this ... and it's open, you know. Whereas otherwise you never get the stuff out. I don't ... if someone upsets me, I don't cry. I just keep it in, it seems so difficult to explain, because it's so like ... I wish I could draw, you know, I wish I could ... when I close my eyes, I can see this cut and I can see all the bad things just going out, like people and places and times. They just go out, you know. I can't, you know, it sounds ... I can't explain this.

It is so easy to open herself up with cutting. Otherwise there is no way for P to get all the bad stuff out. If somebody upsets P she does not cry. She keeps the upset inside. She has an image of the cut releasing all the bad things. She has difficulty putting it into words. She is only able to conjur up a visual image of dispelling the bad stuff.

I: Go on with that, go on with the imagining.

23) It goes like ... it's like open and it's the only way into me, you know. But I've made the openings. I don't allow anything into the opening, I just allow stuff out. The only thing I allow in is me and my blade. That's my opening. No-one's forced it open, no-one's said do it, it's my

choice. It's my cut and it's my blood. And I choose what comes out and everything ... like on Saturday I had a fight with that stupid bitch. It was so stupid but, she's inside me and what she makes me feel and all the anger and all the resentment and all the muck and all the mucky stuff she makes me feel is all inside me. It just comes out, it's like ... it's like there's more ... I can see the little bits of blood that come out, but what I also see, but it's not there, is like a whole ... it's like a stream. It's like a whole big river of gunch, you know, of pus, you know, it is. It's like, obviously I can't see it because it's not really there, but I can feel it and sometimes, that's why I've got to cut more, because I can feel, you know, there's still more stuff in, you've got to open up more, you've got to open it, you got to get that stuff out. That's why, you know, I think that it's beneficial to me, because I think that it does - it opens. I take out all that shit, you know, that everybody else puts into me what I don't ask for.

The cut becomes the only way into P. And she has made the openings. Nothing is allowed to enter via the opening, only stuff can exit. The only things allowed in are herself and the blade.

It is her self-made opening. Nobody else has forced it open.

I: Tell me more about that experience you have -of people putting unwanted things into you.

24) Just as ... the taking in of stuff in a present situation, I'm not gonna talk about the past, if someone says something to me, if someone says: You are really bad! I can't tell her to be quiet. I don't, I don't tell people to stop being horrible to me, and if somebody hurts me, I don't say stop. And if I go and if I see something really ugly and if I watch the news and I see all these people being killed and there is nothing I can do about it, I take it all in visually and through my ears. I am not asking for it. It's not that I want to take a role in society and being my mother's daughter, I have to take all the crap she gives me, and if my kids make me angry, I can't turn around and hit them, so I've got to put it inside. I can't - there's nothing else to do with it. I can't keep it in a bag and carry it around, so the only place it goes to is inside me, you know. And the stuff that I don't want people make me sad, when I start feeling, when somebody said something and it really hurts me, you know, and I can't say you really hurt me, and I can't cry. I can't get upset and I can't say, that's a really horrible thing what you did, so I keep it inside and eventually it comes up and it's like - big. I can take a lot of it, huge loads of it, but I can't stop them doing it to me, but that's a reality and I've got to accept it. People say stuff I don't want to hear, and my kids do things I don't want them to do and I read things I don't want to read, and I see things on T.V. that I don't want to see... I don't say "no" to it, I just say ... I remember when I thought about this on a conscious level, and I think on my sub-conscious level I know, it's sort of okay, because I'm gonna get it out by cutting it open, and they don't know it, and that's the other point, that they don't know it. It's like: carry on, treat me like a piece of shit, I can take it, I can take it and just now, I'm gonna go and I'm gonna get all out, and you will have nothing to do with it. It's like pressure, it's like when I'm under strain, I feel like: come on, it's okay, I can take it, I can take it, go ahead, make my day, give me as much as you could possibly give me, because I know a secret to get it out. But there is some pain there that doesn't have it's still there, no

matter how much I cut, and no matter how much I take the blood and not matter what I do, it's still there. It's like so deep and that's why I, I want to cut really deep and get it out.

When somebody says something negative to P, she cannot stop the other from being horrible. She cannot put her protest into words. And if somebody hurts her she cannot say stop. P is unable to cry or to verbalize her feeling hurt to the person who hurts her. She keeps it inside and eventually it surfaces into her conscious awareness. At that point it feels overwhelming.

I: So after you cut ...?

25) I get - when I try not think about that, I try to say, we do it the next time, okay, we don't get it this time, maybe the next time I cut. But then I try and stay with the calm, I try and stay with the ... and like using them for some ... just leave me alone, I'm not listening to you, I am listening to my little cuts, and my little cuts have said it's okay, and they got rid of today's shit and they're okay, you know. So I just stay with that ... but there's something that I can't get at, you know, and I want to take ... I sometimes ... I want to take out ... I am not such a very big mouth and I thought because it's big, it's gonna be very shocking and I show people my stomach and it did nil, you know, and I was so angry because I thought, gee I could really have got that stuff out now. You know, they deal with ... they want to cut open a ... and cut down and just pull it open and say, let's look first, actually go in and ... it's like people watch stuff on television about surgery and I watch this show, this programme, and someone, they did something on t.v. and showed everything and they said, "Oh, God, it's so revolting" and I loved it and I said, "Gee, how do they do that, let me see, so that I can do it", you know, but there's still something and it's here, it's in my stomach.

P can never get the pain totally out. She hopes the following time she will accomplish this. After cutting P tries to stay in the becalmed state. She reassures herself the cuts got rid of the day's "shit" if not the deeply - imbedded "shit". However, there is always a residue of pain that can never come out irrespective of how P cuts. That's why she wants to cut deep - so as to get the deeply - imbedded pain out.

I: Right in the middle?

26) I can't get at ... that's what I want to try to cut and I can't - I can't get it and that's ... and then I get frustrated and then I say to myself, okay, you've got a next time, okay. I never promised myself, this will be the last time. I always say there will be a next time where you can get it, where you get that feeling. You know, it's frustrating getting the first ... you know, it's like ... it's like buying an ice-cream cone and get to eat this ice-cream and somebody takes the cone and you actually wanted a cone as well, you were waiting the whole time to get a cone, but you say to yourself, "Okay, don't worry too much, maybe next time you get it."

P gets frustrated that there is a stratum of pain that she cannot get at. She reassures herself there is a next time when she can get at the deeply - imbedded pain. Not being able to get all the pain out is frustrating.

I: You described a sense of your skin. How do you experience it in the cutting?

27) Generally, my skin is nothing. I don't even think about it. I hate it. I mean, like any part of me, the skin, the flesh, the things..the toes, anything, I just hate it all anyway. When I cut it ... it's like ... like I don't look in mirrors, but cutting is like my mirror, then I can see my skin, the only time I see my skin, the only time I see me. I always have a sense of like not being here, like not physically being, like I close my eyes and think you can't see me, when I cut myself, I can see my skin. My skin is like so ... I don't normally even think about it ... I'm not somebody who spends hours with body creams, and I can't ... you know when I do it, I can't stand it, I hate it ... but I touch my skin to cut it. And it's like - and then it's pretty, but otherwise it's like ... I don't even like thinking about it, I don't ... I just ... it's because it's part of me that I can't ... it's like when I cut, it's there, when I cut it becomes my skin, but until I cut it I just look at it and say: What is this stuff? You know, like who does this belong to? Whose is it? This is not mine. But when I cut it, I own it, when I cut it, I take it ... it's like when I was little, I loved getting sunburns and peel it and I used to love that feeling. I could sit there for hours and peel my skin. I don't think ... but I mean, that used to make me feel so pretty. I used to peel it off and lay it out and then it was my skin, but otherwise it's just stuff.

P hates her skin like she does the rest of her body. She never looks in mirrors but cutting is like her mirror. Then she can see her skin. It is the only time she sees her skin, sees herself. The only time P deliberately touches her skin is to cut it. Normally it is ugly to her but at a time of cutting it is pretty. Prior to that it does not feel like it is her but when she cuts it (her skin) becomes hers. When she cuts her skin she feels she owns it.

I: What happens to your skin when you cut it?

28) It's mine and I'm making it open, and I'm making it ... and I'm making those pretty scars and I'm touching it, but I don't touch it with my hands. I can only touch it through some media, I can touch it through this cutting I go like this, I can't feel my skin, I can't feel me, you know. It's like ... it's the same as if I touch this, it's exactly the same feeling. There's no ... it's not there you know, it's not ... it's just like stuff. And when I cut it, like the other day I cut round a freckle and I cut ... and before I cut it was never there.

P cannot touch her skin with her hands. She can only touch it via some media, such as the blade. Outside of cutting she is not aware of her skin. Her skin is just stuff to her. It does not feel like it belongs to her. In cutting A feels she is making her body.

29) But once I cut it, it wasn't like a freckle, it was like a beauty spot, once I cut it, it was there and then I saw it, but before I cut it, it wasn't there and my skin, this part of my skin where it's cut is here, and this skin here is here, and this is here, and this skin is here and I got skin on this one, my wrist is ... I don't know what it is ... it is not me.

In cutting a freckle which she was unaware of it turned into a beauty spot. And she also becomes aware of having skin when cutting which before she was not aware of.

I: Tell me about your experience of the thickness and thinness of your skin.

30) There is no thickness. There is nothing between me and this vein over here. Look here, I tried to get it, but I can't get it, but ... it's like ... you don't even have to push hard to get there, you just have to go ... it's so ... it's like ricepaper. You know, sheets of ricepaper that you can just - it's not like typing paper. That's what it is. It's not ... the rest of my skin is typing paper stuff. Skin that I cut is ... like this one, you know, it's like really deep and ... that's lots of layers, that's lots of rice paper. I don't think there are lots of thin layers and each time I'm gonna cut through, a little bit more of the thinness, so I think a lot of thinness rather than one thickness, you know. It's not like a ... it's like fabric. It's not wool, it's cotton. It's light and it's ... I wish I could like take a little piece of it, you know and I just pinch myself, you know, and then I'm somewhere I get and ... obviously if I'm in a supermarket at the till, I can't cut myself but I like to take my nails and put them deep - it's okay, it's gonna go away. Then the skin also, it's thin enough to feel my nose. It's like a bruise, very, very ... just touching a little bit hard and you get a bruise; and I love bruises as well. It's so ... like shows me that my skin is there.

P does not perceive her skin to have texture. Her skin is like ricepaper to her rather than typingpaper. The skin that is cut is like layers of ricepaper but the rest of her skin is like typingpaper. She conceives of her skin as layers of thinness rather than layers of thickness. It is like cotton rather than wool. P loves to press her skin until it bruises. In that way she knows her skin is there.

31) And that's why I never scar to remind myself. It's like taking a photograph or going on holiday and you can forget the holiday if you took a photo of it.

She never scars just to remember. The actual cutting experience is more important.

I: Tell me more about what that presence and absence of the others, what that difference is to you?

32) It's something that belongs exclusively to me. It's not a special thing, you know. It's my thing, if someone had to come in, there wouldn't be any feeling. It's not ... it's like selfish ... it's like, I just want that blood for me and I just want the cut for me. And if someone else is there, I just feel like a ... you know, you're such a good looking girl, we see you cutting, how can you be so stupid, you know, like that to me is like really dumb. You know, what's the point of it? The point of me doing it on my own and I'm doing it secretly and do it sometimes in the dark, I just like to see the blood. And if I tell anybody, I mean, obviously they want to stop you. Sometimes I wish I didn't have scars, so that they didn't know that I do it. But if they were there, and they saw me doing it ... it just wouldn't be nice. It's like ... like someone watching me doing this. It's like, I never get anybody to talk about it anymore. It's like I want to kill you. I mean, really, if I'm doing it and someone opens the door, I would get murderously angry, like I want to kill that person. At that same kind of privacy, it's like toilet privacy, it's like my thing, and you can not see it and it's not fair that you have seen it, because I want to have it for myself. And also like, if somebody had to watch or see me, they wouldn't understand it anyway, you know. They don't get the pleasure from this ... it's like if I had to watch someone else cut ... I wouldn't try to stop him. It wouldn't mean nothing to me.

Cutting is a very private event. If intruded on she loses all of the feeling. The blood is only for her and no-body else. P does not want others judging her as stupid for cutting. Her perception is that an observer would misinterpret the act in that they would not understand it as pleasurable rather than self-destructive.

P wishes sometimes she did not scar in that then cutting would be a complete secret and others would never know. If somebody were to intrude on her cutting, A would get into a rage. It is her privacy, like toilet privacy.

I: After you've cut how is it different?

33) I'm there and I got a lot of power, depending on where I cut, when I cut, and that what happened was, it's okay. I got rid of all what happened all the time, it's like an emptiness, but not a horrible emptiness. It's a nice emptiness, that's ... I got rid of everything and I'm like - in control. I'm calm and I stop ... before I cut I shake ... after I cut I don't shake. I'm there. I got to explain to you, before I'm like that, you know, just like ... once I've cut, okay I'm here, now you can do what you want.

After cutting P feels powerful and with a feeling of a satisfied emptiness as if she has got rid of something. That enables her to feel in control. Prior to cutting she shakes but the moment she cuts she becomes becalmed and in control.

I: You feel that being there feels different?

34) Ja, it's safer, I feel safe now, because I got because I can say, it's alright, it's alright, it's there, you can go back home and ... it's like ... and I'm clean ... and I'm just ... I can put up with the shit. I still just take it, because there is space for it, now. That's what the cutting ... cutting empties it out and gets rid of it. It's like, I can deal with it, because I can take it, you know. My version of dealing with it is, is just saying: okay, I know that it gets to you. I'm never saying no, take it back, you know. In order to be able to keep on taking it ...

After cutting, P feels safe. She can tell herself she is alright and that she is fortified to put up with further shit because she has created space for it. Cutting is not a refusal of shit but rather a fortification to tolerate more of it.

I: You never say "no, take it back", you never refuse it.

35) No, God, no, I never say that word, that no-word ... it's like people say four-letter words I think, the worst is a two-letter word I just don't say no to anything or anybody ... in order for me to empty enough, to take it all the time, I've got to cut it, to get it open, so that it gets ... it's like if you fill up a bath. You can't keep on filling it, it's gonna overflow, you know, and it's gonna run on the floor and it's gonna create one hell of a mess. You got to pull out the plug you got to empty the bath so you can fill the bath again, and that's how I feel. Once I have cut I feel empty. It's there to say, go ahead, make my ... and with everything not, with just bad feelings, with everything ... it's like a sponge and it's like squeezing. That's what it is. It's like a sponge and it's like you mop it up and mop it up and mop it up and eventually the sponge, you can't mop up anymore and you're still leaving stuff behind, and you squeeze out the sponge and you can go and mop again. You can't mop until you squeezed it out.

P equates this inability to say "no" to others with running a bath. The bath will overflow unless one pulls out the plug. Cutting is akin to pulling out the plug. An alternative image is of a sponge becoming increasingly sodden and saturated. it becomes saturated. Cutting is like squeezing the sponge.

I: If you weren't to cut, what would happen?

36) I would just burst. I would just ... I wouldn't have to cut myself because my insides would just ... there would be an explosion ... and just go. My head would come off and all this come up and ... I would actually burst, I would really ... I'm not hoaxed, but I really believe that. I swear to God, I believe that if I don't cut ... all this stuff is just gonna ... my head is gonna

explode and there is shit all over the place, blood and mess and ... I get scared when I think about it. I get really scared, because when I think ... and that's why I always think ... I don't want to stop cutting. You know, because that's how I control everything. If I don't cut ...

P feels if she did not cut she would burst.

I: Tell me a little bit more about that image you had of cutting as a mirror.

37) I can see myself. I don't look into mirrors, unless I really have to, like I have to go out. And whenever I do, I don't know what that person is. I just see, like, that face. But when I cut myself, I can see who I am. I see a face and I see legs and it comes, it's like a creation. It's like a ... it's like beautiful to me what I can see. And what I do is, I join the cuts together, little cuts into one and then I make two long ones on each side so that makes a little picture, I know, that's me... and I know I exist, you know. It's like ... and if I could, I would be like one of those magic mirrors that you can climb into, you wouldn't just see it, you could actually be it, it's like ... it's like all cuts are little pieces and if you take away my cuts, you put them together, then it would be as one, it would be a whole new mirror and it's like ... it's you. If I look at that, I can see myself. And when I cut myself and it's open and it's bleeding, then I can really see it. It's like: what, this is the person I am? ... but it's like ... you know, it's like that I can see ... it's not just the cut, it's the blood that makes me see it. It's like ... it's like if you make really, not a long cut, but you make lots of little cuts next to each other, then you get ... you get a drop of blood, but it joins on to the next one ... and you actually get like a - and if you hold still, you get like a little pool. And it's perfect and it's like looking into a pond, and I wish I could dive in it. And that's why ... then I can see ... then I can see myself. It's not this face what I see in a mirror, I don't know what that is but I know what this is. I know who it is in a pool of blood.

Normally P does not see herself in a mirror. When cutting she sees herself differently. The cuts become beautiful. All the cuts form part of a magic mirror. When bleeding P can see herself for the first time. The cut and the blood enable her to recognize herself as her. The blood from the series of little cuts forms like a pond and P wishes she could become immersed in that pond of blood.

I: Are you aware of your flesh in cutting?

38) I wish I could, because I must say that I honestly doubt that I have any. Sometimes I think, because I can't get at it. I don't know why, even when I cut really deep, I can't pull it out, you know. Once when I was little, my sister climbed a tree and she got a leg stuck through and the flesh actually really deep came out. It was like ... I wasn't scared, but it really did. Whenever I cut, I wish I could get that stuff out. It's not ... I don't think about flesh. I don't think about it... it's just skin ... it's not ... I don't think, because there isn't anything underneath it, you know. I

think in terms of skin and blood. I maybe think that ... these cuts are skin and what comes out is blood. There is nothing else. I don't think of flesh, I don't think I'm even made of flesh, I think I'm made of skin maybe one day I get deep enough. Even when I cut really deep, you still can't get, you can't take it out and look at it and smell it and ...

P doubts she has flesh underneath her skin. She does not think about her flesh when cutting, only the skin. P thinks she is composed of skin and blood, not anything else.

I: Can you recall the first time when you cut?

39) It's like, it's always been there. It's like I can't really remember the first time I did it. I can't remember what it was like. I know I was in a bathroom and I had a fight, the first time I cut was ... and I ... I didn't ... I didn't honestly believe that I did it. It took me a while to realize that I did do it and that I can do it again. And once I had made that clear in my vision, then it was like ... the first time was like irrelevant ... I just ... I remember being ... I don't remember what gave me the idea.

P has no clear recollection of the first time she cut.She has no recollection of the first time precipitants.

I: Where did you cut yourself?

40) On my wrist. I did it on my wrist. The first one ... it wasn't just somewhere like, I suddenly woke up and ... I think that I have planned it for a long time. Because I think ... you can't do it with a stupid plastic blade or ... you have to have proper blades, so I bought the blades ... and I had blades for a while before I did it. I didn't buy the blades and did it straight away. And when I bought the blades ... I kept them and I thought about it, you know, and did it. But I didn't ever think I'm going to really do it. And when I did do it, because I had a fight for weeks, I thought ... it's like, when you practise swimming and you dive, anything horrible, to think about it and imagine something then you can't do it and then you think, it's so easy, you could have done this all the time, and that's why when I first cut I thought, I first got a fright and then it was like: shit, that was easy. It was so easy. As easy as the easiest thing in my life there's no energy, there is no .... it's so easy and I thought, shit I wish I had done this earlier. I wish I could do this when I was little, I wish I could ... I wish I would have always been able to cut, you know. And then I was a bit angry at myself that I hadn't. You know, it took me so long to ... and I often think to myself, where did it come from? Where did this whole thing ... why did I do it? You know, why did I ... and I'm not the type of person that I read in books about while I was trying to do this, because, you know ... cutting in books isn't like real cuts and that is something else that really irritates me because if people look at you and think, you know, you're so stupid because you tried to kill yourself, and you say, I didn't try to kill myself. If I want to kill myself

I know what to do. I just want to cut, I just want an absolute sheer, ecstatic, exquisite pleasure, just cutting.

The first time P cut she was scared but the moment she cut she wished she had discovered this earlier. She notes it is not an attempt to kill herself. Rather, it is an attempt to capture an exquisite pleasure.

I: Now, tell me, the ecstatic pleasure?

41) It's like ... it's like even when I talk about it, I feel ... I feel like ... it's like ... when you have an orgasm, the nicest part of it is not the finishing it, it's that ... just before you get there, just as you get there ... and that's what cutting is. It's just ... it makes me feel ... it's like oh, it's like so ... when I think about that feeling, it's like ... it's like you're just there, but you don't have to have all the messy stuff. You just have the clean blood, and it's like so ... and the bestest, bestest, bestest thing about it is, that you do it yourself. Which makes it even more like ... I can't explain ... my muscles ... the vagina muscles actually clench, they're actually ... and it's even nicer than an orgasm, like an orgasm is nothing compared to it because, it's just so ... it's like ... I wish I could explain to you and if you could sell to make a million dollars because it's the most exquisite, exquisite pleasure in the whole world. Half the pleasure is the blood and seeing it and the other is the feeling that I get here, that just ... I can't explain it to you, it's like so ... like it makes you want to scream and jump and laugh and cry and ... everything. It makes you want to just say: "Yes, I'm alive!" You know, and it's not orgasmic in that, it's ... you know, sex is like messy ... and yucky and ... everything is ... and this is like so clean. And you get the whole pleasure of it, this immediate pleasure and the ecstasy... and it is, it's like a sexual thing. You know, it's like, but it's not a sexual thing, like in that ... like some people say, like watch violent movies and get turned on. It's not that. It's not like the same kind of ... it's like, in fact that's ... to me I never understood ... I had no ... it was like just a word until I cut. Until I cut and I got there. You don't get it through sex. You don't even get it in the most amazing, amazing sex that lasts for like two hours and it's really sore and it's hard and everything, and it's like ... it's not even as good as that. It's more than that, because it starts down here and it just comes up and goes right into your head. It's like ... I feel it in my toes. I feel - every single part of me takes that feeling. And I just want to say woooow, that was really nice, you know ... I just ... and once I cut, I was near my vagina a few times and I thought, you know don't do that because that's been very good. You've already got the feeling, when you cut there, it's like having jellytots and smarties. You know, you mustn't eat two at the same time, one jellytot and one smartie, and cutting my vagina would be like having jellytots and smarties together, and it will be really greedy ... I like to joke but I don't ... but I'm already getting that ... that pleasure is already ... it's like in these muscles, that are like ... I wish I could ... I wish I could put my hand inside and say it's this muscle here and it's this muscle here, because that's where the x is. It's like so ... I can't even talk about it really ... I mean this is like so ridiculous, even thinking about it just makes me feel ... it's like more sexual than anything, you know, and it's like so ... and it's like liberating things.

The ecstasy of cutting is like the moment just before an orgasm. It is nicer than an orgasm because it is the most exquisite pleasure in the world that is near indescribable. Sex is messy but cutting is clean. It is like a sexual pleasure but it also is not a sexual pleasure. Even the most amazing sex does not provide the feeling of cutting.

I: Liberating things ...?

42) In that you can ... you can allow yourself to feel it and it's not ... it don't belong to anybody else and you don't have to please anybody else at the same time. You don't have to take anything from anybody, you can do it all on your own. And you don't have to ... orgasm is like ... when you have an orgasm you wish it, it's like you let go and it goes away but this ecstasy stays, it doesn't go away all there is, is like ... you let go, you know, and it goes away. But this ecstasy stays there. It doesn't go away, it's like inside and it's like just ... it's the most important part, it really is. It's like ... you know, what it's like? If you walked into a big ballroom and they had like a passage and they had a chandelier and when I say a chandelier I mean a massive chandelier like the size of this room made of crystal and sparkling and absolutely exquisite. It's like if you cut the chain that was holding it, and as you watch it fall, the falling is the ecstasy, the watching the shards and the glass and the starting to shatter. When it hits the floor it's finished, and you can't do anything ... and that's - orgasm is hitting the floor, ecstasy is the watching the chandelier and watching it going right through. It's like kind of a staircase. It's like going up as far as the staircase, and the feeling you get of going round and round and round, and when you get to the top it's finished. The ecstasy doesn't finish, it just stays, it's like ...

It is liberating in so far as it belong totally to herself and she does not have to please anybody else at the same time. Whereas orgasm pleasure comes and goes, the ecstasy of cutting remains. P compares the ecstasy with the perpetual timeless, falling of a chandelier. Orgasm is like it hitting the floor but ecstasy is watching it perpetually fall. The ecstasy never finishes. It is a timeless feeling.

I: So, after cutting you have an ecstatic, exquisite feeling that remains?

43) It stays for a while. I mean, not forever, not for long enough. I wish it could ... but when I think about it, it comes back. It's so strong. And that chandelier thing is something that I've always ... I don't know why, but it's like, it's such a nice ecstasy. It's like so ... it's like the feeling of things you get if you jumped out of an aeroplane. The total letting go, it's like ... this gonna sound really silly, really revolting and I'm not telling it to anybody except you, but I read it once. There is nothing as overrated as a poor fuck and nothing as underrated as a good fuck. It sounds really odd, but it's true. It's like, you know, in fact you don't give the best. Did you see the movie "Fisher King"? And when Robin Williams is saying this about his ... and he gets this look at his face and you think: I felt that hey, and I say yes, yes, yes, yes you got it, you got it, you're right,

that's it. That is the most exquisite, ecstatic feeling and it's staying. But the worst is that it goes away, it's finished, you know. Ecstasy is that it stays and it's so ... it fills up, everything ... everything is just all part of it. It's just like my brainstream. It's just like the things ... I don't know what they're called, it's like little, and it's got a stick and you think it and the vibration goes, it's like that it goes ... it just vibrates right through, and it's so ... God, it's beautiful, it really is the most beautiful feeling, it's like so ... so special, you know. If you gave me a blade, I would do it, and I know that I would just ... and just a little cut, just one just to feel it, ... and it's sheer ecstasy. I don't think anybody can ... it's almost a little bit like giving birth ... even giving birth is like a bit ... and like giving birth to me is supposed to be this major experience and it is but ... but it's not ecstatic because it doesn't finish. It's like that last push I actually wanted to last it a long time I actually wanted to carry on because when it's finished it's finished. and that's why I want to cut and I don't get enough ... depends how full I am ... and sometimes it's like a reward it's like I promise myself if I'm really good today and I do what I'm supposed to do, I don't just cut when I'm sad or ... I also cut when I'm feeling very good. You know, it's like you've been a good girl.

The ecstasy remains for a while but not forever. It is a total letting to, like jumping out of an aeroplane. The worst of the ecstatic feeling is that it goes away, it fades. It vibrates right throughout her being. Even giving birth, P claims, is not as ecstatic an experience as cutting. P never wants the cutting to finish. The way to make it not finish is to promise herself further episodes of cutting.

Protocol Two: Qualitative analysis

Interviewer (I): The purpose of this interview is for you to describe your experience of cutting yourself. You can recall a particular incident when you did it, and to think about that, and to describe it in as full a detail as possible.

Patient (P): 1) Okay, I can't really tell you what leads up to it, because it's never been the same thing that's happened before. But I just get this very anxious feeling, almost that I can't actually control what I'm doing and the only way that I'm going to stop feeling anxious and feel calm and relaxed is by cutting myself. Sometimes it's a very cold-blooded thing, I do it without emotion. If I'm cross with myself I tend to cut or slash in a cross way and I just know that once that I've done it I feel maybe the way people feel when they have taken a tranquillizer. It makes me feel calm, I feel warm. And I just feel good afterwards. ... It's ... I have to do it, it doesn't matter where I am, if I get the feeling. No matter where I am, I get up and go somewhere so that I can go and do it. I don't really plan it, it's not - I don't sort of sit down and think I'm going to cut myself, it just happens. And I get up, wherever I am, I arrange to find something. The only time I've really planned it was this last time where I actually phoned the chemist and got them to deliver the blades to my work. And that was the only time I can say I've really planned it.

P is aware of a diffuse, non-specific affective state, but predominantly anxious. She feels unable to contain or assuage the mounting anxiousness or to 'control' it in some way. The only resolution she perceives to this out of control feeling, P surmises, is to cut her arms. She is reassured that her cutting will indeed return her to an anxiety-free, emotionally-controlled state. P then cuts. At times frantically and at times in a deliberate, controlled manner. P does not have intense emotions whilst cutting. The cutting has an immediate tranquillizing effect upon her. She feels warm as a result. The need to cut is not a premeditated desire in her. Rather, it wells up in her and quickly suffuses and dominates her whole consciousness until the act has been completed.

I: Can you tell me more about that anxious feeling and that inner build-up? Can you talk a little bit about that?

2) I can't really describe it, I can't say ... I just know that I feel on edge and the only way I can stop it is by cutting myself. I can't really describe it much more than that. I don't ... the only thing I can think about when I'm like that, is actually doing the cutting and feeling better afterwards. And it seems to happen very quickly, it doesn't take a morning to build up, it can build ... well, all the times I've done it ... it seems to build up within about five minutes from quite normal and calm, sitting and socialising with people and suddenly five minutes later I'm cutting.

quite normal and calm, sitting and socialising with people and suddenly five minutes later I'm cutting.

P describes the prodromal experience to the cutting as a feeling of a build-up of edginess. When edgy, P describes how her edginess builds up rapidly and without any pre-emptive warning. When it does so, she thinks of cutting and becomes single-minded in her assurance that the edginess will only be relieved by cutting. The build-up can mount suddenly such that she can be sitting calmly with people, feel edgy, and then be cutting, all within a five minute interlude.

I: Could you talk more about the actual cutting, the act and the doing of it, and what it's like?

3) It's a good feeling when I'm doing it, because I know that it's going to feel better. It doesn't hurt me. In fact even when I'm not thinking about cutting, even when I'm feeling quite healthy, I know that because of the cutting I could cut myself now and not feel it. So there's no pain involved. It just feels good when I see the blood starts welling up and ... and ... I don't ... I can't say what it is but some days, sometimes I cut myself more than others. Sometimes I'm happy with one or two cuts and sometimes it doesn't satisfy me and I just keep on.

The actual cutting is gratifying in so far as it is not painful and will bring a state of instantaneous calmness. Even when not specifically edgy P reassures herself she could cut and it would be satisfying rather than painful. The instant B sees the blood ooze up from the cut she feels relaxed. Sometimes the initial cut does not have this immediate effect and it takes several incisions to attain the relaxed state.

I: Could you talk a bit about the blood welling up, what it's like, how you experience that?

4) I feel a sense of relief. I feel ... once after I stopped the cutting I got upset and started crying and cried and cried and sobbed and then ... it's sort of almost the same feeling I had like I've been really sobbing hard and I just suddenly feel ... when you've been crying hard for a long time you feel ... sort of tired like relief afterwards. And that's the feeling that I got from the cutting. Immediately as soon as I saw the blood, I would suddenly sink down ... but then I'd also feel very dead afterwards, sort of emotionally - if I saw somebody I loved hurt in front of me I felt that it wouldn't upset me, I sort of felt very distance - distanced from things and it was a way of making me not care about them.

The sight of the blood is followed by an immediate bodily-felt relief. P equates the experience with the relief she has felt after sobbing hard. P also feels exhausted after cutting such that nothing could upset her at that point in time. She experiences it as having no care. At that point she is beyond caring about others around her. She feels very distanced from her interpersonal world.

I: Could you tell me more about the blood. Everything about the blood that comes to mind?

5) The blood doesn't really play a big part in it for me. It's just, I have the initial feeling of feeling better when I feel the blood, but then it's got nothing really more to do with it.

The feel of the oozing blood releases P from the edginess rather than the sight of blood per se.

I: What about the sight of the blood?

6) I've done what I wanted to do and ... but as I see the blood I know, now okay, you've cut yourself - it's gonna be all right now.

The sight of the blood is a confirmatory sign that B has accomplished what she has to and is thus reassured she will now be out of harm's way.

I: When you've cut in that way what do you do with the blood, what happens to the blood?

7) I clean it. I normally clean it up myself with toilet paper or cotton wool and throw it away, and that's the end of it. Or if it's ... in some cases it's been more serious. I had to go to hospital and be stitched up but I normally clean myself up first ... because I don't really want other people to know about it, so if I can look after myself I look after it and I don't tell anyone about it. But sometimes I've gone deeper and then I had to go and have stitches. But I still clean myself up before I get there.

After cutting P cleans the blood up. In situations where she has inflicted deeper cuts she has gone to hospital for suturing. P does not want others to see or know about her cuts, so she attempts to doctor her wounds herself.

I: Are there any other aspects to the blood that play a role?

8) No, the blood doesn't mean anything, it's just incidental. Only once I see it I feel better, but it's incidental to the cutting. I don't cut to look at the blood. I cut because once I've cut I feel better, so the blood isn't important to me.

The sight of the blood is not central to the act of cutting. It is only implicated in so far as it serves as a sign that the cut has been successful.

I: Could you tell me a bit about the cut? Somehow the cutting makes you feel better. Could you tell me a bit about that?

9) I don't really ... it's very difficult because I don't actually know why it makes me feel better. I just know it does and I can't actually ... you know, as I say, it depends on how upset I am as to how badly I cut or where I cut. And ... I just know that it feels good.

P does not know why cutting has such an immediately becalming effect upon her. All she recalls is that it transforms such that she feels good after cutting.

I: Could you tell me about where you cut and how badly you cut? Talk more about that.

10) I cut myself on my arms and my legs and my stomach and ... those are sort of normal times. When I got more upset I would sort of really try and sever all away. But I had one time where I cut my face. And I think it was because I was feeling rejected by somebody and I felt ugly and I felt horrible and ... that was the scariest one for me because I've never been ashamed of cutting. I'm quite willing and always talk about it, but I cut my face and I lied about it and made up this story about being mugged and went about the interview with the police and everything. And for five years I lived the lie and it was only when I came here that for the first time I actually remembered that I had done it, and was able to tell people about it. And that to me was the scariest one because I always tried to do it where people couldn't see it so it wouldn't be obvious and suddenly it was my face and it became a big lie and ... but otherwise ... you know ... it just depends ... I think I just cut my arms and my legs because they are the easiest places to get to when I'm in a frenzy and my stomach as well ... I don't know why ... I don't know why I choose to cut in certain places I just know that the incident about my face was because I felt rejected and I felt ugly, but otherwise I cut ... it just happens. I like ... even now, I don't know what it is, but I like knifes and I like blades. Even though I sort of feel better I still ... if someone at work is working with a knife I want to, it's funny, play with it.

On one occasion only P cut her face. She had felt rejected by someone which left her feeling very ugly, and unacceptable. The facial cutting scared her because, unlike her other cuts, she felt ashamed and distressed at other peoples knowing she cut her own face. What scared her most was that the facial scars were visible for all to see whereas she normally cut privately and was able to keep her scars from public view.

I: Could you perhaps talk to me a bit about the cutting of your skin, what kind of experience is that for you? Of what importance is the experience of your skin in those moments?

11) The only thing I really remember or the only part of the experience I remember is the feeling of watching my skin slice open so easily. It seems to ... every time I do it I just sort of think, you know, how easily it just goes through. And then I thought I was getting better for a while, because I tried to cut myself one day and it was a new razor blade and I just couldn't cut. And no matter how hard I was cutting I just seemed to be getting scratches on my arm and I actually, at that stage thought maybe I was getting over it naturally. And that for some reason I couldn't cut because I was getting over it. And then the next time, of course, it was back to normal again. But it's just ... the only thing that does hit me is how easily my skin seems to just fall apart. ... And also that I don't feel any pain.

P has a strong visual image of the cut skin slicing easily. She is pleased at how easily and skin cuts and how easy it is for her to inflict the incision. On one occasion, P could not slice through her skin and wondered if she had lost the inclination to do so. B is further struck by how easily the skin "falls apart".

I: What is the sensation if not pain. Can you describe it?

12) It always feels as if I had to take a pencil and scrape my legs and arms with it, it feels almost like that. The pain starts once ... once I'm feeling better, once I'm sort of ... have got over the wanting to cut. If I got in and had stitches or whatever, once I'm over the mental side of it, then suddenly my arm starts getting sore. And the other thing that's strange is every time I had to have stitches and I haven't been in a controlled environment, like if I got into hospital and got home straight afterwards, I can't keep the stitches in. That's why a lot of the scars are really ugly because the stitches - I only keep them in for a day and then I pull them out again. I don't know why I do that.

P notes that the sensation of cutting is like a light scraping of the surface of her skin. Only later, after the relief is felt, does the pain begin. Once she is in a post-cutting emotional state, the bodily pain returns to her consciousness. Having to have stitches in hospital feels to P as if she is in an uncontrolled environment. She then takes the stitches out the moment she returns home and is in a controlled environment.

I: Do you open the wound again?

13) No, I don't deliberately pull the wound open, but I don't want the stitches there, so I take the stitches out at the root where it does go open, but that's not why I take the stitches out.

P does not pull the wound open again once it has healed over. It is specifically when she has been stitched that she inadvertently opens the wound in her pulling out the stitches. She does not want her cuts interfered with by stitches.

I: Can you talk more about that, what the stitches are like? Why you want to take them out?

14) They feel uncomfortable and that's just why I take them out. And I think also ... I think in a way, if I feel ... if I take the stitches out ... it didn't happen, you know? There's no sign that something has happened.

The stitches are uncomfortable and if they are out and not visible then it is as if the cutting did not happen. Then there is no sign of the cutting incident.

I: The scars - what's your experience with the scars and how do you relate to those?

15) Most of the time I don't notice them. I got kind of used to them. But every now and again I suddenly see the scars on my arms and realize how ugly they look. But the only problems I really had with the scars were other people, people ask ... I went for a while when it first ... after the first couple of times to try and hide it. I used to put make-up on my arms and things like that but then I decided that I'm not ashamed of what I've done. And I can live with it and if other people can't, well, it's really their problem.

P mostly does not notice her scars. She has become used to them. However, every now and then, she is drawn to the scars on her arms and notices them to be ugly. Nevertheless, the only discomfort P has had over her scars has been when others notice and enquire after them. Initially she tried to hide the scars from the gaze of others with make-up. However, she concluded she was not ashamed of the cuts and was no longer prepared to hide them. She is comfortable living with the scars and is not prepared to hide them for others' sake.

I: Are there any other aspects to the scars? Such as can you touch them, are you showing them to somebody?

16) If I could I would like to get rid of them, because they're just reminders of what I've done. And once I cut it's gone. The scars are ...

P would eradicate the scars if she could in that the act of cutting is more important than the scarring. The scars are a reminder of the cutting that she would rather do without if that were possible.

I: The scars are a kind of memory?

17) Ja, but not an important one. It's one I'd rather not have, if possible.

The feeling of calm and relaxed that comes, that you mentioned, is it almost immediate?

18) Ja, as I start cutting and then by the time that I finished cutting. I cut for as long it takes me to feel calm. So some days I cut twice and feel fine, so I stop cutting. But some days I don't and then I carry on cutting. But by the time I finished the last cut I'm feeling ... it's almost like a drugged state that I feel it.

The feeling of calmness commences the moment P starts cutting and is attained fully by the time the cutting ends. Indeed she cuts until the calmness is consolidated. Some days P cuts more often to attain the calm state. By the time she finishes cutting she feels as if in a drugged state.

I: Could you talk more about how it feels, what it's like, even if you think back of times when you felt that?

19) It just feels ... I feel drugged. I feel as if nothing can hurt me. I feel that nothing can actually get through to me at all. I feel quite dead. But not in a nasty ... I feel dead in a positive way. I feel relief. I just feel that nothing can get to me and I am safe from things that want to hurt me. And I actually get resentful ... I get aggressive when people try and take that away from me. If someone finds me cutting I get very upset, because I know if there are other people hovering around I can't enjoy that feeling.

P feels drugged after cutting. As if nothing can hurt her or get through to hurt her or to upset her emotionally. She feels dead.. in a positive way. A relieving deadness. She feels safe, protected, and out of the reach of anything that wants to hurt her. If discovered cutting P gets very upset and aggressive because she cannot enjoy the drugged feeling in the presence of other people.

I: So you need to be alone?

20) Ja, because if there are other people, if people do incidentally arrive I feel guilty because it's upsetting for other people. So I feel guilty and I feel cross, because they sort of say: are you being stupid or how can you do something like that? And I don't have to be stupid, it's something I enjoy doing and I get cross when people want to try to take that away. And I also get cross because they think you're trying to kill yourself and that's not what it is about.

If others accidentally intrude upon her whilst cutting she feels guilty about their upset and alarm at witnessing the cutting. She also feels angry because of the attitude of these others. She feels indignant at their perception of her as suicidal. She feels she is not lacking in judgement in that cutting is something she enjoys.

I: Can you tell me about the sense of ... you said it in a way satisfies you, that feeling - that sense of satisfaction?

21) In a way it's because when I cut myself, I'm normally doing it because in some way I'm hurting, okay? And if I cut myself because of a reason, like if my dad had to hurt me mentally by saying something or doing something and that drove me to cut myself - once I've cut myself, that thing, that specific incident won't hurt me again. It's like the wish is there of cutting myself and then put some barrier between me and the hurtful incident. So I know, once I've cut myself right it's not gonna hurt me anymore. It seems ... it always feels like I let things carry on and carry on and then I get to the stage where I realize now I've had enough, so I cut myself and I know that it's over. That specific thing is not gonna come back. And then I feel satisfied because I achieved what I wanted.

P cuts because she is hurting in some ill-defined way. If she is hurting for a specific reason such as her father hurt her in something said, then by cutting, that specific hurt will not hurt again. The cut puts a barrier (a protective one) between her and the hurtful incident. P knows that the moment she cuts the barrier will be effected and the incident will not longer have the effect of hurting her. P feels she lets the hurt carry on and on until the only resolution or protection against it is to cut herself. Then she feels satisfied because she has achieved what she wanted.

I: That sense of a barrier between you and a hurtful thing, could you talk more about that barrier?

22) It's not actually a barrier. It's like I put things in little boxes and put them away. They're gone. They can't get out of the box and the only time they can is if I get close to people and start trusting somebody. Sometimes the things start coming out of the box, so what I do is if I ... if I get friendly with somebody and I find that I open up to him in any way, I push them away sort of twice the speed, because I'm scared that the box is gonna open up even more. So it's not really ... I actually pack them away.

P says it is not actually a pure barrier that sets in on cutting. Rather, it is like a series of boxes and the hurtful experiences cannot escape from the closed boxes. The only time they can escape is if P starts trusting somebody. Then things start coming out of the boxes spontaneously. Thus, if P gets friendly with someone she pushes him away out of fear that the box is going to open even further.

I: You have an image of that box?

23) Ja, ja.

I: Could you describe what it's like?

24) It's ... it's just like a little black box that gets stacked into a black hole ... and forgotten about.

P describes the box as a little black box stacked in a black hole and forgotten about.

I: The satisfaction - after you cut you feel different than you did before. I'd like you to think a little bit in how that feeling is different for you.

25) The feeling for me is from my stomach up to the top of my head I feel empty. Afterwards. Now when I'm trying to cut or when I feel that I want to cut, I feel as if my body is filled with too much - and it's gonna burst out somewhere. And then when I've cut I suddenly feel, my whole body feels empty.

After cutting the satisfaction is felt by P as an emptiness from her stomach to the top of her head. Prior to or at the beginning of cutting P feels her body is full and that it is going to burst. But after cutting her body suddenly feels empty of that which is threatening to burst out.

I: Now that's a comfortable emptying?

26) Ja, it's empty because I feel as if I am sitting behind a glass - thick glass window and looking down. And I'm not actually in the room. I'm sort of looking from a distance.

P feels the emptiness as if she were sitting behind a thick glass window looking down upon experience from a lofty, removed distance.

I: The emptying - when you cut, what is your sense of how much emptying occurs?

27) I think it could be with the bleeding.

I: Tell me more about that.

28) I just ... I sat down and thought about it. And I sort of thought - as I cut, whatever is inside ... this is just what I think, I don't know ...

I: That is what I want you to ...

29) ... but I feel that when I cut I'm letting things out, and maybe some of it with the blood, but I don't think the blood is an important thing. I think it's just getting out through the cut. And that's why, when I'm really bad and I do a lot of cutting, there's obviously more that's got to come out.

P thinks the emptying occurs via the bleeding. P thinks when she cuts she is letting things out with the blood. The blood is less important than the "stuff" inside which comes out of the cut along with the blood. P notes that when she is feeling very bad she makes more incisions as she believes there is more that has to come out.

I: When you're cutting you look at your blood, is there a sense of it's carrying this stuff in it, or ...?

30) It just feels like it's cleansing.

I: Cleansing?

31) Ja, cleaning.

I: How do you see the blood?

32) I see it as clean. Because once the blood comes then I know I've sort of done what I wanted to do. And that's why sometimes when I was younger and I used to cut, I didn't cut very well. You'd get a cut and it would be a while before the blood would come up. That was ... then I got cross and I started hacking, because the blood wasn't come quickly enough.

The blood is experienced as cleansing. The sight of the blood welling up to the surface and out confirms for P that she is getting the "stuff" out. When younger and she did not cut very

efficiently, P would get cross with herself when the blood did not well up instantaneously.

I: As you do it, what's your feeling or thought about what is coming out?

33) No, I don't think about it. I just know that once I cut I have this instant relief, I don't have any thoughts going through my mind at all. The only thing I know that happens when I'm doing it is, I seem to say in my head "I must cut, I must cut", and that's the only thing that is important.

P does not have an image of what is coming out of the cut. Her immediate focus is on the felt relief. The only thought she recalls is a repetitive urging herself to effect the cutting.

I: The feeling afterwards you said is like an empty feeling....distanced.

34) But nice, I mean it's not a nasty feeling.

I: Could you perhaps just tell me a bit more about that niceness of that feeling?

35) It's that nothing matters, you know. Nothing is gonna upset me. I remember feeling very guilty because I thought once after I've done it, if my grandmother was lying bleeding to death in front of me, I would just sit there and it wouldn't affect me.

After cutting, nothing matters to P. She feels nothing is then capable of upsetting her. At one point in time she felt guilty about being so emotionally unmoved. She imagined her grandmother lying bleeding in front of her and of herself being utterly unmoved and unaffected by that.

I: Things couldn't touch you.

36) No, nothing could touch me at that point in time.

I: If somebody else would do it for you ...what would be different?

37) I've got to do it myself, because if I do it myself I know it's not gonna hurt me. I've got to be in control of it. And it's got to be ... the first time I ever did it - I was seventeen - and I did

it with a broken beerglass and I know after that it had to be a razor or a scalpel, something like that, I could never go back to glass, I don't know ...it's silly, but to me it had to be a knife, a clean almost surgical thing.

P has to do the cutting herself and solitarily. Then she knows it will not hurt her. She has to be in control of it and it has to be effected efficiently, almost with surgical precision. She recalls first doing it at seventeen with a broken beerglass and knowing thereafter that it had to be a clean, surgical process.

I: Can you recall the first cut at seventeen?

38) Ja, I can. It was the strangest one for me because there was nothing that led up to it. I had moved into a flat on my own, away from my parents. And I went to a hotel and I was sitting with a whole bunch of friends in a hotel. And I had been drinking, I don't think I'd been drinking very much and we were all sitting around the table and suddenly I stood up and I walked through to the bathroom, toilet, quite calmly. I don't think I even knew what I was gonna do at that stage. And I had a glass in my hand and I went into the toilet and I locked the door and I smashed the glass on the toilet-roll holder and I cut my wrist. And somebody came into the toilet and saw blood on the floor and I was carted through to the Jo'burg Gen. That was the first time. I actually, for some reason I remember most of that, it stayed in my mind.

P recalls the first cut she ever inflicted as having no precipitant or build-up. She had moved into a flat alone. She was at a hotel with a group of friends and had been drinking. Suddenly she stood up at the table, walked calmly to the bathroom without any premeditation of cutting. She had a beerglass in her hand, went into the toilet, locked the door, smashed the glass on the toilet-roll holder and cut herself.

I: Do you sometimes remember previous cutting experiences as a sort of satisfaction?

39) No, I don't think about them. The only time I remember them is when people are curious and they ask me, and they ask me about my background, then I remember them. Otherwise I don't think about them. Each one means a new one.

P does not spontaneously recall prior incidents of cutting. Only when others ask her about her background does she recall the cutting incidents. They do not accumulate in their effect on P.

I: Have you ever had, in this period, fantasies of the cut that would be the most satisfying?

40) Ja ... no. I haven't ... I haven't done that as such. What I have done is, I got upset about things and I sat and thought about how good it would feel to feel the cutting, and how good it would feel if I did. And I sort of tried to think what it would feel like, to see if I can get the same feeling. But it doesn't work. But I know it. I know exactly what I would feel like.

P does not daydream or fantasize about cutting. However, when upset, she has sat and imagined the feeling of cutting and how good it would feel. She tried to live the feeling or recapture it by imagining cutting but it does not work the same as the actual cutting.

I: Can anything really in a way compare with that feeling?

41) No.

I: Is it - it's very unique in that way, that feeling?

42) I never felt that way other than cutting.

P has never attained the same relief in any other way in life other than by cutting.

I: How long does that last?

43) It normally lasts until somebody comes along and interferes and breaks the feeling. But if I'm on my own and I do it, I sometimes sit there for about half an hour. Then I start coming back to life again. If I could find a tablet that would make me have that feeling, I would probably get addicted to the tablets.

The post-cutting relief lasts until somebody intrudes into the experience and breaks the feeling. If left alone and uninterrupted, P can sit in a state of deep relief for about half-an-hour. Then she starts to come back to normal consciousness again. P feels that if there were a tablet that had the same effect she would probably get addicted.

I: It's not a feeling of excitement?

44) I would call it a feeling of almost euphoria, but there's no ... but it's a really calm thing. It's not exciting, you know, it's not an excitable thing. It's very, very calm.

P describes the feeling as a state of near-euphoria. It is not an excitement but rather a very becalming euphoria.

I: Do you feel that you are you?

45) No, I know me and I know that it's me doing it. The first couple of times I did it, it didn't feel as if I was really responsible for it. It felt like, maybe somebody else ... but I knew it was me, there was never any doubt that there were two people, but like I had pushed this button and sort of someone else took over, but then, that was only the first couple of times, but then it became a very controlled thing. I knew what I had to do to get that feeling. ... Okay, sometimes when I'm actually cutting I feel excited, when I'm cutting because I know I'm doing what I wanted to do and I'm gonna
feel good afterwards. So I sort of have this little excitement as I start cutting.

P is cognizant of being herself during and after the cutting. The first few times she did not feel responsible for it. She knew it was her doing it yet is was like somebody else had taken over. However, after a few times it became to feel as if she was totally in control of the cutting. At times, when cutting, P does feel excited because she knows she is doing what she wants to and anticipates feeling good afterwards. So the commencement of cutting is exciting.

I: You mentioned that, at the beginning there's a sense of things building up, you become - your body becomes filled and as if it might burst?

46) Ja. My head as well.

I: Just tell me a bit more about that.

47) I don't know what it is. I just have this feeling of things inside and they're all jumbling around and moving, and I get anxious and like I want to run and do things to get away from it. But then I cut, but I'm not conscious of any thoughts, I don't feel it is directly because of this and that. It's a whole lot of things. It's a whole jump full of them. And I feel if I don't cut I just gonna burst, you know?

In the build-up P feels things inside her moving and jumbling about and she becomes anxious such that she actively wants to get away from the anxiousness. Then she gets to feel that if she does not cut she is going to burst from all these things inside her.

I: The experience of satisfaction over time; does it change at all or is it that same calmness?

48) No, it's always been the same.

I: Are you coming to believe that the part where you cut is maybe just decided because they're the easiest to get to?

49) Ja.

I: So is there any choosing of the spot?

50) I don't know ... no, it just seems ... I just seem to cut in a place; I don't think about it. The only time - I didn't even think about it then - but the only time that was different was cutting my face. That's the one I can't understand. The others ... that was the scary one for me and that's why I put it in box and closed it away, because I was very ashamed of myself and I was scary to ... I sort of felt really abnormal cutting my face. To me cutting my arms and my stomach is quite normal, but my face was like, that was forbidden, you know?

P does not consciously select the spot to cut. The only incident with a difference was when she cut her face. It is the one incident she still cannot understand and that scares her. She felt shame and abnormal that she could cut her face. She felt she had done something forbidden whereas arm and stomach cuts are acceptable.

I: What was the difference in the face?

51) Well, it's exposed. Everybody sees it all the time. And I don't particularly want to start walking around with this in my face, bad enough it's on my arms and my legs and on my stomach.

Her face was different in that it is exposed to everybody at all times. And P did not want to carry the scars of her cutting actions on her face and in such an exposed way.

I: You mentioned earlier that idea that you for yourself wouldn't mind so much the scars or the marks. It's rather other peoples' response.

52) Ja. I don't even notice them. I only notice them when somebody draws attention to them. At times, I mean there have been four, five times at the most, I've been doing something and I suddenly see my arm and think: gee, that looks ugly; but apart from that I don't think about scars.

P does not notice her scars unless somebody else draws attention to them. Sometimes she has inadvertently noticed them and noted they are ugly. However, she does not dwell on past scars.

I: Is there something in the smell of the blood that has some meaning?

53) As you say that I can actually smell, you know, I can feel the smell of the blood but I don't think it's important to me at the time. You know, I don't think the smell is important to me. It's the actual cutting, doing it.

In cutting P notices the smell of her blood but it is not a central component in the cutting. The actual cutting of the skin is more important than either the sight or the smell of the blood.

I: You describe the blade, so it's a very - you say surgical, a very clean cut, a very exact cut. Now that's important to you? The exactness has been important for you?

54) Not when I'm actually cutting. I mean, because if I'm cross I don't sort of make sure that I cut in straight line; but I like the metal. I don't know why, I just like the metal.

P likes the metal blade.

I: Could you just tell me a bit more about that?

55) I don't know about it. I just ... even now my boss has got a carpet cutter on his desk, those, and I often go and sit and I just play with it. I just love the feeling of the metal. It's cold, it's clean and it's easy. It's easy to cut like that. I don't wanna cut and have to battle with pieces of glass and things like that. When I wanna cut I'm cutting for a reason and so I wanna do it just as quickly and properly as possible, and that's maybe why I like the razor blade. But if I'm desperate, I mean I ... I buy safety razors; I don't know if it's to keep temptation out the way, but if I'm desperate I break them open and take the blade out.

The metal blade is cold, clean, and it cuts so easily. When she cuts she wants it to be quick and precise and with no delay. The efficiency of new razor blades appeal to her.

I: That feeling of the emptying of what you say behind the glass window, after the experience? Can you perhaps just tell me more about that, of what that feeling is like?

56) It's just ... as I said I - all my worries, everything that hurts me is - it's gone. It's gone away from me, it's outside. And I feel at a distance, because I feel it can't come back. ... And that's ... ja, I mean, it's no more than that. I just know that I'm safe. I can see what's going on around me, I'm quite conscious of what's happening but it doesn't affect me.

The feeling of calm distance after cutting is about the fact that all that hurts P is gone. It is outside her and she feels at a distance from it. She knows then she is safe from those things that hurt. She is conscious of what's happening around her but she is removed and emotionally unaffected.

I: So that safeness - what makes it safe at that point?

57) I think the fact that I've been driven to cutting. I've been driven passed my boundary and once I get passed that I'm safe. And everything that was a threat to me and did hurt me can't get me now because of - in a way I cut myself off.

Cutting drives P past a boundary. Once past that boundary she is safe. Once there everything that has hurt her cannot get to her because she has cut herself off by cutting.

I: I'd like to just ask you one or two things about that. You mentioned very clearly, graphically, you were driven passed your boundary ... ?

58) To me cutting is not a good thing. It's not a thing that a normal, rational person does. So I feel that when I cut myself, things have had to have got really, really bad. It's like my final escape from things. So if a situation or if a person is upsetting me and hurting me, I let them do it, I let them do it and it's almost like giving someone a rope to hang themselves. And I let them do it to a point where this is it. Now you've really done it, I hurt myself, you will never gonna be able to hurt me again.

P notes cutting is not a rational behaviour. It is a final escape. If she is being hurt by someone she continues to let them hurt her to a point where she decides it has become too much. At that point she hurts herself so that person will not be able to continue hurting her.

I: When you say boundary, where, what part is ...?

59) I don't know. I don't ... I can't tell you where it is, I can't tell you how I know I've reached the end of it, because one moment I'm quite fine and rational and calm and the next minute I wanna cut myself and nothing is gonna stop me. And nothing prepares me for the fact ... I can't sort of say to myself, hang on this person is getting to you, you gonna do something, get away, it doesn't work like that, it just seems to slide right into it and then before I got time to do anything I'm cutting. I can't say that it takes weeks. I can't give a time. I can't even say how bad it's gonna be because it just seems to happen. The only thing that seems to be constant about the cutting is it seems to have been once every two years. I don't know if it's co-incidental but that's the way it worked out. But it seems to be in that sort of timesphere.

P can move rapidly from feeling calm to having an unstoppable urge to cut herself. It happens spontaneously. The only observation P has of it's timing is that it happens approximately once every two years.

Protocol Three

Interviewer (I): The purpose of this interview is for you to describe your experience of cutting yourself. You may want to think of an incident when you've cut yourself. Tell me your experience of that cutting, and describe in as full a way as possible.

Patient (P): 1) The most ... I think the most important one, all the others were related to it, but they weren't as ... as full. I don't know what happened, but it was in the night and it was full moon and it was quite late and I was very, very, very emotional and I just had this ... actually it ... I always had it but it was so strong, I couldn't - I couldn't rationalize it, I couldn't rationalize anything, this whole initiation thing, and I always had this belief since I was little, that I was a Sioux Indian. And I've tried to ... subconsciously I should have directed my life so that I, my experiences you know, my horses were central. And I had a horse at that time, I was living on a farm next to Kyalami, and my horse was up on a paddy next to a koppie and I had my dog, two dogs, and so I cut marks on my face and on my nose.

2) And it bled quite a lot and then I went to the ... it was misty about eleven, eleven at night. And I went to ride my horse without saddle or anything and my one dog, she was with me, and it was the most ... it didn't have a context. And I just had this weird feeling that I had ... I had ... no-one was gonna initiate me and life hadn't given me the opportunity to be initiated into, and there was nothing specific that I wanted to become part of. So it had to be my animals and my natural surroundings. And it was really quite traumatic because I didn't ... I didn't have anything to really share with them. I have my animal world but ... I still wanted to go and ... I wanted some kind of contact as well ... I didn't ... I was torn between actually ... I didn't wanted to break this, it was like a spell.

3) And the next day I had to go to the races with my gran, and we went to the chairman's table and I had these huge marks on my face, and I felt totally ... I didn't give a shit. And then I was ... I felt like I just ... I wanted them to stay forever.

4) It ... it's the same kind of thing when I cut my arm. I drew with a razor, a horses' head or a word that was really bothering me or ... and I didn't ... I was a bit frightened of being misunderstood, but I didn't feel ashamed ... but it was still a ... it was a ... I don't know, it's a whole blood thing.

5) It's a relationship I've had since I was about five; this blood being very, very central. Telling the blood "No" and sitting in a bath of blood and just ... it's been so integral ...so part of everything. If I get an injury and it doesn't bleed I am very scared. That's almost my worst fear that if I have a cut that there won't be any blood. It's just ... it's so frightening. I can only understand it on my sort of primary level.

6) When I really feel out of touch and I feel very, very emotional, and sort of when I'm in a dream world and not really here and that's the only way of kind of reassuring myself that I am physical. And it's strange, it's the same kind of feeling when I'm sick and when I get sick, if I get a flu or something - I'm so relieved. It's such a - it's a ... it confirms that I am tangible. It's the same thing with cutting. I feel really confused because I don't want to hurt myself. I don't wanna take life for granted or ... you know, I have expected too much. But there's such a ... there's something missing. That the only thing that can really be a substitute is blood.

I: Tell me more about your experience of the blood.

7) It's so clean. It's the only thing in your body that's always new. ... I mean, that dies so quickly, it solidifies when you touch it; whatever is coming up is absolutely fresh, and I would say, that this is everything that really lives in the world, but not contaminated because your skin actually protected it and only when you open it, it's exposed. ... So it got a life on its own.

8) You know, I can't tell it what to do. I can't stop it from bleeding and yet it feels itself, and watching the bleeding is actually as exciting. It's got the same kind of power because it's ... you can't be controlled by anything and you can't say now stop, you know, that feel that ... is bleeding. I just want to bleed forever. It's gonna heal itself, come what may and ... and then in a week, two weeks, three weeks, it's going to leave a tiny little scar of nothing and ... I don't know, somehow I always think it's gonna ... what I expect is that it's gonna give an answer or something. It's just ... it's such a miracle.

I: Go on with that.

9) I don't know. The less ... there seems to be ... there are quite a few different things that are motivating the cutting. And the one is when I feel surrounded by indifference. People that don't ... it's not like a personal indifference, it's not like they don't care about me. They don't care about life. And it seems really I'm alone. I want to remind myself even more how sensitive life is and how beautiful it is. And ... you don't get ... there are not a lot of things when you look around, I mean, only in nature, and that's the only place I can see miracles, where it can reveal its beauty, and so the ... and the blood is the only way of sort of saying, well, humanness has its miracles too.

10) And it's not ... I don't know ... that there is a link between us and nature; because I don't really believe that. I don't ... I don't ... think that humans really have a place in the world, but somehow the blood is the only bridge. At least it shows me that its not so bad to be human. There is still a part of us which needs to be recognized and respected as ... as special.

11) But blood has never frightened me. I mean, it's ... if a horse got a cut or something, you know, I clean it up or stich, whatever I have to do. I just find it the most exciting thing, because its just life. It doesn't ... you can't really deny it, its brilliant.

I: Are there any other qualities in the way you experience the blood?

12) The taste. I don't know whether it's just because I had such a bad blood, so the taste became a ... you know, I used to have this thing, that I remember pulling my head back, because I didn't wanna loose my blood. It was mine and you know, it was ... you know, I often put it in a cup or something, just to look at the colour.

13) The colour, I mean when it's fresh, you know. And each person, each animal has a different colour. And I used to ... I used to put it on the wall to see in what colour it would change, on a piece of paper ... you don't ... you can't use a picture, it's just ... it's just bleeding. It's ... it's almost clear.

14) And the taste is ... also, it's also clean. But I know you ... if you eat more meat and stuff, that's supposed to be impure, but to me its just ... I often eat meat, just because I love it, whether it's sushi or whether it's just a piece of steak that's hardly cooked. And it may upset me, because I don't ... I don't like to eat animals, because they're always been, you know, like my family and they were the ones I grew up with. But the smell and the taste is so powerful and oh, ... it feels unnatural. It just feels ... totally unique. You can't replace the taste and the smell of blood with anything.

15) It's ... you know, it's really hard. It's very wild at the start, so it's like a ... I haven't really thought about it, I know it's incredibly ... it's important. I mean, smells are really central to it, actually. It's a kind of a mixture between ... for me it's ... it's not completely animal. It's not the smell I take from my animals, but and it's not ... but it isn't, it's a mixture. It's like a mixture of a wild animal and a kind of a forest species, something dark, almost cavy. I mean, that musty sort of a wet ... it's not a fresh outside smell. It's very ... sort of musty, but not musty, because it's got the animal, it's got ... it's not just vegetable matter like. I mean, that ... I suppose if you could put the smell of a wild horse and a sort of forest cave kind of deep soily smell, it's a liquid, but ... fresh liquid ... it's totally ... I don't know ... I often used to fill up a cup and smell it. I haven't really thought about it, because you can't ... it's an essence.

I: What is that essence?

16) Well, it's ... the intellect is powerless. Everything becomes subordinate to this ... it's virtually another world. It's a world within this world. It's a ... strange, it's like ... like a spiritual world, but it's a most physical ... that can be. I mean, like ... there's ... a most tangible quality of the

distance, and yet it's the smell and the taste, and the feel is completely spiritual. ... but it's spiritual in a very final way. I mean it's not a spiritual sort of ... I always feel like, you know, that ... I can never really advance passed that stage, it's pure spiritual rather than the ... intellectualized spirit, and that stage of being where you can meditate and think deep and wonderful thoughts about existence.

17) I mean, I ... the things I've done because ... you know, I filled up a whole glass and gave it to my aunt and told her it was a cocktail. And the absolute repulsion when she realized that it was blood. And I couldn't I said to ... it is funny, I mean, it is. It's ... she were ... she didn't forgive me for long time, but I didn't actually see how that could have an impact. If somebody did it to me, it couldn't ... I couldn't respond in a way she had responded. I said to her, I don't understand, it's not like it's snot or it's shit or it's something. This is pure. This is untainted ... clean liquid, you know, it's not ... it's not that if I have spat in it or something. Because to me, I don't know, I kept that in a glass for weeks ... I don't ... I know that it means something. And I know enough of it ... and ... it's something you can't really ...

18) It's a very unsharing state of mind and activity. You don't want anyone to be around. You don't ... you know, if you couldn't see any signs of any cut the next day, it wouldn't make any difference. The actual scarring is like ...

I: Let's move on to that. Tell me what your experience is of scarring the skin.

19) I don't mind harming my skin, it's ... I don't really see it as something living. It's a ... it's a kind of false sense of security. You know, it's containing something or restraining it. It's keeping a shape to something which hasn't really got a shape. You see, it's just a sort of cloth. ... I mean I'd say that afterwards, if the scar wasn't there, after cutting, that it wouldn't be important ... I think that's why I didn't do ugly scarring ... and it was really upsetting when my horse went and it lasted for almost a year, the way it was scarred. It was reassuring.

I: Reassuring?

20) These ones lasted just ... they were ... they didn't last long, you can hardly see them. But I did a horse here, and if I'm really looking hard, I had look for it again when I was talking to you last night and there was a faint shadow of it. And the shadow tells a story and in the shadow parts it's, a ... I don't want anybody to see, I mean ... it's just like having a friend. It's an experience you can't experience when you're with people. But you like to remind ... there's a certain peace in ... it's like really being with yourself, when you bleed or when you ... it's like creating. I mean, it's like when you get into that whole writing mind set or making something ... I have the same attitude towards things I made. But I make them and the actual passion and the ... the focus that goes into it will last ... I will do it for seven hours, just without knowing

parts it's,. a ... I don't want anybody to see, I mean ... it's just like having a friend. It's an experience you can't experience when you're with people. But you like to remind ... there's a certain peace in ... it's like really being with yourself, when you bleed or when you ... it's like creating. I mean, it's like when you get into that whole writing mind set or making something ... I have the same attitude towards things I made. But I make them and the actual passion and the ... the focus that goes into it will last ... I will do it for seven hours, just without knowing what the time is. And then it's finished, and I'm amazed that something has come out of it, and then I don't do anything about it. It can break, you know, if I've done a sculpture or something, it can just fall to pieces it doesn't matter anymore, after that. I keep that, if it's falling to pieces and just like as the scar I watch it as it heals and stuff and there's always a little bit left. But scars have been very important to me.

21) And I don't like bruising. It must be ... if I am hurt, or if I have been hurt, there must be evidence. I got a soccer wound about six month ago and it was so deep that, I had studs on, and it went so deep that it was just white, and that was the most horrific feeling I've ever felt. Because there was no blood and there was ...

I: Flesh there?

22) Ja. it was gone sort of white. And I suppose it's almost ... you don't ... I felt so helpless because I couldn't do anything. I couldn't feel it, I couldn't ... I couldn't attend to it at all. Because as yet no blood would come, there was nothing to touch. I knew it was painful, but it wasn't painful, because it was frighteningly painful, but it wasn't ... only when the blood came, it was ... it took away the pain, blood takes away the pain. I don't know how.

23) But the scars, they're like ... it's like carrying your life experiences around on you. You don't ever have to be afraid of losing them. You can't feel scared because you know that, that happened then and then everything can ... everything has some kind of secret. Whereas even if I write, if I have my book and my words and my drawings or whatever, that can be lost. I can't guarantee that they actually are where I left them.

I: You mentioned that the blood takes away the pain - what is the experience there?

24) I couldn't ever have pleasure without pain. Because I used to feel if there is something pleasurable, that I couldn't feel as a painful ... in a painful way, then I felt like it wasn't happening. I cut once with a knife, that was very sharp and it cut ... it was two years old and it was ... it just sliced. And I had this gaping hole and there was actually no pleasure from it, because it didn't ... it wasn't painful. And it really upset me because only the superficial ones, or unless it was an injury, were the ones that were sore. ... There is ... I don't know, there's a really big difference. I could never really ... the cutting that was too deep was, I might as well have

been slicing a piece of cheese. It didn't bring me closer to myself. It made me feel more objective. Whereas the smaller ones, the ones that are more ... when I was using as a razor as if it was a pencil or a pen, they were the ones that felt ... I felt much closer to my own feelings. And to ... I can't ... I mean it's really ... it's always confused with this whole pain and pleasure.

25) I am ... I asked my sister the other day, I said, I don't understand this whole thing. I used to ... I used to pretend that I was a horse and she the rider, and it would only, you know, it was ... it never became a sexual thing but it was just that pain. It was that feeling of nearly that sexual, but not sensual just in pleasure, I mean just not in, in ... you had to feel like on edge.

I: Feel like on edge?

26) Because it's a very, very delicate point. Because if you get whatever, that can be lost over the pain threshold, then it becomes numb again and just before the pain edge it's numb as well, because it isn't ... it's too pleasurable. You know, it's too easy. It's like lying in a temperate bath and it's nothing which it is to be; either be colder or it must be hotter, but it ... the right temperature is hard. And that is where the pain is a guide to ... it's a very ... I mean, I suppose ... I don't know.

27) The thing is, you can't be reached with anyone else. It's not something which you like to have ... you know, this is really orgasmic and I can't have this in a relationship, because it doesn't happen. It's so private. It's the privacy which makes it even more extreme. There are no words. There is no ... I think that the word is central.

I: There are no words?

28) There is no explanation. You don't ... You don't have to explain why. You don't have to ... just feels so ... so strong. If there was somebody else there, that wouldn't just be the same. I mean the whole, the whole reason for cutting is to get ... it's a ... totally internal ... you know, if you focus on something which takes away all consciousness, self-consciousness, and it could never be achieved with anyone around.

29) Because I would have mentioned to bring in awareness of being ... of being ... you know. As soon as the blood comes into it, there's a certain humanness which just goes. It doesn't ... there's a way, it just ... it allows for freedom of ... it's so awful, I didn't think that it was so important to me.

I: Allows for freedom of?

30) Just being, just being ... being a part of life. You know, you don't have to apply for blood. You don't have to apply for ... for an allowance. You don't have to apply for a license to cut. You don't, you know, it is so personal and so sacred. And that is hard to put together, because if it's so sacred, you know, why cut, why hurt yourself?

I: Does it feel like hurting?

31) No. It feels like ... sometimes, I mean if it's ... if it's out of hurt and there is ... if I'm really upset, it's a kind of rebellion against being, ... feeling something and being something else. Of feeling like a free spirit, and yet being heavy and earthbound and ... and unable to explode, you know.

32) Maybe that's why that the scarring is such a strange thing and a whole healing complex ... even ... it's almost proved that as soon as anything comes out into this world, it has to immediately solidify and becomes stationary.

33) And it's quite ... I mean, although you don't want to bleed forever, because, you know, that would mean bleeding to death ... it's ... you want something that is always bleeding, that isn't always contained ... and I know, I know it means a lot of hard work.

I: How do you mean that?

34) Well, I think that the feeling can be achieved in another way. It's just hard to find the ways. I think that it has so much to do it with creativity.

I: You mentioned it earlier that it was like creating. Could you say more on that.

35) It's ... it's almost where ... it's creative and then ... when you create something, it becomes separate from you and only in the creation of it is that like cutting.

36) It's a sense, it's a feeling of bleeding yourself, you're flowing from one form into another. But what you create doesn't have the same sensuality, that's why the blood can only ... that's so frustrating, because you can't, you know when ... every time I made something, it doesn't matter how, you know, how good it is, it doesn't smell, it doesn't taste, it doesn't ... it's really frustrating, because ... I mean, I write and I ... it's almost annoying that in the writing I can smell and taste

what I'm saying more than when I create something physically. I need that physical ... I need the sculpting. Drawing doesn't do enough. It's too ... it hasn't got the dimension of it. But then when I created a sculpture, and I love it, but it doesn't feel nice. It doesn't live.

37) And I'm always drawn back to horses, because you can create a horse. I mean, I have created horses, I mean from what they are really, when you see the potential. It was an addiction, because they smell and they breathe and they feel and they ... and you can put your hand on their skin and you know there's a whole living world under that.

38) Just like humans, each one has a different type of skin. It's containing a whole mass of living cells and things. And that's the part that is missing when you create. That's another thing with babies and foals, and I delivered a few foals and I was banned when a baby was being borne... I couldn't understand this repulsion all the guys felt that were around. Oh God, is that what it's been living in? Look at that. The whole, you know, when the whole interns come out, it's just, it's so beautiful and hasn't been touched by a single person, and yet here he's asking how can you even look at it. I mean, this is the grossest thing I have ever seen. And it's the most beautiful thing that anyone could wish to create. And it creates itself. It doesn't have ... there is no thought, there is no planning, there is no ... it gets self-created ... and putting a whole new foal into the world.

39) And that whole blood thing as well, I mean, that smell is so strong. I just don't wanna wash, you know, when I ... just don't wash it. You know, just leave it on. And I think that's also what it puts you back to. I mean, you've been born with blood all over you. It's the first smell you have and it's the first taste, because I mean, it's on your face. It's a ... going back to a very ... you know, the earliest experience of life you ever had. I don't ... I mean, I don't know how to quite deal with it.

I: When you cut, how do you change or how do you differ at the end of the experience?

40) It takes away the irrational. It takes away the loneliness, which is too overwhelming to think through, so the cutting releases the ... it's like pulling a plug.

41) If I'm feeling very, very confused and very emotional and there's a part in me which knows that whoever I'm ... I sort of concentrated this ... I mean, if it's another person or if it's just an experience I've been through or whatever, it's so you know, kept over every sense, and cutting puts some kind of perspective to that, because it firstly takes care of the ... that whole physical sense of being scattered. It focuses me so immediately there's pain, that feeling of ... as if your soul has jumped out of your body, that's the feeling ... everything is so confused and so distorted, that I feel like ... I feel like my whole body has just gone its own way, you know, my head is in one place thinking, my soul is just flipping out somewhere, you know, just really like ... not expressing, just in that completely distractive sort of stage, and my body is in another place.

42) And the cutting brings everything together, because the pain has to bring me back into my body to kind of deal with it. It's like it just seems to happen, like it just seems to be an automatic reaction, and my mind has to become clearer because it has to focus on what's being done. And then I'm cool.

43) Then I can sit down and I can think through what has just happened and what I'm missing. What is the point I'm missing that isn't ... that broke me into so many little pieces. And then I'm fine, because then I can consider.

44) Like the other night when I cut, and I haven't cut for a long time, and I was very, very hurt by somebody. I was very down, just the whole uncaring thoughtless motivation, and it was motivation but it was, they didn't know while they were doing it and I cut, and then I was really, really angry, and I was just ... but I felt - I felt very strong. And now that I didn't really understand, how I could feel so strong at the same time. And then I tried to sleep and I don't have the feeling, I was thinking but I'm missing a point. And the point I came up with was, that I had to take responsibility for being sensitive and caring. And the more I denied myself caring for things the worse it would get. The worse the anger would get and the more I abuse myself and hurt myself; and I felt so relieved. But if I hadn't cut I wouldn't have been able to ... I don't know, there is something that it does. It's just ... I expect too much. ... it doesn't feel at all.

I: Tell me a little bit more about the matter of caring.

45) ... I always thought ... I always thought that I didn't care about things, because I didn't want to, but ... when it came to people. ... and it came very much to me, I just - I didn't ... I didn't care about myself because I didn't have any respect for humans, but I have absolute respect for life, in whatever form it came. So it would confuse me when I care about somebody because of them being part of life, but I didn't actually like them for what they did. And so I couldn't truly care for them, because I wasn't ... I wasn't motivated by wanting to have them as part of my life. And yet cared for them as part of life ... but I find it very difficult to ...

46) The whole feminine side is best in what life is about. I don't know how to be ... I don't know how to express myself femininely with people. And then the feminine is so strong, that when there's full moon I become very affected. Dreams, emotionally, but I don't ... haven't ... take a feminine attitude towards people, so it's not a - I can't develop it.

47) But I always had a very masculine approach to my protection. ... and so it left me where I can't ... can't ... naturalise it. I can't ... when I get into the bloody state of life, when I just become totally ageless and then when it just don't ... I can't care for myself ... I can't ... I don't know ... ja, I lost it so long ago and keeps fighting to put it back, and that's why I can't back the strongest is in the pattern, the whole ... it's really maternal, in a way. That's when I feel most feminine.

I: When you're cutting?

48) Ja, when I'm blood letting. It's like a virgin, you know. It's like a secret society that ... it's a very collective conscience of ... because it's not cutting to kill, where I associate masculine cutting with killing ... and cutting for suicide. ... It's also totally different, I mean ... cutting is not an escape. It's trying to bring together. It's trying ... it seems to inspire courage. ... It's like a ... no, it's ... it gives a sense of renewal and beginning and ... and initiation. It's like a ... somehow it's confirming a commitment ... you know, when I get really, really depressed, which is just spaceless and disorienting, and I know that I got to pull myself up. I've got to remind myself of why I'm here, that I'm here for a reason, and I haven't ... I mean, I'll never be sure, completely sure, maybe I'll be really sure of why, but you know, later, but I have to maintain my conviction and my love. It's not enough. It's just - passion for life. It's through the passion, I can't allow it to consume me. ... and I mean, I don't know whether it's relevant, but I am bulimic.

49) And I've been bulimic for seven years and I started to get out of it now, but the cutting actually - it does what the bulimia tries to do. You can only, with a certain kind of mind thing I know with me I have to be in a very ... cutting isn't just releasing a whole lot of anxieties. It's ... I mean the bulimia is important. The whole throwing up is just a release. It's just a ... get of my life, I don't feel like this, I don't know how to keep going, I ... it's depressed, it's negative, it's destructive. It's very, very destructive.

50) I can only cut when I feel ... like some kind of feeling when there is ... it's ... I can't just cut, I can't just cut for the sake of cutting. I mean, I often sat there and I didn't ... I didn't quit cutting. I mean, I can just cut now, but ... it would be disrespectable, because it's ... I'm not ... it would be abuse. It would be just doing it for the sake of doing it, rather then doing it for the love of doing it.

I: So the love of doing it and passion motivates the experience?

51) Well, it's sort of festive. I mean it's a rejoice in life. It's a ... that's why I say I can't be in a really bad depression and do it. I have to be feeling passionately upset and passionately hurt or ... well, just being sick is just a ... it's not a passionate thing.

52) It doesn't have the ... I don't know, the whole love part, it's ... it's quite central. It's motivating, I mean ... somehow it expresses a love and I don't know how? ... It sounds quite peculiar, if you live around ... I mean, I live around animals and they'll pick up a scent, it doesn't make them frightened or anything. There is a curiosity in their behaviour whatever it will be, the smell or the scar or whatever it is, with the dogs and horses and cows. And there's a bond. I think that that's what the whole thing is, that a bond is created and it's ... it becomes such a typical kind of thing. I'm sure a lot of people pick it up but they - it doesn't even register. It doesn't ... I don't know, it really makes me sad. It's like the whole policy of life is gone.

53) People don't - the blood doesn't mean anything. They can be afraid of it, they can be repulsed by it, but it's so symbolic how people see life. Like they honestly believe that if they cut themselves they gonna find a whole of little wires and a battery. I mean, it just seems - it's totally ... it's beyond me to imagine not knowing that your body is blood and that life is blood. It doesn't play any role in our society. Only witches and a few people and doctors can play with it, but there's no real spirituality.

I: Is the flesh part of the experience?

54) I've always been fascinated by it. Just in, you know, if you, you know, through biology and whatever, just watching it and just ... it doesn't - it's ... because you can't really see what's happening. The only way I've seen it's alive is by bleeding.

55) It's quite a frustrating organ. It doesn't tell you anything. And you know, it used to amaze me, like I've never had bad acne or anything, but if I got a spot, it wasn't the spot that was bothering me, but I had to know where it came from. And I mean, I would literally hack it away to find out the origins. I mean, nothing ever happened except I looked like I had run into a door, but it just used to amaze me how this thing could produce stuff and have a colour and have a ... you know, all this movement underneath, you know, and it wasn't showing anything. I mean it doesn't show any movement, it just doesn't lie or something, but there is a ... I suppose it's ... it's quite frustrating, because like everything that I do, everything appears so tranquil and then underneath, there's a whole tide of things going on.

I: Is menstrual blood any different?

56) Ja. I mean, I think ... I always, I never wanted to grow up, so the thought of any kind ... menstrual blood was just a lot of pain.

57) It is different, because it's been rejected by your body. It's not ... I've noted to feel a lot more ... you know like, it's a part of me now and it's not that bad. I think because there's no ritual around. There's no custom or anything. It's not part of our social life. It doesn't - it never feels like it's flowing from me, you know, because - because of tampons and all this makes it a dirty business. It's not a cleansing thing which it should be. I mean, it should feel like it's cleansing, I mean I think.

58) But blood isn't the same. It hasn't got the same style. It's just different, a totally different feeling, but again, I mean, it is - it's become more part of the whole ... it's the same body, but it doesn't ... it definitely doesn't have the same experience about it ... and a totally different colour.

Protocol Four

Interviewer (I): The purpose of this interview is for you to describe your experience of cutting yourself. You can even think back to one incident when it happened, and give as full a description of that experience as possible.

Patient (P): I) Well, I can think about the first time after a year, that I did it. I was in my flat and I was alone and I was very depressed. I drank a glass of wine and was sewing and was listening to music and then, and the heater was on, and then ... then I drank another glass of wine and then I started getting more depressed.

2) And I just suddenly, I scratched myself with a needle on my arm and I saw the blood coming out, so I thought ... I don't know ... I went to the bathroom and I got my Inti-cutter and I went and sat in front of the heater. And I cut myself in the arm.

3) I wasn't scared because it ... I knew its only the first bit would hurt and then it goes away ... and then Frikkie, my ex-boyfriend came into the flat, and he grabbed the Inti-cutter away and then I went to the bathroom and I locked myself in and I cut myself further and then he went ...he phoned the ambulance and then they came and picked me up ... and that's it.

I: You were depressed.Could you talk more about that experience. What was it like?

4) It was ... at that stage, I didn't know I was depressed, it was like waking up and you know you're not happy and you're not - well, I wasn't sad because I didn't cry but it's ... it's like floating. ... I don't know what to say. ... I think the time that I cut myself in my neck was when I really felt depressed, you know really ... then I really thought I was gonna die, when I cut myself in my arm I didn't ... I knew I was gonna go to hospital and get stitches and come home and everything was gonna be the same.

I: Tell me more about blood.

5) Once I saw it I just wanted to see more. ... I don't know, it's warm and dark. ... Probably made me feel like - probably has the same effect as a baby getting a warm bottle of milk.

6) I don't know, I just ... the more that came out the more I wanted it to get out ... you know like empty myself.... I don't know. ... it was probably like ... I really wanted to commit suicide but I couldn't, because I was too scared, so that the more blood that came out the more of my

life was coming out.

I: So the more blood coming out, the more you were emptying yourself of ...?

7) Of life? ... probably of hurt and anger.

I: Can you go on with that?

8) I suppose that was the only way that I can ... that I could show what I really felt ... without hurting anybody else.

I: As the blood came out, what effect did that have on you?

9) It's like before I cut myself, there was this tension and this build-up, and then as soon as I cut myself I got calm and ... it sounds very silly - I got calm and I felt like everything would be fine now.

I: What did you do with the blood?

10) I let it drip. When I cut myself in my neck, I sat in the bath with my ... pressed it out and I just let it spray all over. ... And then the bath got full, so I pressed it out the plug.

I: What are your feelings?

11) It's like, you know, it's the same feeling you get like when you're little and you cut your finger and that bleeds, that actually a drop falls from your finger and it's bad enough that your mum comes and hugs you and pampers you, because you hurt yourself... it's that security?

I: Can you tell me about the scar afterwards, about having scars, what you felt about that?

12) You see, on the one side I was always scared that it would make a big scar. That's why I never cut on one previous cut, because they don't give stitches or that's what I heard. And on the

other side, when I started feeling down, then I would sit and look at my scars and think about how I felt when I cut myself and then get comfort. It's quite warm.

I: You say you got comfort. Could you go on with this?

13)But at that stage I think that was something what I achieved, you know like: at least one thing that I could do well. Well I wasn't hurt or anything else at that stage. ... I don't know, it's just something I did for myself against other people.

I: Something for you, for yourself. Can you tell me more about that?

14) I think it made me feel free. Because if I couldn't do anything else, then at least I could cut myself anytime anyway without anybody being able to do anything about it, if I didn't let them. Because I was very trapped and didn't feel secure at that time. It was also to make people realize that I am serious.

I: Can you go on with that?

15) I don't know ... that people could believe me, that .. that I wasn't happy and that it wasn't something which I just made up again, or I overreacted about ... I don't know what to say anymore.

I: You mentioned your skin, tell me a bit more about the experience of your skin.

16) Well, I didn't have any other scars, it was something just clean, I mean out of fault. Afterwards when I saw the scars or while I was cutting? ... I don't know the feeling, just satisfaction.

I: What was satisfying? What was it like?

17) It's like looking at a baby's bum and it's clean and it's soft and it looks ... it looks beautiful. And then you cut and it pops open and all the blood comes rushing out and ... and that's what it looked like.

I: And how was that feeling? What reaction did you get?

18) Well, a deep satisfaction when I ... I was able to like open the skin, get through the skin, and come to the veins where the blood is, where ... where all the problems lay.

I: How was that, that getting through the skin. What did you think about that?

19) It was annoying because it was so thick. I don't know. I don't know whether I really thought about the skin, it was ... it's like a bullterrier, once the skin is open then you just want to go deeper again. Like smelling the blood and you just, dogs just go crazy, you just go crazy and you just want to get more and more, bigger and bigger.

20) It's like going to a destiny ... to a destiny or ... getting excited because you're nearly there and then ... and when you've cut deep enough that you get enough blood out then I just wouldn't wait for whatever gonna happen next ... you know? Whether I'm gonna pass out or whether somebody is gonna phone or somebody is gonna ... Frikkie is gonna come to the bathroom or come to my flat or ... whether I'm gonna faint, or ... do you understand what I'm saying?

I: Just say more about it.

21) No, just then, and then afterwards I'm calm, because now I've done what I wanted to do ... once Frikkie came in before I could cut myself too deep ... and I wasn't finished so we went to the car and he had to go inside to try to phone the ambulance, because he didn't want to mess his car and in the boot there was a razor, so I cut myself further until I felt ... until the blood ran up my arm and onto my clothing and onto my shoes and then I felt better and then I waited for him to come and so we could go to hospital.

22) It's like the same feeling I got in one movie, the women, her neck was cut off at the end of the movie, "Sorrow" or something. No it wasn't that, but in any case a little girl cut the women's neck and she sat like this and then they turned her around and then the blood, with every heartbeat ... the blood slashed out ... and I liked that.

I: Could you tell me a bit about your experience of pain and cutting?

23) Well, the only pain that there was, was it's like when you're getting an injection the only pain you feel is the needle going through your skin. It's like quick ... I don't know, it's like one

cut and then you just tense your teeth and wait for the burning to go away and then you cut again and wait for the burning and go to a when you're through the skin there's in any case no pain, I think ... I never had ... I never had pain like for instance if you stepped on a piece of glass that cut you and you had to go to hospital to get stitches or whatever because that's something that you, I think it was more part of shock than anything else that made it hurt more, but I never, when I cut myself I never had real pain, it was just in the beginning, that was a quick little burn.

I: How were those feelings you described as anything other than pain.

24) Numb.

I: Could you tell me more about that "numb"?

25) Well, I think the whole experience was always like you are in this cocoon and there's ... it's like there's no heat and no cold, it's just everything mellow, it's like everything is in slow motion and no sounds and ... it's probably like hard concentration, you're not aware of anything else but what you're doing and what you're doing doesn't hurt, because it's something you want.

I: Tell me more about the relief.

26) It wasn't like running a marathon and at the end you're thinking shhh, I've done it, now I can go and have a glass of water or ... it was like peaceful, suddenly everything was ... you know like this huge mountain and ... is now broken down and then there's just peace and then ... and satisfaction because I achieved what I wanted to. ... Is that good enough?

I: Afterwards, what do you think about cutting yourself?

26) Most of the times I couldn't wait until I healed ... so, I don't know, because one of the first times, ... about three days afterwards, after they took out the stitches, I pulled it open, I think I was probably just scared that I might do it again. ... It's like something is driving me, driving me, you know ... it's like ... I don't know, looking for, wanting a cigarette and there's no cigarette in the house and you get all tight and you look around and walk around but you can't get any money and, you know, but you have to do it and eventually you walk ten miles and go and borrow money to get cigarettes, it's like you just have to do it, you can't, there's no ways that you can just leave it. ... Uncontrolled.

I: Where do you cut?

27) Well, on my pulse, on my arm because that's where your pulse is and on my neck, because that's were the other pulse is, I don't know what you call that, and in the vein, on the side here and there where you can feel, that was my ... and once on my leg because when I was in hospital somebody told me that works.

I: Is how deep it is important?

28) If it wasn't deep enough and it didn't bleed enough and it didn't, wasn't open enough then I didn't have to have stitches ... don't ask me why.

I: Tell me about the stitches.

29) People comforted me. They probably comforted me because it was something that they could see, if I went to hospital and I said to them I've got no hole, nobody would comfort me.

I: How long did the relief last?

30) Until everybody freaks out how bad it is and how could I do it and ... till I got to the hospital.

I: When you were cutting, did you ever cry?

31) Only once, but then I didn't really want it ... that was because I cried I did it. And that was, I cried because I knew I couldn't do it this way. ... And other thoughts I also had before I cut was that if I don't do it now then I won't have the guts to do it later. ... no, ... not will - the courage.

I: Courage. Tell me about courage?

32) Because I always did it when I had ... even a glass of wine could ... when I had alcohol, but I was never so drunk that I didn't know what I was doing. ... and at that stage people were

checking up on me, because they didn't want me to drink, because they were scared that I was gonna cut myself again so ... if I ... the times that I was able to get a glass of wine or I don't know, anything ... because I was feeling bad, then I had the guts to go and cut myself because it was lighter than if I couldn't get any alcohol then I probably would feel pain and I probably wouldn't be so motivated, wouldn't have courage.

I: The feeling of satisfaction, is it different to other senses of satisfaction?

33) It's a mental satisfaction, it's not ... it's personal, it's not something that somebody else could prize me on, but that's something I prized myself on, or praise myself on.

I: Have you ever attained what you would consider a total satisfaction from cutting?

34) I think I got it. I think I achieved my greatest cutting satisfaction when I cut myself and I nearly passed out in the bath.

I: Would you compare that blood with say, menstrual blood?

35) It's the same smell. Menstrual blood is dirty. The blood of my body is cleaner. ... It was bright ... menstrual blood comes whether I want it or not, and when I cut myself I get my own blood. Two totally different things. Menstrual blood is something that comes naturally, and my own blood is my own. I don't know, my wording are very bad.

I: Tell me more about that, that of "your own".

36) Well, it's something that I can keep in or bring out on my own will, so if I decide to stay alert I can keep my own blood, if it's possible. If not then I open the tap. When I want my own blood then I cut myself and I open the tap and I just let it run out.

I: How did you feel afterwards about having the scars, marks, about other people seeing the various marks?

37) Sometimes there was a connection like people saw my scars then ... once in a while I got somebody that felt the same way, but didn't have the guts to do it, or ... or somebody realized

that it's ... that ... that I wasn't always happy as I seemed. ... And at other times it gave me a lift ... but I don't really care. I mean, I don't really ... it doesn't really matter that it's there, sometimes when I feel ... down or scared then I suddenly look at my scars and I think back, then it still gives me that comfort, that I got at that stage. ... And for a while it also meant that if I could do it once then I will always be able to do it, it doesn't matter ... it's not that my courage will go away.

I: So seeing the scar reminded you, you can always do it again.

38) And at that stage it reminded me that I should do it.

I: Could you tell me more about loneliness?

39) I don't know, it was like, I'm always misunderstood or misinterpreted, and on the other side I went out with Frikkie and nothing that I did was good enough, so ... and there was nobody else I could tell because nobody approved of the relationship, so I was still alone.

40) And then later on it was loneliness that I've been doing it for three years and nobody knows what's wrong with me, and everybody else is freaking out and nobody can help me and I was still alone. I didn't even go out with Frikkie anymore. ... And they probably all thought I was crazy and that made me even more alone. ... That was probably also one of the reasons why I cut myself because I thought a lot about ... if you die you go to heaven in any case, or you go to hell; but that's after life, so there's no ways you can get away from anything, such is probably just ... it made me feel, at least I'm trying to get away, even if I couldn't.

I: To get away from?

41) From life and death. Not people ... from life and it's fear, and death and also it's fear. But at least when you're dead for a while until there's another life, you don't know anything about it.

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