

SAMPLE CHAPTER

Managing Self-Harm

Psychological
Perspectives

Edited by Anna Motz

First published 2009 by Routledge
27 Church Road, Hove, East Sussex BN3 2FA

Simultaneously published in the USA and Canada
by Routledge
270 Madison Avenue, New York, NY 10016

Routledge is an imprint of the Taylor & Francis Group, an Informa business

© 2009 selection & editorial matter, Anna Motz; individual chapters, the contributors

Typeset in Times by Garfield Morgan, Swansea, West Glamorgan
Printed and bound in Great Britain by TJ International Ltd, Padstow,
Cornwall
Cover design by Andy Ward

All rights reserved. No part of this book may be reprinted or reproduced or utilised in any form or by any electronic, mechanical, or other means, now known or hereafter invented, including photocopying and recording, or in any information storage or retrieval system, without permission in writing from the publishers.

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library

Library of Congress Cataloging-in-Publication Data

Managing self harm : psychological perspectives / edited by Anna Motz.
p. cm.

ISBN 978-1-58391-704-6 (hardback) – ISBN: 978-1-58391-705-3 (pbk.)

1. Self-mutilation. I. Motz, Anna, 1964–

RC552.S4M36 2009

616.85'82–dc22

2008052887

ISBN: 978-1-58391-704-6 (hbk)

ISBN: 978-1-58391-705-3 (pbk)

Contents

| | |
|---|-----------|
| <i>List of contributors</i> | ix |
| <i>Acknowledgements</i> | xii |
| Introduction | 1 |
| ANNA MOTZ | |
| | |
| PART 1 | |
| Understanding self-harm | 13 |
| 1 Self-harm as a sign of hope | 15 |
| ANNA MOTZ | |
| 2 The paradox of self-harm | 42 |
| ANNA MOTZ AND HEATHER JONES | |
| | |
| PART 2 | |
| The wider context: systemic issues and self-harm | 53 |
| 3 ‘Why do you treat me this way?’: reciprocal violence and the mythology of ‘deliberate self-harm’ | 55 |
| CHRISTOPHER SCANLON AND JOHN ADLAM | |
| 4 The trap: self-harm and young people in foster care and residential settings | 82 |
| VIVIEN NORRIS AND MICHAEL MAHER | |

| | | |
|----------------------------|--|------------|
| 5 | Self-harm and attachment | 97 |
| | ELIZABETH GROCUIT | |
| | | |
| PART 3 | | |
| Women and self-harm | | |
| | | 117 |
| 6 | Speaking with the body | 119 |
| | PAMELA KLEINOT | |
| | | |
| 7 | Absences, transitions and endings: threats to successful treatment | 142 |
| | LYNN GREENWOOD | |
| | | |
| 8 | Self-harm in women's secure services: reflections and strategies for treatment design | 157 |
| | REBECCA LAWDAY | |
| | | |
| 9 | Self-harm cessation in secure settings | 180 |
| | ELIZABETH GROCUIT | |
| | | |
| | Conclusion: 'If you prick us do we not bleed?': (Act III, Scene 1, <i>The Merchant of Venice</i>) | 204 |
| | ANNA MOTZ | |
| | | |
| | <i>Further reading</i> | 219 |
| | <i>Index</i> | 221 |

Introduction

Anna Motz

This book is designed to help clinicians, people who self-harm and their families to understand its causes, meaning and treatment. The notion of managing self-harm is central to this text. The idea of managing self-harm is inextricably tied into understanding it. The book does not offer a prescription for stopping self-harm, or specific behavioural guidelines but rather describes therapeutic approaches to working with self-harm, and outlines the complex, subtle and meaningful interaction between those who engage in self-harm and those who seek to understand it. What needs to be managed is not only the behaviour and distress of those who self-harm, but also what can be the overwhelming and potentially unhelpful responses of therapists and other workers, who may find the intensity of their own feelings in relation to self-harm too much to bear. When these countertransference feelings can be thought about and contained, they become a tool to understanding what it is that self-harm communicates. At this point, meaningful engagement and therapeutic work can begin.

There are many voices in this book, and each chapter integrates theory with clinical illustration, enabling the direct experiences of those who self-harm to be heard. Throughout the book, the contributors provide clinical material to bring theory alive. The book is designed to describe, illustrate and make intelligible the function, meaning and complexity of self-harm, in the populations most at risk. The selection of contributors reflects the populations in which self-harm occurs most frequently – adolescents, young people in care and women in secure mental health and custodial settings. Many of these people will not feature in the official statistics unless they make actual suicide attempts or are treated in emergency rooms, and disclose that the cause of their injury is self-inflicted.

Self-harm is often characterised by secrecy and so may not actually reach the public domain as the prevalence of self-harm websites demonstrates to.¹

There are other groups of people who self-harm, for a variety of reasons. The book does not contain any discussion of those who choose to self-harm for political purposes through, for example, hunger strike or those who do so purely for sexual or religious reasons.

This volume devotes itself to understanding self-harm in adolescents and adults; the greater prevalence of female self-harm is reflected in the fact that four of the chapters deal specifically with women. The term 'self-harm' in the specific sense is generally confined to burning, cutting, strangulation, head-banging and insertion into the body of sharp or painful objects. Although burning and/or cutting oneself may appear to be highly unusual and bizarre activities, they are not, in fact, uncommon in certain populations, for example among adolescent girls who have been sexually abused. These acts of violence, while directed against the self, also have indirect victims, such as parents and medical professionals who witness these acts of self-mutilation and the scars that are produced. The failure to protect the young women from self-harming can induce strong guilt feelings in these carers when they are faced with these indelible images of distress. Managing these responses is an essential part of the management of self-harm, in that the two are deeply interrelated.

My aim is for the book to be accessible not only to those who work with people who self-harm, but also to people who have inflicted or still do inflict violence on themselves, so that they may find some understanding. Voices of self-harmers themselves are integrated into the book in many of the chapters, in the form of both direct quotations in Norris and Maher's chapter on self-harm in young people in foster and residential care (Chapter 4) and Grocutt, Kleinot and Lawday's chapters on self-harm in women in secure units (Chapters 6, 8, and 9), and written words in the chapter on 'The paradox of self-harm' (Motz and Jones, Chapter 2). Throughout the book, clinical details have been disguised and

1 Available published figures vary from between four per cent in the general adult population to 82 per cent in adolescent psychiatric inpatients (Ougrin, Ng and Zundel, 2009).

anonymised to protect client confidentiality; wherever possible, permission has been granted for clinical decisions to be described.

The contributors are drawn from a variety of backgrounds and, all aside from Heather Jones, are mental health professionals, based in widely different settings. The book presents a range of psychological perspectives on self-harm, its development, manifestation and treatment. While a largely psychodynamic perspective is represented by Motz (Chapter 1), Scanlon and Adlam (Chapter 3) and Kleinot (Chapter 6) other theoretical models presented here include an attachment perspective, described by Greenwood in her chapter on self-harm and eating disorders in terms of their relation to loss (Chapter 7) and by Grocutt in her chapter on the development of self-harm and early attachment disorders (Chapter 5), and in her later chapter on self-harm cessation by women in secure mental health facilities (Chapter 9). Additionally, Norris and Maher present an integrative model to formulate the particular meanings of self-harm for young people in care; they outline systemic and psychodynamic perspectives (Chapter 4). Lawday presents a model of care for self-harming women in secure services that relies primarily on a dialectical behavioural approach, but also draws on findings from attachment research and the experiences and views of service users (Chapter 8).

The contributors are wholly united in their attempt to explore the meaning, function and goal of self-harm, and to understand the individual who relates to them through self-inflicted violence, rather than simply viewing self-harm as dangerous behaviour that must be eradicated at all costs. This does not mean that they ignore its potential destructiveness or lethality but that the focus is on its function, meaning and communicative power. Within this volume, all contributors make a clear distinction between suicidal behaviour and self-harm, whereas other texts written from a psychodynamic perspective highlight the murderous intentionality of suicidal states of mind in acts of self-harm.

Clearly, self-harm can be associated with mental illness, personality disorders, substance and alcohol abuse, and learning disability. Adshad (1997) suggests that an understanding of self-harm should co-exist with a psychiatric evaluation. A central question is whether self-harm will lead to suicide, or whether it can be considered a meaningful form of behaviour that does not have self-annihilation as its aim. The two phenomena of self-harm and suicide are often classified together.

The suicides of 20 young people since 2006 in the Welsh town of Bridgend have focused attention on this serious problem. Despite initial reporting of a ‘suicide cult’ and a high level of concern about whether the suicides were triggered by social networking sites, a more measured response addressing both self-harm and suicide has emerged, with research and a plan for intervention: the Welsh Assembly Government (2008) has recently announced the launch of a five-year action plan to reduce suicide and self-harm in Wales. This is a thoughtful document that attempts to identify the real social and psychological issues that may trigger such hopelessness in young people, stressing the crucial need to enhance awareness of mental health issues such as depression and the need for early interventions. The draft plan calls for intensive training and support across various agencies dealing with young people, including schools and general practitioner (GP) surgeries.² The consultation document is called ‘*Talk to me*’, highlighting the understanding of suicide and self-harm as a communication.

The draft action plan places emphasis on the role of psychosocial interventions, improving the response of specialist services including Youth Offending and Child and Adolescent Mental Health Services. The action plan also stresses the crucial role of voluntary sector help, which can be invaluable in enabling troubled young people to find a place where they can be heard, and recognises the need for such help to be available day and night.³ In the document, self-harm is defined as ‘an intentional self-poisoning or self-injury, irrespective of the nature of motivation or degree of suicidal intent’ whereas the premise in this book is that self-harm refers to those acts of self-injury in which the conscious intention was not to

2 In order to provide the necessary skills in sectors such as health and education for staff to identify signs of mental distress, a training programme – Mental Health First Aid – will be rolled out across Wales. Assistance for those who may be experiencing mental distress will also be available through a Welsh Assembly Government-funded all-Wales, 24-hour, seven-days-a-week telephone and text messaging service. The Community Advice and Listening Line (CALL) will provide an easy way for the people to access emotional support and information on mental health and related matters in a confidential environment via a simple text message or call. The Samaritans also offer 24-hour telephone support for those in distress or despair that could lead to suicide.

3 The new post of National Samaritan Co-ordinator for Wales funded by the Welsh Assembly Government will work closely with other organisations to develop services further for people who need someone to talk to.

die. The existence of unconscious wishes, which can include both suicidal and murderous intentions, means that this distinction is, at times, difficult to sustain.

The Welsh Assembly Government document acknowledges that self-harm is particularly prevalent in young people and that it is ‘an indication of underlying social, relationship, emotional and psychological problems. Sometimes it is a way of expressing and coping with the emotional pain they are experiencing’ (Welsh Assembly Government, 2008: 7). Ougrin, Ng and Zundel (2009) also emphasise the role of immediate psychosocial intervention in ameliorating distress, outlining how a “therapeutic assessment” following self-harm and suicide attempts can reduce risks for adolescents.

Greenwood’s chapter in this book (Chapter 7) echoes this call for pathways for communication to be made available to people at risk of self-harm, raising questions for clinicians about how resources are to be deployed, and what help is to be made available at key transition points in therapy. She highlights the vulnerability of women with eating disorders at these points in their treatment, when they move from an inpatient to an outpatient setting. Such transitions can reactivate experiences of loss and abandonment in an unbearable way; Greenwood suggests that therapists should be available for communications outside of the consulting room. She has modified the traditional model of analytic psychotherapy into a more integrative model, and poses the following challenge to clinicians:

We cannot be available 24 hours a day, seven days a week but can technology help address some of the problems? For example, some clients may reach a point where they can call, feel reassured by a recording of a familiar and trusted voice and leave a message that requires no response. My colleagues at the Clinic for Dissociative Studies have described to me their clients’ use of text or email and similarly, even when I do call back, the client may not pick up but I can leave a message that provides some support until the next scheduled session – or, admittedly, sometimes the next voicemail. Sometimes clients want a response from us (and I include professionals in the NHS, the private sector and private practice). Can our schedules be flexible enough to allow a ten-minute phone call?
(Greenwood, this volume: 155)

The notion of self-harm as communication, requiring an urgent response, raises the central question of how we as clinicians and carers can respond effectively to that request.

STRUCTURE OF THE BOOK

The book is divided into three parts: understanding self-harm; the wider context: systemic issues and self-harm; and women and self-harm.

Part 1: Understanding self-harm

- 1 Self-harm as a sign of hope (Motz)
- 2 The paradox of self-harm (Motz and Jones)

In Chapter 1, 'Self-harm as a sign of hope' I suggest that self-harm is fundamentally an attempt to stay alive. It expresses a communication to others and serves a powerful function for oneself, and must be distinguished clearly from suicidal behaviour, although it is clear that, at times, there is a real risk that death could occur. I argue that the main motivation and reason for self-harm is self-preservative rather than destructive.

The title of the chapter refers directly to Winnicott's (1956) notion of the antisocial tendency as a sign of hope, in that the act of aggression, apparently destructive and hopeless, in fact reflects the antisocial person's hopefulness in an environment that can recognise and meet their needs. In this sense too, self-harm can express the hope that there will be a response from others so that a need can be met, and that an environment exists that can withstand assault.

Self-harm serves a multiplicity of functions for the individual, who can achieve a great sense of release from unbearable states of mind and direct violence towards themselves rather than another, enabling what could be considered a 'safe' expression of rage. The functions of self-harm need to be clearly delineated and explored for each individual, and the particular situation in which they find themselves. In Chapter 2 I present a personal perspective on self-harm by Heather Jones, interwoven with my text. Her descriptions offer an eloquent, and hopeful, insight into self-harm, and how other forms of creativity can ultimately help replace the impulses to harm oneself.

Part 2: The wider context: systemic issues and self-harm

- 3 'Why do you treat me this way?': reciprocal violence and the mythology of deliberate self-harm (Scanlon and Adlam)
- 4 The trap: self-harm and young people in foster care and residential settings (Norris and Maher)
- 5 Self-harm and attachment (Grocutt)

Scanlon and Adlam's chapter on self-harm and reciprocal violence (Chapter 3) looks beyond individual acts of self-harm to wider society and the sense in which those who self-harm are dismembered, and themselves the victims of societal acts of violence. The authors argue against what they consider to be the fundamentally misguided description of self-harm as 'deliberate' and consider this to be an example of an 'intentional fallacy'. The chapter is predicated on the premise that self-harm expresses most clearly, the violence that we, therapists, mental health professionals and other integrated members of society, do to those who self-harm. The chapter offers a direct challenge to traditional conceptions of self-harm as intrapsychic events with a deliberate meaning and invites the reader to review their implicit understanding of self-harm. The chapter serves as a critique of existing models of self-harm and offers a radical understanding that puts social forces in shaping and creating individual behaviour at its core. It introduces a section on social systems and the interrelation between self-harm and those who encounter and, they would argue, create it.

In Chapter 4, Norris and Maher present a powerful picture of the real difficulties for staff and young people in foster and residential care, for whom self-harm is a potent mode of self-expression, but also part of a cycle of behaviour that leads to rejection. Dealing with some of the most vulnerable children and young people in society – those in foster and residential care – is a challenging and highly complex area. These young people often self-harm in ways that put their placements in foster, residential or adoptive care at risk, and the response to this can also be destructive, leaving carers feeling helpless, angry and confused. The urgent need to understand this behaviour and to find ways out of 'the trap' of self-harm and its impact on carers is highlighted in this lively, clear and moving chapter. The authors outline a model for understanding self-harm and moving out of the 'stuck-ness'. They state:

Our aim in this chapter is to look beyond risk and consider the perplexing question of ‘What is going on?’ for the young people and for those around them when they self-harm . . . and we draw on both psychodynamic and systemic ways of exploring the meanings contained in this behaviour. Our focus in this chapter shifts from the individual to interpersonal and group processes.

These authors draw on a range of theoretical ideas, including attachment theory.

In Chapter 5, Grocutt describes the links between early attachment disturbances and self-harm. She outlines the development of self-harm in the context of attachment theory, also exploring some of the themes presented in the previous chapter dealing with self-harm in the looked-after children system. Grocutt uses both clinical material and theory to demonstrate how self-harm can be understood as an expression of attachment disturbances in childhood, which continue to affect people over their lifespan; the model also situates self-harm in adulthood within the context of ongoing attachment difficulties. Grocutt identifies the ways in which nursing systems and other aspects of caregiving within therapeutic settings can reinforce self-harming behaviour and re-enact earlier disturbances in relationships.

Part 3: Women and self-harm

- 6 Speaking with the body (Kleintot)
- 7 Absences, transitions and endings: threats to successful treatment (Greenwood)
- 8 Self-harm in women’s secure services: reflections and strategies for treatment design (Lawday)
- 9 Self-harm cessation in secure settings (Grocutt)

As I have shown elsewhere (Motz, 2008), the typical target of aggression for women is their own body, or those who they can consider to be extensions of themselves – their children. Women typically locate their sense of identity and their power in their own bodies, which have become their private spheres of influence, to be used as weapons or canvasses on which to depict their painful experiences. In self-harm, this is clearly and graphically articulated, particularly for those women who are confined in secure mental health settings.

Deliberate self-harm is a powerful bodily enactment of psychic pain, which women demonstrate much more frequently than men. In the UK, one in seven women prisoners will self-harm and self-mutilate, while the comparable figure for male prisoners is one in thirty-three (Lloyd, 1995: 178).

The gender difference in self-harming rates is striking. Attacking themselves is not only one of the legitimate channels allowed women to express their anger; it can be considered a form of protest against the idealised and sentimental view of femininity. Self-harm may be seen as an attempt to use the body to point to an underlying, psychic damage, and, as such, is eloquent. It reflects the way that women communicate their experiences and assert control over their private spheres of influence – their own bodies. It can also be understood symbolically as an attack on the body of the mother, as symbolised by the woman's own body (Welldon, 1988). Women typically locate their sense of identity in their bodies; this reflects the tremendous cultural emphasis placed on women's bodies in general, and their reproductive capacities in particular. Self-harm can often involve the insertion of objects into the body, whether orally or vaginally; this has, in my view, powerful symbolic functions and allusions to other, earlier, violations, penetrations and disfiguring trauma.

The rates of self-harm in women are therefore significantly higher than in men, and these rates are even higher when women are placed in confined settings, where their usual controls are absent, and they may feel increasingly helpless and furious, and self-harm becomes the acceptable currency of communication. It has both actual and symbolic functions, that is, to bring the distress to the attention of others who can respond, even if this response only takes place at a physical level, but also to communicate in symbolic form an earlier, apparently invisible trauma.

This book devotes three chapters to exploration of the unique experience of self-harming women in secure settings, from different angles, and one on the association between eating disorders and self-harm, particularly multi-impulsive bulimia and self-harm. In the first of these, 'Speaking with the body' (Chapter 6), psychotherapist and group analyst, Pamela Kleinot, describes her experiences of working in a women's prison. She presents the reader with a rich and highly relevant theoretical understanding of the development of self-harm, with reference to early trauma and severe disruptions in the ordinary experiences of maternal containment

and reverie. This sophisticated theory is brought to life with four clinical illustrations of her psychotherapeutic work with women within the prison, over an extended period of time. While her work offers some glimpses of hope and the possibility of change, it also points to the depths of deprivation and disturbance in this population, and to the intrinsic difficulties of working therapeutically within a custodial institution.

Eating disorders are another form of damaging the self, with the same psychic structure as cutting, burning, mutilating and scarring the body, and have self-preservation rather than self-destruction as their aim. They serve a crucial communicative purpose and establish strict boundaries in relation to what can be taken in and what must be expelled violently from the body. The perverse aspects of eating disorders, and the potential for death in what can also be a quest for purity and peace in life, link them inextricably with other forms of self-harm. As the following quotation from a pro-anorexia website illustrates, starvation can be an attempt to obliterate the unacceptable aspects of being alive, while preserving something beautiful and essential, albeit through destruction:

This is forever. I will do whatever it takes. I want to be thin more than anything, even food.

Starvation is fulfilling. Colours become brighter, sounds sharper, odours so much more savoury and penetrating that inhalation fills every fibre and pore of the body. The greatest enjoyment of food is actually found when never a morsel passes the lips.

One day I will be thin enough. Just the bones, no disfiguring flesh. Just the pure, clean shape of me, bones. That is what we all are, what we're made up of and everything else is just storage, deposit, waste. Strip it away, use it up.

The association between self-harm and eating disorders is well documented, in the psychological literature, in psychoanalytic accounts and in the first-person accounts of women who have self-harmed. In Chapter 7, Lynn Greenwood offers an understanding of eating disorders and their intrinsic connections to self-harm, providing an extended case illustration based on her work in an eating disorders unit. Greenwood (p. 145) describes the intricate connection between eating disorders and other forms of self-destructive behaviour:

In this chapter, I am consciously choosing to use the terms 'self-damaging' or 'self-destructive' behaviour instead of 'deliberate self-harm'. The latter generally describes attacks against the body: cutting, burning, blood-letting, head-banging, or the insertion of sharp objects. Self-damaging behaviour is a far broader term, encompassing deliberate physical harm and other destructive acts . . .

The third chapter dealing with the particular issues of self-harm in women, its understanding and containment is Chapter 8, written by forensic psychologist, Rebecca Lawday. She focuses on service development and design, rather than individual clinical situations. In this chapter, Lawday presents a comprehensive working model for a women's enhanced medium secure unit at Arnold Lodge in which particular expressions of female distress, such as self-harm, are anticipated and sensitively addressed. Throughout Lawday's rich and informative chapter, the words of one of the clients, Wendy Iffil, remind the reader that this is a service whose development has been directly affected by the views of the service users themselves. Wendy says: 'I feel that women's needs are complex and that they often end up in mental health services as a direct consequence of traumatic life experiences . . .' and poignantly describes the absence of the ordinary experience of touch for women in these environments, perhaps indicating that one of the functions of self-harm is to provide an alternative to other, loving or intimate ways of making contact, touching another person. She writes: 'Women miss out on non-sexual and sexual physical contact. For example, where do you get a cuddle from? Women are restricted from having sexual relationships but nothing is offered as an alternative'. This chapter also situates the challenge of self-harm in the context of service development, offering some best practice guidelines, in accordance with recent Department of Health documentation outlining the need for women-only therapeutic settings, within and outside of secure mental health provision.

Continuing the theme of women's use of self-harm in secure mental health situations, clinical psychologist, Elizabeth Grocutt, describes the process of self-harm cessation in Chapter 9. This chapter is based on her doctoral research in which she explored how seven women who were inpatients in secure mental health units achieved this. She elucidates the various factors that helped

the women to stop their addictive behaviour, focusing on the themes that they provided in their descriptions of how and why they stopped self-harming. The individual pathways that these women went down are revealed through an analysis of their interviews, and subdivided into three main themes: the importance of accessing support from valued relationships; regaining control over their lives; and identifying personal incentives to influence and sustain cessation.

Conclusion: 'If you prick us do we not bleed?' The meaning and management of self-harm

In the final chapter, I draw together the ideas and understandings of self-harm that have been explored throughout the main body of this book and offer some final thoughts about how the various strands of the arguments and perspectives fit together.

REFERENCES

- Adshead, G. (1997) 'Written on the body: deliberate self-harm and violence', in E.V. Welldon and C. van Velson (eds) *A Practical Guide to Forensic Psychotherapy*, London: Jessica Kingsley Publishers.
- Lloyd, A. (1995) *Doubly Deviant, Doubly Damned: Society's Treatment of Violent Women*, London: Penguin.
- Motz, A. (2008) *The Psychology of Female Violence: Crimes Against the Body* (second edition), Hove: Routledge.
- Ougrin, D., Ng, A. and Zundel, T. (Eds) (2009) *Self-harm in Young People: A Therapeutic Assessment Manual*. London: Hodder Arnold.
- Welldon, E.V. (1988) *Mother, Madonna, Whore: The Idealisation and Denigration of Motherhood*, London: Karnac.
- Welsh Assembly Government (2008) *'Talk to Me': A National Action Plan to Reduce Suicide and Self-Harm in Wales 2008–2013* (Consultation Document), Cardiff: Welsh Assembly Government.
- Winnicott, D.W. (1956) 'Delinquency as a sign of hope' *Collected Papers: Paediatrics Through Psychoanalysis*, London: Karnac Books/Institute of Psychoanalysis (1992).

Self-harm as a sign of hope

Anna Motz

INTRODUCTION

In contrast to the view that it is a pathological expression of underlying distress, without meaning, reason or hope, I argue that self-harm is a powerful, silent language. It communicates states of mind to others, inscribing a narrative on the body itself. Self-harm embodies unbearable feelings and memories of trauma; it expresses the hope of being understood and cared for.

In this chapter, I present my model for understanding self-harm as an expression of hope in an environment that can respond to this communication and bear its meaning, acting as a call to a longed-for other to see, hear and respond to distress. This model of self-harm does not ignore the fact that it is a serious and potentially life-threatening activity.¹ In this chapter I focus on self-harm as distinct from suicidal behaviour, because, with the former, the intention is not death, but self-preservation. Despite its horror, violence and the genuine despair it expresses, there are other aspects of self-harm that contain within them the hope of meaningful relationships with others, and with oneself. The most commonly seen forms of self-harm are cutting, burning and head-banging while other types of self-injury may be less visible – for example, picking at wounds or tearing or biting at the skin.

Members of the public and psychotherapists alike view self-harm as an attempt to connect with others, commonly considered ‘a cry

1 It is on a continuum with suicidal behaviour and has the potential to lead to death, whether accidental or deliberate. There is an association between self-harm and suicide such that episodes of self-harm increase the risk of completed suicide in the following year.

for help', rather than a suicidal expression of isolation, desperation and anger. Throughout this chapter I will present arguments for the understanding of self-harm as a choice to preserve life. I suggest that its central purpose is to escape unbearable pain and establish a private, internal relationship with the self that can nonetheless relate to another person in a profound way. It is both retreat and approach, and is essentially paradoxical, using injury to create healing and withdrawal into the self as an attempt to make contact with others. Despite its conflicts, it is ultimately meaningful.²

I consider self-harm to be consciously chosen and, in this sense, deliberate, although there may also be unconscious motivations and meanings of which the individual is unaware. It is behaviour that is without conscious suicidal intent but which harms parts of the individual's own body, with the potential to destroy or damage body tissue; common acts of self-harm include cutting, burning, head-banging and inserting objects into the body. I accept Favazza's (1996: xviii) definition of self-injury as 'the deliberate destruction or alteration of one's body tissue without conscious suicidal intent'. Some authors within this volume argue that self-harm is not deliberately chosen, but rather a forced choice, an involuntary evacuation of a violent state of mind (Scanlon and Adlam, this volume) but I disagree. In my view, the conscious as well as unconscious meaning self-harm has for the individual is central. To deny this is to disregard its communicative function and its role as an expression of hope, not simply despair.

In this chapter, I focus on self-harm as intentional, sometimes an expression of murderousness, at other times an attempt to create order and meaning in the face of confusion and turmoil, and to demarcate an important boundary between self and other, between internal and external and to give shape, colour and texture to overwhelming feelings. Blood is an important symbol in self-harm and connotes purification, liquid containment, warmth, fluidity, sensation and the exposure of what lies within, hidden under the skin, to the outside world. Not all forms of self-harm involve blood-letting, but all have their own private and public symbolism

2 Favazza distinguishes between culturally sanctioned acts of self-mutilation, and those that constitute self-harm, making the important statement that 'self-mutilation is distinct from suicide. Major reviews have upheld this distinction. . . . A basic understanding is that a person who truly attempts suicide seeks to end all feelings whereas a person who self-mutilates seeks to feel better' (Favazza, 1996: 262).

that needs to be understood and responded to. The objects used in the injury, the parts of the body that are hurt and the ways in which the wounds are tended to, and by whom, have unconscious meaning as well as overt meaning, accessible to the self-harmer. Fantasies of self-harm, whether acted on or not, also play a significant role and can offer solace, imagined revenge, and release.

BORDER CONTROL: SELF-HARM AND THE CREATION OF BOUNDARIES

Self-cutting is the most common form of self-harm, and appears to serve a variety of functions, including that of creating an immediate sense of order, sensation and release in what was a state of pure distress and anxiety. The slicing of the skin can be precisely and delicately performed as an attempt to delineate and demarcate boundaries on the surface of the skin. This also symbolises the creation of an internal boundary between difficult psychic states and the creation of a sense of order. Caroline Kettlewell's memoir describes the fascination with seeing how the inside comes out, how the self is constituted internally and the release that this provides, both psychically and physically, as she first uses a razor to cut herself:

In the razor's wake, the skin melted away, parted to show briefly the milky white subcutaneous layers before a thin beaded line of rich crimson blood seeped through the inch-long divide. Then the blood welled up and began to distort the pure, stark edges of my delicately wrought wound.

The chaos in my head spun itself into a silk of silence. I had distilled myself to the immediacy of hand, blade, blood, flesh.

(Kettlewell, 2000: 27)

It is clear from the above account, frequently echoed by self-harmers, that it serves a powerful function, which enables a kind of purity, focus and order to return to a restless mind. The body survives the assault.

SELF-HARM AS A SIGN OF HOPE

Donald Winnicott's (1956: 314) description of the hope in the antisocial act applies equally to self-harm: 'In the hopeful moment

. . . the environment must be tested and re-tested in its capacity to stand the aggression, to prevent or repair the destruction, to tolerate the nuisance, to recognize the positive element in the antisocial tendency'. In self-harm, the holding environment is the body itself. Self-harm offers the possibility of testing the body to see whether it is an object that can be relied on to withstand and survive assault. It also acts as a test of the mind and its strengths, to defeat the fear of pain and its consequences. I consider the main function of self-harm to be self-preservative rather than death-driven action although, of course, the possibility of death is often present.³

As well as being an attack on an individual's own body, self-harm can also attack the minds of others (Campbell and Hale, 1991) who may desperately attempt to stop or prevent it, fearing that suicide or other destruction is the ultimate outcome. Managing self-harm requires the capacity to live with it, as carer, friend or therapist, in order to enable the self-harmer to find other ways to communicate unbearable states of mind.

My central hypothesis is that self-harm is a communication to oneself and others that serves several functions for the individual by offering them a variety of ways of relating to themselves and enacting certain essential roles. In this sense, self-harm reflects a split and divided self, and its enactment offers a sequential series of rewards and compensations. There are a series of splits, both psychic and physical, underlying self-harm; these splits require integration before a self-harmer can give up what has been an effective strategy for survival.

SELF-HARM AS DIALECTIC

The notion of the divided self is central to my conception of self-harm. It relies on a primitive defence mechanism – splitting – as

3 Glasser's (1979) notion of the difference between sado-masochistic and self-preservative violence is relevant here. In sado-masochistic aggression, of the kind found in core complex phenomena, the object is kept alive to be tortured. In self-preservative aggression, the object is considered a threat to survival and must be annihilated. Self-harm can express both types of aggression; at times the intention is to eliminate the badness, through a kind of self-murder, to be allowed to live. At other times it has a more perverse, sado-masochistic quality in that the body becomes the object tortured by the part of the self that identifies with an aggressor. The body in pain is the victim, which is, in turn, tended to.

described by Klein (1946) in her account of how a preverbal infant develops a means of protecting good internal objects from the perceived threat of bad ones. The mother is not viewed as a unitary creature capable of both feeding and depriving the baby, but as either Good Breast or Bad Breast.⁴ In crisis, facing psychic threat, an adult individual reverts to using this defence mechanism and divides the world into good and bad. In self-harm, this type of dichotomy is expressed when the toxic contents of the mind are violently discharged onto the body. One part of the self can become calm, purified and released, while another is violated and intruded upon. The movement does not end here though: the body that has been injured, and thus the victim of a savage attack, is then tended to and cared for. The attacking self then becomes the caring, nursing self.⁵ The movement from thesis to antithesis and finally to synthesis can be identified in self-harm in that the ultimate aim for the self-harmer is to develop an integrated sense of herself, and to recognise that she is the containing receptacle in which both good and bad impulses inhere. She is both savage aggressor and wounded victim. She is also finally the nurse who can facilitate recovery and act as witness to the violence and its aftermath. The individual moments of contradictory impulses seem altogether disconnected, which I suggest is the function of dissociative mechanisms, preventing the sense of a continuous, remembering self that performs the various actions. Instead, the person who self-harms experiences themselves as wholly aggressor, or pure victim. These discordant states of mind appear to have no sense of continuity.

It follows from this model that one of the aims of the therapy is for the therapist to act as container of both toxic and good feelings, to enable the self-harmer to integrate both sets of feelings into themselves without needing to take violent action to discharge

4 In Klein's (1946) view, the infant evolves from merging with the mother to becoming a separate and integrated self by moving through two positions: first, the paranoid-schizoid position, characterised by splitting (i.e. the satisfying part of the mother and the frustrating part are seen as two distinct entities, the 'good mother' or 'good breast' versus the 'bad mother' or 'bad breast'); and second, the depressive position, which entails an integrative experience of both the mother and the infant himself/herself as a whole person, both good and bad at the same time.

5 This fits the notion of a dialectic movement as first described by Hegel (1979) in *Phenomenology of Spirit* and later adopted by Marx in an understanding of political and economic developments in history.

angry, anxious or shameful states of mind. This mirrors the development of the depressive position in Kleinian terms, in that there is the gradual evolution of a capacity to tolerate ambivalence rather than to function in a state of rigid splitting in which the external world is terrifying – what she calls the paranoid-schizoid position. The self-harmer acts as Other to herself, and what is urgently required is for a re-integration to end this self-alienation; otherwise it becomes increasingly frightening, creating a sense of profound isolation and loss of contact with reality.⁶

When someone penetrates their skin, defaces it, marks it or bruises it, there is a violent intrusion from the external world onto the point of contact with the internal world and the harmed person is left damaged, disfigured and filled with impinging sensations. To do this to one's own body is essentially to become Other to oneself, to enact a split and an attack that could come from an alien outsider. Penetrating the skin thus reflects a divided self and can be a violent replication of the earliest relationship between self and Other. After the penetration and intrusion, the person who has been perpetrator to themselves can now become nurse, tending to the injured body. Nursing the self-inflicted wounds can also be seen as a re-enactment of the early infantile experience of being tended to and cared for by another, usually, though not always, by the mother. This is the other side of the divided self, the caring, nurturing and attentive aspect. It can also be a vital communication to oneself as well as to others; it is a request for a healthy, nurturing part of the self to attend to the injured aspect with care, respect and understanding. Nursing the wounds often plays an important part in the ritual of self-harm.

We can therefore see that there are a series of roles, taken on and played out sequentially, all of which serve important psychic functions for the self-harmer. At the moment of self-harming, the individual is in a highly unpleasant state of emotional arousal – anger, anxiety or acute distress – and needs to discharge this unbearable state through violent action. They become their own tormenter and subject the body to an assault, releasing the unmanageable states of

6 I suggest that this type of state, so typical of women diagnosed with borderline personality disorder, can be exacerbated by therapists who attempt to reify the individual states of mind as distinct personalities, as can be found in some work with 'multiple personality disorders', because this only perpetuates the sense of splitting and fragmentation.

mind through a conversion of mental to physical pain. Scanlon and Adlam (this volume) understand this as the expulsion of a violent state of mind. In this moment of self-harm, they treat the body with cruelty or indifference, seeing it as a poison container, perhaps also replicating a relationship they had with a violent or abusive parent, who met their own needs through a similar kind of cruelty towards them, in childhood. After this violence ends, a wound is left, whose blood needs to be stopped; there may be other physical consequences in the form of bruising, scabbing or pain. Sometimes, inserted objects remain obstructive in the body, preventing the ordinary function of the digestive system or causing internal cutting. The situation is not one that can simply be left. Another persona is now summoned up, a healing, nurturing and altogether more benign source of comfort. This is another aspect of the self, the witnessing and nursing self. At times, this Nurse part of the self can accompany the self-harmer to an actual concrete hospital, and there will be a public disclosure of what has happened; at other times, this Nurse self works in secret, tending to the wounds.⁷

The body is used as the stage onto which these dramatic aspects of a divided self can express themselves, both as aggressor and nurse, in the service of the final aim of re-integration and creation of a coherent sense of self. The skin as boundary acts as a kind of psychic container, but for those who do not have an interior sense of integration, the dis-integration is played out on the body and its surfaces.

Underlying self-harm there is a divided sense of self. Self-harm can form part of an 'elimination fantasy', based on a primitive defence of splitting, in that the 'bad' aspects of the self are cut out, allowing the 'good' to flourish. It can also be a vital communication to oneself as well as others in that it is a request for a healthy, nurturing part of the self to attend to the injured aspect with care, respect and understanding.

THE LANGUAGE OF SELF-HARM

Self-harm can be understood as a way of saying through gestures and acts of violence, that which cannot be put into words. Through

7 Motz and Jones provide a personal account of the Nurse in Chapter 2.

self-harm the body speaks. I will begin the exploration of the language of the body with a description of the meaning and function of the skin, and being held, in infancy since the skin and its mutilation is a central feature of the act of self-harm. Bodily symbols and gestures develop from these crucial early experiences; they pre-date language but articulate the most fundamental human needs. When these experiences have been traumatic, the infant can be affected in a way that leaves them 'stuck' in a preverbal stage of distress, without the use of words to describe their painful experiences. In adulthood, times of crisis can re-awaken these early feelings, whose intensity is then managed through violent action rather than language or reflection.⁸

From earliest infancy, skin and its sensations are central to the emotional experience of the baby, who is held against their mother's breast, nursed, caressed, tickled and bathed. For some babies the experience of being dressed and undressed is itself an attacking, disintegrating event, and for almost all, comfort is derived from skin-to-skin contact with mother, and the experience of being put down, away from her, is distressing, causing them to cry. The psychological evidence for the significance of skin-to-skin contact in early bonding is robust,⁹ and the analytic literature asserts the primacy of early experience in providing the foundations for the construction of an integrated self.¹⁰

For babies who have not had the reliable presence of the maternal holding environment, the physical sensation of being held, fed, bathed, soothed and having their needs met, this has a dramatic impact on their sense of internal integration. It is evident that from infancy, integration starts from the outside in – physical containment enables psychic containment and the development of

8 The role of early attachment experiences in the development of an integrated sense of self and the link with self-harm is explored further in Chapter 5.

9 'Regardless of their theoretical position, many scientists and pediatricians are convinced that touch and close bodily contact are necessary conditions for the infant's normal and healthy development (Ainsworth *et al.*, 1978; Bowlby, 1958; Brazelton, 1977; Hassenstein, 1973; Ribble, 1944; Spitz, 1945; Stirnimann, 1940/1973)' (cited by Grossman *et al.*, 1981: 159).

10 'In its most primitive form the parts of the personality are felt to have no binding force amongst themselves and must therefore be held together in a way that is experienced by them passively, by the skin functioning as a boundary. The stage of primal splitting . . . can now be seen to rest on this earlier process of containment of self and object by their respective skins' (Bick, 1968: 484).

a coherent sense of self, and ultimately the construction of a perception of internal and external, a notion of one's own mind. The body ego, as Freud (1923) termed it, is the first ego, and disruptions in its care have a significant impact on the development of the psychic structures, the ego or the sense of self in mediation with the external world.

Skin is the boundary, the protective shield, that separates self and other but also the point of contact with another, and the line between inside and outside, the surface onto which sensation is felt; it is a boundary, site of perception and point of impact. Separation can be understood as the loss of the shared skin and contact with another can be experienced as a form of penetration, in which the skin's barrier is threatened. Skin gives us the possibility of touch, with its desires, some forbidden, others permitted.

The connections between disorders of the skin and early attachment experiences are central to understanding both the development and meaning of self-harm. Dinora Pines' (1993) fascinating work on unconscious uses of the female body, explores the impact of trauma on the skin and on other facets of the body. Bick (1968) too provides rich illustrations of how the path of early experience can be traced on the skin, and its disorders. The link with early infancy, and its embodied memories, is central. This work is developed further in the studies of Ulnik (2007) on skin disorders, viewed from a psychoanalytic perspective, based on the idea that the skin has important links with unconscious processes and is originally experienced as a common, or shared skin, linking infant with mother: Ulnik (2007: 14) describes how memories can be re-awakened through contact with the skin:

Feelings of excitement, ideas and old memories, but also new associations can be revived or awoken by a mere physical contact with the skin. . . . The simple stimulus of a tickle, a pinch, a feeling of warmth on the skin, the feeling of getting close to someone, are re-translated and re-transcribed . . . and are interpreted as estrangement, cruelty, getting close, cuddling, aggression or detachment of the skin. This could be explained by the link between touching and the cruelty drive, by experiencing the feeling of contact as a loss of the protective barrier against stimuli and also by experiencing separation as the loss of a skin shared by the significant other, which wraps the bodies of both.

Trauma and self-harm

The role of trauma in creating a disturbed sense of oneself, and giving rise to psychic defences against pain, has been well documented in both analytic and empirical literature, including work by Yates and colleagues (Yates, 2004; Yates *et al.*, 2008) in the United States, which identifies developmental pathways to self-injury. In this illuminating work, based on prospective studies of adolescents who were abused in childhood, either sexually or physically, the role of self-injury as a regulatory mechanism for coping with the consequences of early childhood trauma is clear in that the trauma creates disturbed and impoverished ways of managing emotion and affect – the self-injury enables some kind of coping to take place.

For people caught up in the compulsive behaviour characteristic of self-harm, libidinal energy has become intertwined with death instincts, the pull towards destructiveness. The desire for self-harm has the force of an addiction, which is beautifully articulated in Betty Joseph's (1982) paper, 'Addiction to near Death'.

My impression is that these patients as infants, because of the pathology, have not just turned away from frustrations or jealousies or envies into a withdrawn state nor have they been able to rage and yell at their objects. I think they have withdrawn into a secret world of violence, where part of the self has been turned against the other part, parts of the body being identified with parts of the offending object . . .

(Joseph, 1982: 455)

In this paper she describes the pull of the death instincts, the masochistic constellation of these forces and the powerful compulsive aspect of this in patients intent on creating despair and hopelessness in their therapist through projective mechanisms. To achieve this is, however, to triumph in a death-dealing way, because the person who could help, and act as a healthy and hopeful part of the mind, gets caught up in destructiveness, rather than the possibility of recovery.

The task of the therapist is to remain in touch with the part of the patient that wants to preserve life and to retain their own capacity to think about the experiences they are being shown and made to feel without losing themselves in the hopelessness; they need to withstand assaults on this life-affirming aspect and allow

the patient to re-integrate it into themselves. Joseph powerfully argues that the person caught up in this kind of hopelessness and self-destructiveness experiences unconscious excitement as they immerse themselves in the pull towards despair and near death. This takes place within the subjective experience of intense depression and can manifest itself through self-mutilation, biting, eating, tearing the skin and other acts of violence against the self. The turmoil and destruction are, nonetheless, addictive, and offer a kind of pleasure. The notion of nearly dying, but not quite, also conveys the sense of risk and experimentation that can be found in those who enact dangerous levels of violence on their own body.

Welldon's (1992) seminal work on the development and manifestation of female perversion further illuminates the function and meaning of self-harm. For self-harmers, the aggressive impulse is turned inwards onto their own bodies. This may have a sexual component, creating a release from tension similar to that achieved through orgasm. For Welldon, the origin of this self-harm is the woman's early object relations, that is, her experience of being mothered:

During adolescence, if she hates her mother's sexual body and is unable to identify with her and her body, the adolescent girl will use her hand to attack her own body in a compulsive way by, for example, cutting her arms or wrists . . . In doing such harm to their bodies they are expressing tremendous dissatisfaction, not only with themselves but also with their mothers, who provided them with the bodies they are now fighting.

(Welldon, 1992: 40)

The following material illustrates the models presented above. It describes Crystal, a 32-year-old woman on a locked secure ward, whose treatment revealed a kind of 'addiction to near death' in her self-injuring and in the depression that at times threatened to overwhelm her and me, her therapist. Her attacks on her own body also had some perverse elements, namely their addictive quality and the sense of enlivenment they generated. She demonstrated some hopefulness in the therapy and went on to make some substantial changes in her self-mutilation and dramatically improved her quality of life. Some aspects of the case study have been changed to preserve Crystal's anonymity.

CLINICAL ILLUSTRATION: CRYSTAL, A WOMAN MANAGING EXTREME SELF-INJURY

Crystal was a large, imposing woman, with striking, bright eyes and a radiant smile, often hidden by her tendency to hang her head down and avoid eye contact. She was an inpatient in a mixed-sex secure ward, following her admission to an open unit where she was considered 'unmanageable' because of her frequent assaults on her own body, including inserting and swallowing sharp objects. She was an eloquent, intelligent woman who engaged in various forms of self-injury; she said that this was to express her distress and relieve her of painful memories.

I worked with Crystal for a year of once-a-week psychotherapy until she was transferred to a female-only ward. Like so many women in secure conditions, she had been brought into the forensic services because of violence towards herself. She had occasionally been violent towards nursing staff, who felt that she was not suitable for the open ward. In the past she had made threats to kill her stepfather, who had abused her sexually for many years during her childhood while living in the family home. She had not known her biological father, who had died before she was born.

Almost as soon as Crystal had been admitted onto the ward, she evoked strong reactions from other patients and staff; some felt concerned, protective and curious, while others became angry and disturbed, feeling that she should be stopped from behaving violently towards herself or moved to another ward. Her large, unkempt presence conveyed the impression of something wild or even inhuman and this created fear and a sense of helplessness in many who watched as she banged her head against the wall repeatedly. She frequently cut her arms and would often ask for help with dressing the wounds. Crystal secreted weapons, in the form of broken fragments of DVD cases, and pieces of stone from the hospital grounds, and would use these objects in her self-harm, through cutting, or vaginal insertion of broken shards of glass or plastic; she also scalded herself with hot liquids and burnt her arms with cigarettes.

The symbolic significance of cutting and burning her arms struck me as profound. She craved arms that could hold her, caress her, but had only known arms that held her down, to rape and beat her. She often kept her arms folded up, protecting herself against

unwanted contact and displaying the deep scarification on them. She embraced nurses to whom she was close in a kind of 'bear hug' and her arms enveloped them. A mother's comforting arms and gentle touch had been painfully absent from her early life; her mother, like her stepfather, had treated her violently. Inserting painful objects into herself also had clear symbolic significance, as she seemed to attack her own insides, particularly her sexual organs; in a sense, this repeated the violent sexual assaults of her past.

Crystal paced the hallways frequently, sometimes appearing quite dissociated,¹¹ in a world of her own, muttering as if in conversation with invisible enemies, or friends, sometimes laughing to herself, at other times cursing. Her language at other times could be lucid, colourful and expressive, as revealed in conversation and in her writing, but she avoided talking about her early life experiences.

Crystal's psychiatric diagnosis had changed from psychopathic personality disorder to borderline personality disorder, from schizophrenic to schizo-affective disorder. Her current consultant psychiatrist was considering returning to her original diagnosis as suffering from psychopathic personality disorder in the light of her recent disclosure that she wanted to murder children, and her apparent lack of remorse following severe assaults on nursing staff and patients on the open ward.

The complexity of her presentation and the sense in which she defied categorisation was clear. She inhabited the borders of psychiatric categories, as she did the borders of past and present, as memory constantly intruded on her waking mind. In this sense, she was indeed a woman with a borderline disorder, seemingly borne of her past experience of humiliation, emotional, physical and sexual abuse, terror and betrayal.

The severity of Crystal's self-harm was mirrored in the severity of her history of childhood sexual, emotional and physical abuse. She had been the victim of incest and sexual abuse by multiple perpetrators from ages 9–17. Her stepfather, a religious man and public figure, had been sexually predatory in private and had passed her around his friends to abuse. She had been the eldest of four children and was a pretty, intelligent child, who had learned that she must not try to disclose the abuse because she would only

11 Dissociation is a psychic defence often found in individuals who have experienced severe trauma, as a protective mechanism to prevent emotional overload. See de Zulueta (2006).

be accused of lying and punished by her apparently depressed mother, as had happened on the two occasions when she tried to tell her what was going on. She believed that her mother had also been the victim of incest from various statements her mother had made, and from her refusal to allow Crystal to see her own father, Crystal's grandfather.

As the abuse had progressed to full intercourse and gang rape, Crystal could not contain her distress and wet the bed frequently, resulting in further beatings and verbal chastisement by her mother. Sometimes her mother would run her scalding hot baths in an apparent attempt to cleanse her of the urine, but at a symbolic level to rid her of the impurities of sexual violation, as though she had somehow encouraged or invited this. Her mother knew about the abuse without acknowledging what she knew, and this left Crystal in a place of deep pain and isolation, desperate for some witness to her traumatisation. Her mother could not bear to act as witness, or protector, and Crystal had, instead, to be punished and cleansed through the burning baths, which were painful on her skin. Social services had been involved briefly with the family because of the mother's own terror of the domestic violence to which she had also been subject and Crystal recollected a peaceful time where she had been in foster care for several months, before abruptly being brought back home where the abuse had started all over again.

When Crystal was 11, after a night spent in the hands of her stepfather and his friends, she had found a razor in the bathroom and made small incisions on her feet and on the inner sides of her thighs. Crystal described this as marking to herself what had happened, and also providing a sense of relief that she explained was a physical release from psychic torment. She had felt altogether helpless at home and harming herself in this way was, she explained, a way of reminding herself that her body was in fact hers, not her stepfather's or the other abusers; she wanted to mark and scar it as she chose. She saw her self-harm as a kind of branding and an outlet for anger and guilt, saying that it also helped her to 'feel real' at times when she felt quite dissociated. She also wanted to protect others from the rage she felt towards her abusers, as she wanted to prevent her younger sister from being abused as she was. She felt that she needed to sacrifice herself for her sister. In this sense, the self-harm was closely associated with a desire to protect others; it enabled her to express fury at herself, rather than at others, and to endure the trauma of abuse so that her sister would be spared.

Therapeutic contact

When I first began therapeutic work with Crystal she appeared eager, and quickly engaged with me, saying that she was desperate to make sense of what had happened to her and to stop hurting herself. I felt overwhelmed as she poured out memories of the extreme abuse to which she had been subject, drew pictures of herself in symbolic form, with images of monsters, blood, snakes and fire, and presented me with well-crafted but violent poetry. My awareness of her intense hopefulness was painful as I wondered how to help her manage and contain the raw power and perversion of her experiences, still tormenting her in memory and enacted on her skin. She seemed to put me in the role of the thoughtful and protective maternal presence that should have stopped the abuse she had endured, and in the role of the rescuer who could somehow find the magic words that would make its horror bearable.

The early sessions were filled with descriptions of the past, in terms of vivid and detailed accounts of sexual violation by men and neglect and beatings by her mother, and also with exposure of her recent self-harm. I felt moved, protective of her and, at times, enraged by the treatment she had endured, but this was challenged when I saw how she re-victimised herself. Occasionally too, I felt physically sick when she seemed to flash her scars at me, as if inviting some kind of dramatic response, which I resisted making.

I felt that my bodily countertransference of disgust and my fascination reflected her feelings as a victim of childhood sexual abuse, as did my profound sense of helplessness. Her rage was directed not just at the incestuous stepfather who repeatedly raped her, passing her around like a doll, but also at her distant, rather brutal, mother, who was unable to listen to Crystal's disclosures of incest and abuse. In turn, she targeted her fury at her own female body, emerging herself fully in the task of self-torture and then a kind of nursing, a parody of ordinary maternal care as she tenderly bathed and dressed her wounds. Crystal's sado-masochistic relationship with her own body also expressed female violence that bound her intimately to herself, to the exclusion of others.¹² She directed her rage against her own body, representing both the

12 This is described in my earlier work on maternal abuse and female perversion (Motz, 2001).

sexually and physically abused body of her child-self and also the adult body of her mother. She also attacked her reproductive organs through her internal injuries. The sudden exhibitionist quality of 'flashing' her scars also communicated the perverse aspect of her self-injury that, at times, seemed to give her an erotic satisfaction. This is not unusual in self-harm and is connected with the sense of immersion in the self, and the eroticisation of hatred of one's own body.¹³ My desire to flee or, alternatively, to stare at her naked wounds, seemed to connect with her sado-masochism, her fascination with her wounds, and their symbolisation of her sexual abuse. Her internal injuries also re-created an experience of intrusion, violation and pain, occurring in secret but sometimes requiring external agents to tend to, in an exposing intervention. 'The public expression of her private pain' (Adshead, 1997: 111) was all too evident.

By flashing her scars at me it seemed that Crystal was both entreating me to become the perverse maternal object and also making me a helpless witness to her self-destruction, and its evidence in her vivid, raw scarring. As she invited me to view her self-mutilation more, exposing both her scars and wounds, my mind seemed to be assaulted more powerfully and my body became hyper-responsive to her communication. I responded with intense visceral feelings to these intrusive and violent projections. There was some danger that I would be caught up in some kind of perverse enactment as my thinking was attacked and my own body brought into play. I reflected on this possibility in supervision and this enabled me to resist the desire to retreat, or to become collusive in Crystal's secret acts of self-harm.

The meaning of the scars, the sites of the injuries and the balance between secrecy and public exposure were significant and she began to put her thoughts and feelings into words and to process them in visual narratives rather than simply in lone images of power and terror in her drawings. I, in turn, felt less under siege and the sessions became calmer and more thoughtful. I also became increasingly aware of strong feelings of warmth, interest and empathy towards Crystal, as I saw how she struggled to manage her

13 Stoller (1975: 4) describes perversion as 'the erotic form of hatred' and explores the sense in which sexualised aggression in adulthood is an attempt to master earlier trauma.

memories and fears, and how her creativity enabled her to make some kind of sense and order out of inchoate feeling. These positive countertransference feelings provided a balance to the fear she also evoked, not least, for her own survival, and served as anchors for me, so that I could stay still and calm in her presence.

As therapy progressed, Crystal began to explore the extent of her own murderousness, as well as self-destructive feelings. The link between her homicidal and suicidal feelings was clear, although she still did not wish to die, and used her self-harm to help her to live. She described a recurring dream of killing a child, and intrusive memories about a particular episode of her own abuse that had involved women as well as men. Her horror at her own murderousness, her strong identification with her own abusers and desire to harm others as she herself had been harmed, took centre stage in the sessions. The fact of her dual status as perpetrator as well as victim became painfully clear and destabilised her. Crystal's self-harm escalated significantly at this time; she began to use ligatures and to make hanging attempts, timed to coincide with times when nurses would check on her as part of the ward's observational regime.

Crystal's descriptions in the sessions of her physical urges to damage herself and others, and the immediacy of her memories of abuse, were raw and disturbing. During one of these sessions I felt out of control of my own body; I had a powerful urge to interrupt the session to evacuate, to leave the room to expel the awful feelings. I found it increasingly difficult to think about what she was saying; my mind was focused on my physical discomfort. When I thought more about this almost unmanageable feeling of wanting to escape, to rush to the toilet, to breathe again, I realised that Crystal's violent and excited states of mind were projected into me, enabling me to know firsthand what she was experiencing. I understood that it was this state of uncontained violent, fearful excitement that led to her self-harming, and the dissociation that accompanied it. I found it impossible to breathe and think, just as she did when she tied ligatures using the sheets on her bed.

The domestic nature of the weaponry appeared to me to have great symbolic value, not only indicating the creativity and ingenuity of her capacity to construct weapons out of ordinary objects but also in terms of perverting the function of what she was given by the hospital. For someone who has been sexually abused

in brutal and violent ways for years, sheets no longer have a benign and comforting meaning and indeed may be reminders of previous suffering and helplessness. Using sheets to self-harm may, for example, be an unconscious attack on the system of care that fails to protect her. Likewise, overdosing on prescribed medication can be seen as an assault on the help provided by the medical and nursing staff, a clear statement that the attempts at comfort are useless, and can be used to poison rather than treat the patient. Being in the room with Crystal, where her memories lived, revealing themselves on her scarred, unhealed body, was unbearable for us both, at times, but we were able to hold on to the hope that the violence would eventually subside.

Crystal's use of her writing, drawing, dreams and memories in our sessions, and my capacity to bear and articulate the lived experience of parental cruelty and perversion, seemed to provide her with a degree of containment but ultimately did not take away her need to self-harm. At times, this urge was intensified after therapy sessions in which particularly difficult experiences and memories came back to her, and eventually she became mute and curled up in the sessions, turning away from me in a foetal position and losing contact altogether. I understood her deathliness in the therapy to reflect a kind of 'cutting out' that reflected her 'cutting up'. When feelings became overwhelming, she felt that she had no choice but to go inwards, cutting out thought, memory and the presence of another. She told me that at such times she could only think in images, and flashes, not in words.

Following the physical turmoil of earlier sessions, this middle period in the therapy became a kind of retreat, as Crystal largely withdrew into herself. After several weeks of remaining largely mute and remote, her voice, and a more connected quality, returned. She told me that she no longer wanted to explore what had happened in the past, as she had felt compelled to do in earlier sessions, but wanted to focus on 'the here and now', and learn how to relate to her present surroundings as they were, not as shadows of the past. As I had never directed her in any way this presented no difficulties for me, and showed me that her capacity to confine memory to a psychic space and begin to demarcate a boundary between past and present seemed to have developed. We continued to meet weekly and her self-harm also continued, but its frequency and intensity abated. She was eager to enter a female-only unit, where she wanted to feel 'safe' enough

to return to exploring her early life experiences, although she expressed reluctance to end therapy. Shortly before she left she began to have sexual feelings towards male staff, which both disturbed and excited her. She herself understood this to be a kind of hope, that her libidinal feelings could once again emerge, directed towards other people rather than distorted and used masochistically, through self-harm.

Through working with Crystal, albeit for a shorter time than originally envisaged, I learned about the power of dissociation, the confusion between suicidal and murderous impulses, the pain of giving up self-injury, as well as the horror of being made to bear witness to it. In her penultimate session Crystal described her wish to have been killed in childhood, not to have remained alive to be tortured, saying: 'I wish I had been a murdered child'. She accepted my interpretation that through her self-injury she had repeated this pattern of keeping herself alive to be hurt, becoming the perpetrator of her own abuse. It seemed too that she had shown a degree of hope in showing me her wounds, her scars, such that I might understand her trauma and self-harm and, through recognising their significance and meaning, allow her to defeat the compulsive need to re-enact the trauma on herself. I suggested that ending therapy might evoke thoughts of death, and loss. She became tearful and told me that she wanted to write to me, and that she had felt not judged, but understood by me. Unlike her mother who could not bear to listen to her disclosure of incest, I could hear and believe her and respond with some understanding. She did, in fact, write to me, and had engaged well with the group therapy programme on the women-only ward to which she moved, saying that her self-harm continued, but with less intensity. Although ultimately I could not prevent Crystal from inscribing her history on her body, I could, at least, read it with her.

Crystal gave consent for this description of our work to be published, and told me that she had been able to give up the impulses to self-harm, except for 'once in a blue moon', after almost two years in the women-only unit. In this setting she felt supported in expressing feelings of anger, frustration and sadness in the daily community meetings, whereas on the mixed ward she felt she was re-living traumatic experiences on a daily basis. She had been able to find alternative ways of expressing her feelings and managing distressing memories in the women-only unit, where she was able to engage in non-verbal therapies, including art, music

and drama therapy. Crystal required not just one voice to speak with, but a wide repertoire of expressive modes, and was, with the help of female therapists and patients, able to build on the hope and creativity she had always shown, even at the depths of her self-harming.

SIGNING WITH A SCAR

Self-harm can be seen as more than just a form of communication but also as a means of self-creation and closer to affective states than words are. Straker (2006) considers self-cutting an act of self-identification. She terms this cutting 'signing with a scar' and views it as a form of affective communication, arguing that it is a mode of expression that is not just an inadequate form of language for the inarticulate. To view self-harm as simply the inability to verbalise fails to account for the high levels of literacy and eloquence of many self-harmers about themselves and their emotions and essentially misses the main function of self-harm: 'over and above the function of self-soothing, self cutting is the attempt to put into place the elements involved in the building of a self-structure. These include mirroring, the establishment of a boundary, the building of an autobiographical narrative, and the impregnation of verbal signifiers with signifiers of the flesh' (Straker, 2006: 93).

The limits of words are rarely confronted in accounts of self-harm, as the silence surrounding it can be deep and shameful, and the hope is that language will bridge the gap between alienation and acceptance. The belief is that if words can be found, the urge for various forms of self-mutilation will abate. Straker asserts that self-harm is not a lesser language but can actually be a more meaningful one for the person who is attempting to know and understand themselves through it. This challenges the underlying assumption that once it can be spoken about, the compulsion to self-harm will dissipate. If the 'language' of self-harm is more than just a message to others, as Straker describes, it is more difficult to give up. Self-harm does more than just signal to others, it meets deep needs for identity, beyond the communicative function.

My emphasis on self-harm as a form of language that creates as well as expresses, accords with this conception, adding weight to

the notion of the flesh-made word. Indeed, the religious connotations of this idea have great relevance, as there is often a profound transformational act intended by self-harm, with echoes of scarification and stigmata, signifying the presence of another, unseen aspect to the self that is made explicit through scars.

The significance of scarification is culture-specific, but there are certain patterns that emerge cross-culturally. Favazza (1996), in his discussion of culture and psychiatry, describes how, in the Tiv tribe in West Africa, scarification serves as an initiation rite marking the passage from girl to woman, and boy to man. He shows how the scars themselves signal allegiance to a particular family and heritage, serving to signify fertility and locate people in time and place. He writes: 'Thus, the scars serve to anchor time and space and to ensure the continuity of life' (Favazza, 1996: 155). This has clear parallels with self-harm in the UK and the United States in several respects: it begins in adolescence, it is often learned through social interactions with others who engage in it, and it has unconscious links with identity as adult sexual beings. Favazza uses the cultural examples he provides to explore the significance of the scar itself and concludes that 'it seems likely that the scars resulting from self-mutilation may themselves have symbolic meaning relating to notions of rebirth, the continuity of the life process and the stability of relationships' (1996: 156). Meaning is clearly ascribed not only to the wound but also to its visceral evidence in a scar, whose presence may reflect a psychic, as well as bodily, healing. The scar as emblem, as the signifier of what has gone before, is essential.

This idea is substantiated by the empirical work of Grocutt (Chapter 9, this volume) looking at how and why women in secure settings stop self-harming. She describes how showing the scar was a feature of her clinical interviews:

During the interviews many women revealed the physical scars and burns from their self-inflicted violence. This form of exposure could be interpreted as a need to communicate the level of extreme distress and chaos they had experienced, or to initiate a response or reaction. Alternatively, revealing their scars established a context for their cessation narrative and may have served as symbolic of the 'old self' and what they had since achieved.

(Grocutt, this volume: 185)

SIGNING AS METAPHOR

Clinical illustration: Signing and self-harm

Although in this chapter I have mainly concentrated on self-harm in women, men too self-harm. The following clinical material relates to a man who used violence, in self-harm, as a powerful means of self-expression. The reasons for his self-harm apply to women in similar situations and have a more general resonance. Again, I have disguised aspects of the case to preserve anonymity.

A striking example of the impossibility of being heard in one's own voice comes from the experiences of a man, Thomas, who was profoundly deaf, and who had spent much of his early life in a residential school for deaf children, where, unsurprisingly, he felt wholly isolated and abandoned by his hearing family. He was not taught how to use sign language, as at the time it was thought best to teach deaf children to lip read and to make the sounds of speech.

In the home for deaf children, Thomas had been known only by a number, without a name, revealing how he was seen as without identity, dignity or true subjectivity. He was one in a series of abandoned deaf children, who could be abused without fear of disclosure. His later savage attacks on himself – his arms and genitals – seemed to be re-enactments of what had been done to him, and signifiers of the flesh – self-inscribed aspects of his history and its impact on his identity. When hearing from him, through an interpreter/signer, about being called by a number, and his use of self-harm, the image it evoked for me was of the numbers tattooed on the wrists of concentration camp inmates during the Holocaust; for many, these became an indelible mark of horror, and survival.

The cruelty to which he and thousands of other deaf children were subject is hard to imagine as, for many children who could not speak and had no other language with which to articulate their pain, to experience physical discipline or even sexual manipulation was simply a way of life. These children had been sent away by their families of origin to be cared for in residential schools where they could be taught to speak, without hearing. Parents were told that such education was in the best interests of their child and had little sense that there could be a way of integrating a deaf child into their own household. It was rare that parents could use sign language and indeed the idea was that deaf children should, instead, be taught to lip read as if hearing and to make speaking sounds, without hearing the sounds that they made or the quality of their

mimicry. The aim was to appear to others as though they could hear, regardless of the actual state of their deafness, and the tremendous isolation and vulnerability this created.

At this residential school, Thomas endured repeated experiences of physical abuse and punishment, ways of being controlled and restrained that restricted and pained him, in an attempt both to control unruly behaviour and to instruct him in the art of speaking – saying words whose sound and meaning he did not know. Additionally, his only form of physical affection and concern came from a teacher, who incorporated sexual abuse of him in bathing and dressing routines. This powerful association of sexual behaviour between adults and children with affection and attention was to shape this man's life, presenting him with enormous difficulties throughout adult life, coupled with a pervasive sense of isolation and desperation. Years later his presentation at psychiatric services was conceptualised as reflecting a personality disorder, and he was admitted to mainstream psychiatric wards where some of his early experiences were unconsciously re-enacted by staff, in a catastrophic manner.

Thomas's isolation and fear in adulthood, and its echoes of his early life, symbolised to me the unbearable experiences many have lived through, the horror and shame of which simply cannot be put into words. His memories were visual – flashes of horror – and his distress visceral – literally written on his body through self-harm, in which he pierced his flesh. His wounds appeared like maps of pain and chaos. It was almost impossible for those around him to offer him the proper help and understanding that he sought. He looked 'normal' and his deafness was invisible to others, who treated him as though he could, and should, hear, failing to respond to his communications that he, in fact, could not. He was the proverbial good child who should be 'seen but not heard' in a way that left him vulnerable to abuse.

His voice sounded frightening and unusual when he spoke. Other forms of expression, like using sign language, were not accessible in the mainstream ward; this was reminiscent of his early abuse in a children's home where he had not had other ways of letting people know what was happening to him, too young to write, unable to speak and without carers who could 'read' him. He had to show his feelings on his skin, through dramatic and alarming acts of self-harm, which elicited the care of those who nursed him. These attacks on himself also contained rage at those who could not

respond to his needs without seeing it writ large, in angry wounds that made no sense at first glance. He turned his rage onto himself, perhaps protecting others from the force of his murderousness.

The fact of his deafness, without the capacity to sign, and his emotional, physical and sexual abuse in residential care as a child had sealed his sense of isolation and exile, and intensified his desperate and unfulfilled desires to disclose both past and present abuse. Those who were there to care for and protect him had either neglected or abused him, at a time when he could not write, sign or talk.

Thomas stands metaphorically for all those men and women whose pain and trauma cannot be told, or heard, and dramatically demonstrates the creation of another form of language through violence and self-injury. He was still inscribing his experiences on his body when I saw him, even though he now had the possibility of other forms of communication. His self-injury encoded earlier trauma and was an important part of his sense of himself. The description given by Miller and Bashkin (1974: 647) in relation to a client they describe also fitted this man who 'preserved in the flesh, in a dramatic and conspicuous manner, the history of events he could not integrate into the fabric of his personality'.

For many self-harmers, the language of the body is a source of free expression as well as a compulsion. The element of choice in self-harm is one of the central paradoxes in understanding its meaning. On the one hand, images of self-harm can feel like alien voices and thoughts that dominate and control the waking mind of women and men in response to stress and rage. On the other, it can be a potent symbol of ownership and control of the body, whose occurrence itself is an act of protest. It is a re-assertion of control and ownership of a body that may have been used and violated by others. For others it is seen as a form of antidepressant, an effective, if addictive means of release from unbearable states of mind, which has its own internal and external meanings.

CONCLUSION: MANAGING SELF-HARM

Countertransference responses to self-harm are meaningful sources of information, providing therapists and other workers with essential data about the intentions and states of minds of their clients. The dilemma for the practitioner is to accept the self-harm as

important while enabling their client to give it up, if and when they choose to (are able to) and become free of its hold on them. For therapists to be able to manage responses to the violence and intense distress that self-harm can create, on the body and in the minds of those who encounter it, it is essential to have supervision and teaching, as well as reflective space, to try to process the meanings and feelings it evokes: 'The task of mental health workers is to be receptive to hearing about experiences that can feel beyond words, without becoming unthinkingly caught up in the clients' projections, and taking part in destructive re-enactments . . . Patients are trying to live with overwhelming emotional pain and project this into staff through various communications such as self injury, very direct sexualised communications, physical assaults and vicious personalised attacks . . . the unconscious hope is that the nursing staff can do something positive with the communication' (Aiyegbusi, 2004: 114).

Until the communications and significations of self-harm can be recognised and understood, and where possible replaced with equally potent modes of expression and self-structure, it will retain its hold. The many needs it serves will continue to be met until other ways of soothing, creating, relieving and articulating the self can be found. The task of the therapist is to retain hope, at times when the self-harmer feels it is lost, and show them that despite their assaults on themselves and others, they can withstand this death dealing drive and re-integrate aggressive and loving feelings in a safe and manageable way. The hope can eventually be returned to the self-harmer and the addiction to these near-death experiences (Joseph, 1982) can loosen its grip. But for the therapist, who mirrors the despair as well as the hope of self-harm, it is essential to retain a sense of the meaning, order and private symbolisation that is being presented to them to unravel, respect and de-code.

Attacking the body to see what it can withstand and retain in embodied memories can be an attempt to know oneself. The capacity of those who work with people who self-harm to withstand its hostility, and their own distress, offers hope for the possibility of containment, and understanding. Through true relational contact, and the experience of a 'mental nurse', that is, another person whose mind can survive assault and remain intact and thoughtful, the self-harmer can eventually relinquish their own attacks on themselves and the pleasure of their own self-nursing. Murderous and suicidal thoughts can be kept in the mind, rather

than enacted. It can become possible for emotional communication to be achieved and for the overwhelming pull to self-harm to diminish. Intimacy with others becomes increasingly possible without the overwhelming immersion in the self and its wounds; the self-enclosure, secrecy and ritual that self-harm creates can eventually be transformed into contact with another, a reaching out rather than a reaching in. The sense of becoming a whole person who can contain discordant parts and fragments will also be invaluable in the development of a capacity to manage self-harm. We have a duty to recognise and meet the hope expressed through marks on the body with the belief that we can contain and nurture the personal struggle to find a less self-destructive way of being and relating.

REFERENCES

- Adshead, G. (1997) 'Written on the body: deliberate self-harm and violence', in E.V. Welldon and C. van Velson (eds) *A Practical Guide to Forensic Psychotherapy*, London: Jessica Kingsley Publishers.
- Aieyegbusi, A. (2004) 'Thinking under fire: the challenge for forensic mental health nurses working with women in secure care', in N. Jeffcote and T. Watson (eds) *Working Therapeutically with Women in Secure Settings*, London: Jessica Kingsley Publishers.
- Bick, E. (1968) 'The experience of skin in early object relations', in M. Harris Williams (ed.) (1987) *Collected Papers of Martha Harris and Esther Bick*, Perthshire: Clunie Press.
- Campbell, D. and Hale, R. (1991) 'Suicidal acts', in J. Holmes (ed.) *Textbook of Psychotherapy in Psychiatric Practice*, London: Churchill Livingstone.
- de Zulueta, F. (2006) *From Pain to Violence: The Traumatic Roots of Destructiveness* (second edition), New York: Wiley.
- Favazza, A. (1996) *Bodies Under Siege: Self-Mutilation and Body Modification in Psychiatry and Culture* (second revised edition), Maryland, MD: John Hopkins University Press.
- Freud, S. (1923) *The Ego and the Id*, SE XIX.
- Glasser, M. (1979) 'Some aspects of the role of aggression in the perversions', in I. Rosen (ed.) *Sexual Deviation*, Oxford: Oxford University Press.
- Grossmann, K., Thane, K. and Grossmann, K.E. (1981) 'Maternal tactual contact of the newborn after various postpartum conditions of mother-infant contact', *Developmental Psychology*, 17: 158-169.

- Hegel, G.F. (1979) *Phenomenology of Spirit*, Oxford: Oxford University Press.
- Joseph, B. (1982) 'Addiction to near death', *International Journal of Psycho-Analysis*, 63: 449–456.
- Kettlewell, C. (2000) *Skin Game: A Memoir*, New York: St Martin's Griffin.
- Klein, M. (1946) 'Notes on some schizoid mechanisms', in M. Klein (ed.) (1980) *Envy and Gratitude and Other Works 1946–1963*, London: Hogarth Press.
- Miller, F. and Bashkin, E.A. (1974) 'Depersonalisation and self mutilation', *Psychoanalytic Quarterly*, 43: 638–649.
- Motz, A. (2001) *The Psychology of Female Violence: Crimes Against the Body* (first edition), Hove: Routledge.
- Motz, A. (2008) *The Psychology of Female Violence: Crimes Against the Body* (second edition), Hove: Brunner-Routledge.
- Pines, D. (1993) *A Woman's Unconscious Use of Her Body*, London: Virago.
- Stoller, R.J. (1975) *Perversion: The Erotic Form of Hatred*, New York: Pantheon Books.
- Straker, G. (2006) 'Signing with a scar: understanding self-harm', *Psychoanalytic Dialogues*, 16: 93–112.
- Ulnik, J. (2007) *Skin in Psychoanalysis*, London: Karnac Books.
- Weldon, E.V. (1992) *Mother, Madonna, Whore: The Idealisation and Denigration of Motherhood*, New York: Guilford Press.
- Winnicott, D.W. (1956) 'Delinquency as a sign of hope', *Collected Papers: Paediatrics Through Psychoanalysis*, London: Karnac Books/The Institute of Psychoanalysis (1992).
- Yates, T.M. (2004) 'The developmental psychopathology of self-injurious behaviour: compensatory regulation in posttraumatic adaptation', *Clinical Psychology Review*, 24: 35–74.
- Yates, T.M., Carlson, E.A. and Egeland, B. (2008) 'A prospective study of child maltreatment and self-injurious behaviour in a community sample', *Development and Psychopathology*, 20: 651–672.