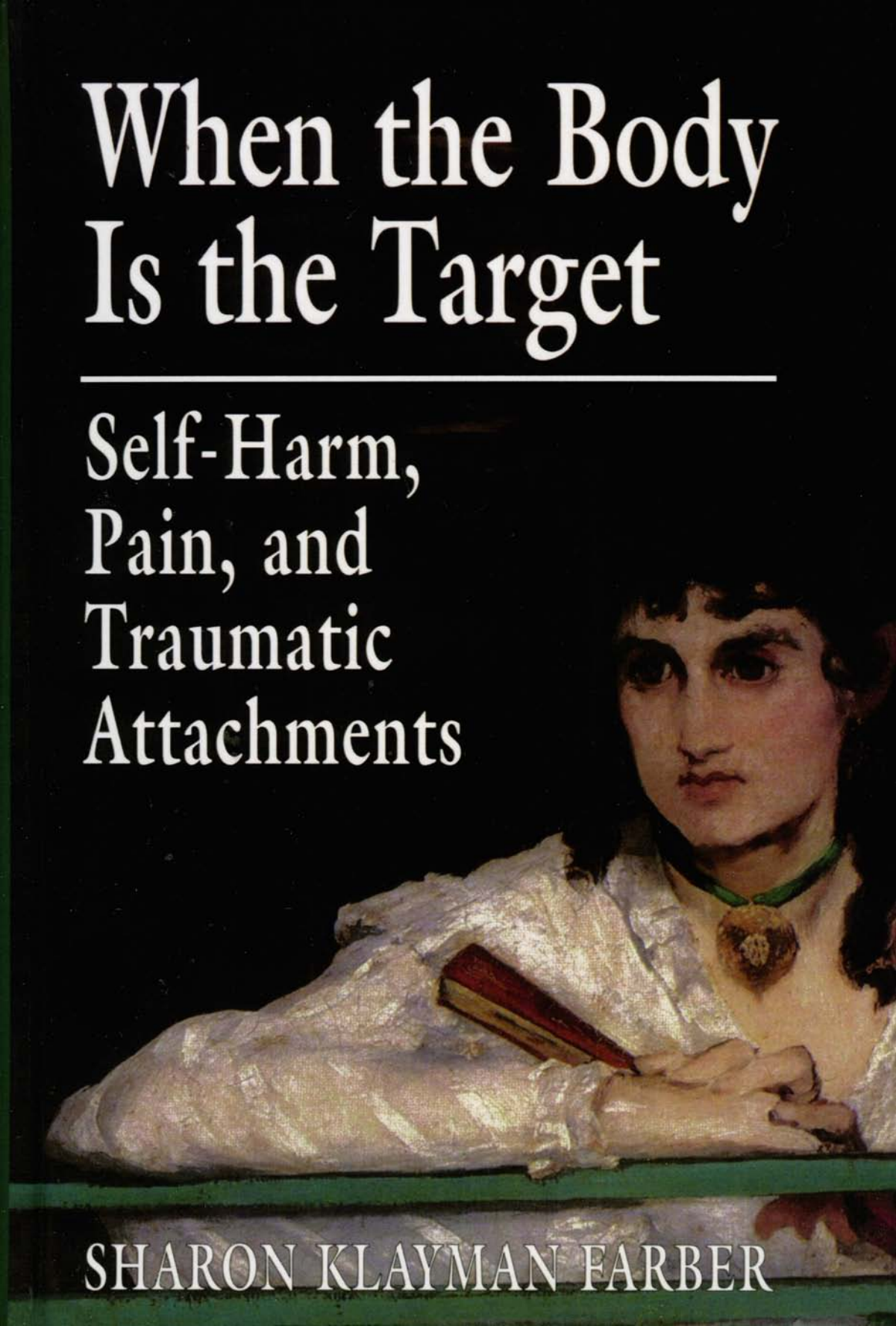
When the Body Is the Target

Self-Harm, Pain, and Traumatic Attachments



SHARON KLAYMAN FARBER

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SHARON KLAYMAN FARBER, PH.D.

A JASON ARONSON BOOK

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This book is dedicated to my husband, Stuart, and my son, David, both of whom have taught me so much about attachment and love.

This book is dedicated to my patients and the courageous people who participated in my study, for allowing me the privilege of entering their lives and teaching me so much. To all who struggle with self-harm, I wish you hope, health, and healing.

This book is dedicated as well to the memory of Kathy, who left this world far too soon.

"Few patients evoke in their therapists the kind of dread that those who continue to mutilate themselves during treatment do. Dr. Sharon Klayman Farber earns our gratitude for venturing deeply into this difficult domain. Every therapist treating these patients will learn a great deal from this book, but beyond the immediate, all those who are puzzled by the nature of human aggression will appreciate the many insights the author has assembled."

—Martin S. Bergmann

"Using clear and incisive language, Dr. Farber elegantly and empathically cuts to the core of the extreme suffering that our patients who repeatedly harm themselves endure. She provides an exhaustive, scholarly review of the underpinnings of self-mutilation and related behaviors in this beautifully written book. She then goes on to present one of the most sophisticated theoretical and clinical explanations to date showing why these behaviors have become so pervasive, how we can understand them, and what we can do to alleviate the suffering that is at the root of such disorders."

—Edward J. Khantzian

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Preface: Genesis

This book had its beginnings in the curiosity and passion that power the wish to understand concepts, people, and connections. My interest in self-harm began a long time ago, in a creative writing class in high school, where I learned about the process of stream of consciousness, the technique used by many writers of fiction and poetry, of whom James Joyce is probably the best-known example. The class was given the assignment of writing that way, allowing our minds to wander wherever they wanted, not censoring anything that we might ordinarily censor. I began to write in that mode, which I came to know later was akin to the process of free association. I was astounded and intrigued at what I wrote. It was primitive, strange, and so different from what my usually logical mind produced. I wanted to understand it.

A few years later when I was an English major in college and had begun my own psychoanalysis, I stumbled upon Georg Groddeck's *The Book of the It* (1923), which was very exciting because it linked free association with the mystery of the mind–body relationship. Groddeck, I soon discovered, was regarded by some as the father of psychosomatics, an eccentric angel, and a genius. He was regarded at the same time by others as a "wild analyst," a lunatic, a terrible embarrassment to psychoanalysis. Many of his ideas were wild and irresponsible, provoking a number of his colleagues to wash their hands of him. Nevertheless, I thought his ideas were exciting and brilliant.

I have been interested for a long time in understanding the mysterious, and certainly mental illness is very mysterious. After college I worked in the recreation therapy department of Gracie Square Hospital, a small private psychiatric

hospital with locked wards. It was an unsettling experience, shaking up my notions of normality and abnormality. That first week I saw a young woman my age in restraints in a "quiet room," and was shocked to recognize her as one of my college classmates. I barely knew her, but she had seemed normal. I began to question what normal was.

The first week I did not have a set of keys to unlock the ward doors and had to depend on other staff members to let me in and out. Initially it was just a nuisance but then, to my astonishment, it became a problem. I had introduced myself to a nurse and asked her to unlock the door for me. There was an unsettling pause and I realized that she did not believe that I was a new employee. She spoke to me in the well-intentioned but infantilizing way that many clinical staff members used with patients. "Yes, dear, we all work here. Some of us work here as staff and others work very hard to get better. Why don't I make a call and find out on which floor you belong?" I was shocked at being mistaken for a patient. I told her that she didn't understand, that she should call my supervisor to verify that I really was an employee. Again, the patient smile. Realizing that she had the power to limit my freedom, I became frightened, the experience began to feel unreal, and I wondered if this could really be happening to me. It was. I became a bit agitated and tried again. And again. She said I was becoming hostile (I was) and said perhaps I needed to take something to calm down if I couldn't calm down on my own. Life got easier after I had my own set of keys because the keys made my identity clear; I was not one of them.

Years later I could look back at this episode and think: So, this is what it was like to be a mental patient. You are not taken seriously, you have no credibility, your freedom to come and go is taken away. I learned a lot there. I was told that the schizophrenic patients could not be treated with psychotherapy, only managed with medication, and was advised not to bother listening too carefully to what they were saying because it was meaningless. Although many of the patients had a diagnosis of schizophrenia and spoke to some extent in the language of primary process, I found that if I listened closely and carefully, some of what was thought to be meaningless seemed to have meaning for them and made sense to me when I could supply some of the linguistic links that they omitted. I was able to do this when I could bend my unconscious to meet theirs in the space where they veered away from reality. Schizophrenia was becoming less scary. I began to think that maybe schizophrenics could be treated with psychotherapy. Certainly I had no training to do it other than my own experience of being listened to as an analytic patient, but it took no training for me to listen to them and find that what initially seemed mysterious and remote became more understandable.

Like most clinical social workers, from the beginning of my career I worked with many patients considered to be untreatable by means of psychoanalysis or psychoanalytic psychotherapy. At that time treatment by social workers was typically supportive, as training for more demanding work was not so readily avail-

able. Fortunately, my own treatment was with an analyst who was a social worker, one of a number who had obtained psychoanalytic training from the few "renegade" analysts who were courageous enough to train lay analysts in the way Freud wanted, at a time when the American Psychoanalytic Association's policy was to exclude nonmedical professionals from training.

From the beginning of my career I worked with patients who lived in the most impoverished and traumatic environments, and who had to adapt to human jungles in order to survive. I worked with the urban poor in the toughest neighborhoods of New York's Lower East Side, with survivors of the Holocaust, and with hospitalized mentally ill adolescent girls from Brooklyn's ghettos who, for their own safety, carried switchblades. I worked in the department of psychiatry in a municipal hospital in a rough Bronx neighborhood, a hospital that has since been razed, paved over, and turned into a parking lot. I did psychotherapy on the street, on the fly, in snatches of brief contact in hallways, in the emergency room, by phone, in formed and in unformed groups, and, more traditionally, behind closed office doors by appointment.

Later, working in both psychiatric and medical settings further stimulated my curiosity about the mind–body relationship of several patients who had decidedly mysterious relationships to their own bodies. There was a 13-year-old girl, a psychiatric inpatient at Kings County Hospital, a city hospital in Brooklyn, who kept using her left hand to try to "catch" her flailing right arm that looked as if it were running away from her or did not even belong to her body. There was a 15-year-old girl thought to have attempted suicide whom I was asked to see in the Fordham Hospital Emergency Room. She had carved "The New York Dolls," the name of her favorite rock group, into her arm with a razor blade. She expressed no wish to die; she felt only warmth, relief, and no pain. Carla, at 19, was a puzzle to the dermatology clinic, where she was repeatedly treated for skin infections on her left arm. She was given oral antibiotics and ointments, which she used as prescribed. Her skin condition did not improve. In fact it got worse. She developed open sores and pus-filled lesions. What she did not tell the clinic personnel was something I learned after a few weeks of psychotherapy, that she regularly raked her infected arm hard with her metal-bristled hair brush, promoting and maintaining the outward signs of something very wrong on the inside. Also at Fordham was the schizophrenic woman I treated. When I became pregnant and the pregnancy became apparent, she asked about it and I told her that yes, I was pregnant and would in time be leaving the hospital. There was no expression of feeling about this, but the following week and the weeks after, she arrived looking quite pregnant. Her periods had stopped, she said, her breasts were tender. I referred her to the OB-GYN clinic, but oddly they found she was not pregnant. I called and they agreed to examine her again and again, the report was negative. So was a third. When I called yet again and they said quite definitely that she was not pregnant, it finally occurred to me that this was a case of pseudocyesis ("hysterical pregnancy"), something I had read about as one of those

mysterious leaps from the mind to the body. At New York University's Rusk Institute for Rehabilitation Medicine, I worked with Tommy, an 8-year-old boy who had become paralyzed from the waist down. He drove the medical staff to distraction by regularly digging into his legs with pins, scissors, pens, or any sharp object he could find, continuously infecting and reinfecting himself.

The experience with Tommy caused me to think about the drug addicts with whom I had worked in a detoxification center before entering social work school. Many seemed to be as addicted to the act of sticking a needle in their arms as they were to the heroin that they injected into their bodies, and some could even get high injecting water. I was asked to run a weekly group therapy session. I wanted to get them to think about something other than drugs. Whether it was because I had no training for what I was doing or that the power of the addiction was extraordinary, or probably both, I found that group therapy became immediately an animated exchange of favorite "recipes" for getting high. These men seemed addicted to sharing their recipes, entering altered states of consciousness as they spoke of how they would "shoot up two nickel bags of horse, take a couple or so bombitas, then a bottle of Thunderbird" or advising, "no, man, bombitas aren't worth shit; you take cibas, you are *gone*, out of *sight*."

One of the positive aspects about not being a professionally trained drug counselor in the 1960s was that nothing was expected of us in terms of effecting any significant change. We were just meant to help the addicts go through the detox program. Most of the patients had done time in prison for drug-related crimes. Most had come into the detox center for "three hots and a cot," three cooked meals a day and a bed, to escape the harshness of the addict's life in winter—sleeping in alleys or on rooftops—or to cut down on their habit to make it less expensive. We were expected to do intake drug histories, counsel patients as needed, and try to dissuade them from signing out against medical advice so that they would complete the thirty-day detoxification period. We had not yet experienced the often stultifying influence of dogmatic theories, training institutes, or teachers and analysts whom we had idealized to quench a youthful impulse that ran toward rescue fantasies. This allowed some freedom for innovation, if one was inclined, and after the group therapy experiment, I was. I decided to try a different group approach, using acting for its expressive potential. Addicts were some of the best actors I knew, their bravado and swagger covering a lifetime of hurt, violence, and trauma. Bored with waiting for their thirty days of passive detoxification to be up, they picked themselves up from their beds, their interminable games of checkers, their hoarded stashes of cigarettes and Kool-Aid, to follow me into the dayroom, muttering self-conscious jokes about their "acting careers." I was surprised to see how readily they gave themselves to improvising a scene when a situation was given to them. Even more surprising was that although initially they managed to introduce drugs into every improvisation, after some time this stopped, and they became engrossed in the acting. To my astonishment, after an hour and a half had elapsed and dinner was announced, they

did not want to stop. They asked if they could continue the next day. Two men told me with tears in their eyes that this was the first time in many years that they felt normal, the way they do when they were "high." Beyond the initial rush, what they craved from the drug experience was the feeling of normality and well-being that so eluded them. They had been able to use the freedom to play, to enjoy for awhile a sense of creativity and well-being, the wonderful sense of being part of a group, like kids at school putting on the senior play.

The women addicts once put together a variety show to dispel their boredom, and one act was unforgettable. A woman pantomimed to driving jazz the sequence of getting sick, going out to turn a trick, meeting her connection, copping a few bags of heroin, inserting them into her vagina for safekeeping until she got home, tying off her arm to prepare the vein, preparing the syringe, then injecting herself, feeling a rush of pleasure, then her body relaxing into limpness. What was astounding about this was that the others watching seemed to be mesmerized, going into a trancelike state with the performer in which their muscles moved, tensed, and then relaxed in concert with her. A roomful of women got high together without taking any drug and reached some erotic crescendo and release, a most powerful interaction between mind, emotion, and body. I was peering into the mystery of dissociated states and wanted to understand more.

Several years later in the early 1970s there occurred a disturbing moment in my life that fueled a fierce interest in understanding the strange, trancelike states of mind of those involved in the various religious and mental health cults that seemed to be cropping up. Transcendental Meditation (TM) was very popular at that time and my brother not only practiced it but had become a TM instructor, going to Spain to learn whatever mysteries were involved from the Maharishi Mahesh Yogi's videotapes. The Beatles had studied with the Maharishi and their album, *Magical Mystery Tour*, reflected it. TM was in the air. It never occurred to me at the time that TM could be harmful. I learned the method myself but found it annoying, finding the yogic breathing I had learned in college better for relaxation. In one shocking moment, however, when my brother was talking with me and my husband about TM, I realized that he was talking like a robot, like a human machine. When I asked him thoughtful questions about his TM practices, he could not answer, except to recite from memory what I later came to understand were the rote teachings he had committed to memory, the TM "party line." He was talking only to my husband and me and yet he addressed us as "ladies and gentlemen," the same way he might have addressed a roomful of people who had come with their flowers, fruit, and money for their initiation into TM. There seemed to be nothing behind his eyes when I looked into them, no emotion, just a void, blankness. Ever since that moment I have been struggling to understand what happened. How could a personality change so suddenly? How could an intelligent person suddenly lose the ability to think? To feel? How could someone who had been there all of a sudden not be there?

A few years later I treated my first patient who had been profoundly damaged by her cult experiences and then a few others whose experiences in EST (Erhardt Sensitivity Training, later known as The Forum), in nominally Christian sects, and with various Eastern guru entrepreneurs had left them in what seemed to be ongoing states of confused floating and dissociation. Ultimately, I integrated what I had learned from my personal and clinical experiences and from doing consultations with people who had had a family member lost to a cult. I came to understand how the strange process of what had happened to my brother, the process that had caused him to snap, had also happened to lesser or greater degree in those who harm themselves. I also came to understand the importance of ongoing active intervention to correct the enormous cognitive distortions both in cult members and in those who harm themselves.

I learned that dissociation was essentially a phenomenon of those who do not experience the unity of mind and body. After getting my master's in social work, when I was studying with Dr. Gertrude Blanck and the late Rubin Blanck at the Institute for the Study of Psychotherapy, Gertrude Blanck made a statement—about people with borderline ego organization and those who had an inordinate narcissistic investment in their bodies—that stayed with me, providing much food for thought: "They tend to live more in the body and less in the mind." I came to think of the patients I have described above and many others as living more in the body and less in the mind. Their experience of events that one might expect to be experienced emotionally were not, but were experienced by them as physically charged experiences. I came to understand that living more in the body and less in the mind was a certain form of adaptation to their environment—a psychosomatic adaptation.

Even after going into private practice and seeing more middle-class suburban patients, I soon realized that many of the people I saw with borderline personality organization, dissociative disorders, posttraumatic stress disorders, psychosomatic disorders, and pronounced sadomasochistic pathology had suffered the effects of violence. While many came from environments that superficially looked good, from intact families, some even with high-achieving functional parents and attractive, affluent homes, they nonetheless came from environments of neglect, abuse, or other trauma. I became more aware only in the past decade that those who actively engaged in self-harm behavior seemed to be repeating the violence they had suffered or witnessed passively, inflicting it upon their bodies.

After postgraduate training in psychoanalytic psychotherapy, psychoanalysis, and child and adolescent treatment, I decided to get my doctorate in clinical social work. During this time I was fortunate to have the experience of teaching first-year medical students about psychopathology and the role played by psychosocial factors in the etiology and maintenance of illness and recovery from illness. This stimulated more thought about how the mind and body can work synergistically and unconsciously to inflict harm on the body. Soon after, I undertook

training in treating patients with eating disorders, and came to understand eating disorders as a paradigm for understanding psychosomatic processes. I learned that all disease is psychosomatic and somatopsychic, in that psychological and somatic factors are always present to a greater or lesser extent, actively intertwining at many levels (Weiner and Fawzy 1989).

Having obtained specialized training in eating disorders, I began to study the strong association between binge and purge behavior and self-mutilating behavior.
in relation to other forms of self-harm such as drug and alcohol abuse, anorexia nervosa, compulsive eating, suicide attempts, compulsive sex, shoplifting, compulsive shopping and spending, accident-proneness, and compulsive risk taking. I thought that what I was learning would be helpful to clinicians, researchers, and patients.

Many colleagues were repelled by the nature of my study, others were fascinated. Some began to look at their skin picking, nail biting, and autoerotic habits in a new way that was somewhat disturbing to them. Some wondered if they too were "self-mutilators." Applying that label to themselves seemed to be the equivalent of acknowledging a stigmatized status, one shared with hospitalized psychiatric patients and prisoners. If these acknowledged behaviors are forms of relatively mild self-mutilation, perhaps the difference between "us" and "them," self and other, the normal and the pathological, is not quite so great as we like to think. The more I came to think this way, the more I continued to find it unsettling, disturbing my sleep and my dreams as I had to wrestle more and more with what I was coming to acknowledge and understand in myself. At times I thought I had bitten off more than I could chew, and wanted to turn back. Despite these reservations, what remained constant was the passion for knowledge and the fascination of discovering and exploring a mystery.

I came to understand that nail biting and other habitual behaviors were low key versions of human impulses that were articulated far more powerfully by the severe eating disordered and self-mutilating behavior of the subjects in my study. I appreciated how very human these behaviors were, how many functions they could serve, and how many meanings they could have. As I learned how necessary and useful they had been, I could better appreciate the mysterious creativity of the unconscious in creating them. Borrowing from Joyce Mcdougall's provocatively titled book, I join her in making *A Plea for a Measure of Abnormality*. If we understand and accept our own very human impulses, we can more readily find empathic identification with our patients, which can only promote better informed treatment, and we can come to see those who severely harm themselves as being as much like ourselves as they are different.

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Introduction

Suddenly self-cutting, a clinical problem that evokes considerable anxiety, seems to be almost everywhere, bursting onto the cultural scene in very much the same way eating disorders exploded into our awareness twenty or thirty years ago. Both are hot topics now. After years of researching the relationship between two specific kinds of self-harm, bulimic behavior and self-mutilating behavior, I am asked to lecture on how to get patients to stop cutting themselves, or starving themselves, or bingeing and purging, and I am asked to do this in an hour. It is all too easy to focus on stopping self-harm without understanding it. The behavior is only the tip of the iceberg.

Self harm is about people who cannot live peacefully in their own skin, whose emotions are not experienced in their mind but in and through the immediacy of their bodies. It is about individuals whose predominant mode of self experience is sadomasochistic pain and suffering, and whose most comfortable terrain in which to live is the "borderland" (Novick and Novick 1996). Although written primarily for the clinician, there is much here for any reader whose interest has been captured by the violent destructiveness to others and self that has ascended to the foreground of our cultural consciousness. This includes those people whose lives are wrapped around a self-destructive core. Any thoughtful reader who wants to understand more about why we are hearing so much about self-mutilation, tattooing, body piercing, food-related disturbances, substance abuse, sadomasochism, and other disturbing trends in the youth culture will find something of interest here.

This is a book for clinicians who may or may not have psychoanalytic training. Whether one comes from a psychoanalytic, family systems, or cognitive-

behavioral orientation, a psychoanalytically informed case formulation offers a good opportunity for designing an empathic and pragmatic treatment meant to transform the nature of the sadomasochistic attachments. A psychoanalytically informed case formulation can be quite useful not only in informing a psychoanalytic treatment per se but also in designing a group therapy program, cognitive-behavioral treatment, family systems treatment, or a largely supportive treatment for self-harming patients.

In this book I attempt to make self-harm understandable as a creative unconscious solution to formidable problems of living. It may be a dark kind of creativity, but the paradox is that even the most seemingly self-destructive acts often have creation as their goal. Clinicians must understand and appreciate the creative functions of self-harm behavior and their creative etiology. Helping a patient to give up self-destructive behavior and relationships is a complex and circular process, requiring the clinician to appreciate how the libidinal and aggressive drives and a sense of self have become trapped in the body's symptoms. If the heart is the representational source of our emotionality, then telling the patient to "amputate" the self-harm symptom is equivalent to telling him to eat his heart out or to cut his heart out.

Many self-harming patients will say that they would give up their bodily symptoms if only they could, but because they know no other way to live, they simply cannot give it up. This is where we need to start, because even though clinicians can get patients to give up the self-harm behavior, getting a patient to give it up before he is capable of functioning without it can result in even more severe self-harm. Self-cutting and eating disorders are disturbing symptoms, and we hope we can help our patients who are attached to pain and suffering to find more growth-enhancing attachments. In this age of managed care, the focus is on symptom reduction through behavioral treatment, psychopharmacology, and tiny bits of psychotherapy—short shrift to patients whose difficulties require complex and necessarily longer-term treatments.

Some time ago, I got a call from a clinician who worked with psychotic patients at a prestigious teaching hospital and was interested in eating disorders. She told me that as the patients on the eating disorders unit got better (getting better was measured behaviorally in terms of weight gain and stopping bingeing and purging), many of them began manifesting psychotic symptoms just at the time that discharge plans were being arranged. The plans for discharge were halted and the patients were transferred to her unit, where their psychotic symptomatology was the focus of treatment, paid for by insurance companies using managed care criteria. I suggested that to understand the phenomenon of eating disorders, one must know something too about the kinds of severe ego and psychosomatic regressions that can occur when the patient is forced to give up symptoms before the ego is able to relinquish them. The emerging psychosis can be an iatrogenic illness, precipitated unnecessarily by the patient's treatment. Managed care, although committed to cost-efficiency, was actually promoting iatro-

genic illness by insisting on short-term, symptom-focused treatment, and then having to spend even more money to pay for the treatment of the iatrogenically induced illness!

In my research, I began looking for a way to illuminate a dark mystery, that of self-inflicted harm and its mysterious companion, self-inflicted pain in those who need to cut or scratch their skin, rip up their insides with self-induced vomiting or abuse laxatives violently, or other self-destructive acts. I wanted to understand the demonic powers by which some lives are lived. I wanted to better understand the concept of the *It* in Georg Groddeck's *Book of the It* (1923). Groddeck never clearly defined the *It*, but it was virtually synonymous with the forces of the id. In fact Freud (1923) derived the word *Id* (*Es* in German) from Groddeck. Groddeck spoke of the mind and the body not as separate entities but as facets of the whole, and said in a letter to Freud that "the distinction between mind and body is only a word, not an essential distinction. . . . The body and mind are a joint thing which harbors an It, a power by which we are lived, while we think we live" (Grossman and Grossman 1965, p. 69). Once we can face our deepest and darkest urgings, our *It*, said Groddeck (1923), we will be free to live in harmony within ourselves.

Novelist E. L. Doctorow described the creative process in writing as "going down to the rag bin of your mind and pulling up whatever you can find and somehow stitching it together, making a whole something out of little bits and pieces (Lahr 1998)."[1] Healthy artists or writers have the ability to reach into their unconscious, into the whirling chaos of primary process, to create something new of aesthetic value in the transitional space between the unconscious and the conscious, and then resume functioning in the ordered thought of secondary process. The borders are not threatening to creative people with intact ego functions, because the regression to primary process is a controlled regression in the service of the ego, and so they can readily emerge from it to use the bits and pieces they have come up with to fashion something new and of enduring value to society. The self-harmer, on the other hand, does not dip, but instead plummets down precariously into the unconscious mind, retrieving bits and pieces of memory—cognitive memory, memory traces, and somatic memory—to create various self-harming acts. Like the poem or painting that is meant to communicate to others, the self that is harmed also serves as unspoken communication to others, and sometimes it serves as a presymbolic communication to the self. For the self-harmer the regression to self-harm may devastate and engender more pain and suffering, and sometimes death. Yet strange as it may sound, some have been able to transform the enactments on their bodies into a communication to the self, using their self-harm to grow into a newer sense of self, one with a greater aware-

1. I thank Jeanette Bertles for introducing me to this quotation and for pointing out its source.

ness of options and choices that has enabled them to relinquish their self-harm. I have been helped to understand this last point through dialogues with writer Catherine Taormina and writer and publisher Ruta Mazelis, of *The Cutting Edge*, both of whom have lived with and relinquished self-harm.

The concepts about self-harm discussed in this book have evolved from my training, clinical experience, research, and self-analysis. In conducting a study on the relationship between two very similar yet different kinds of self-harm behavior, binge-and-purge behavior and self-mutilating behavior, I found that these two severe and mysterious forms of physical self-harm were prototypes for understanding other kinds of self-harm.

CONCEPTUAL THEMES

Psychoanalysis is given to metapsychology, simultaneous multiple points of view, rather than mutually exclusive dichotomous categories. We need a broadened integrative psychoanalytic frame of reference with which to understand and treat patients attached to self-harm, one that can transcend disciplinary boundaries and intellectual disciplines. This is not the same as a random eclecticism that takes bits and pieces from potentially incompatible models of therapy (Holmes 1996). Attachment theory offers a new paradigm that can synthesize and integrate the best ideas from different disciplines within such a broadened frame. We can look through the lens of attachment theory in order to tolerate ambiguities and dualities, to appreciate the dialectics of attachment and autonomy, control and dyscontrol, spoken and unspoken, mind and body, the revealed and the hidden, the sacred and the demonic, prey and predator, the wish to know and the wish not to know.

There is, I suggest, a relationship between the culture of violence in which we live and the increasing tendency of human beings in Western societies to inflict violence not only upon others but upon themselves. Our attraction to violence may well be rooted in the trauma experienced by our prehistoric ancestors when they were preyed upon by carnivores bigger and stronger than themselves, early in our evolutionary history when lions, tigers, raptors, and dinosaurs roamed the earth hungry for flesh and blood (Ehrenreich 1997). In the process of thousands of years of evolution, prehistoric man became transformed from being prey, occasional food for bigger carnivores, to becoming.a meat-eating predator, hunting and preying upon other animals. According to Ehrenreich, man's propensity for bloodshed is derived from ancient blood rites of human and animal sacrifice, which were performed by early man to reenact their terrifying experience of predation by stronger carnivores, a way of mastering the trauma and a way of appealing to the gods for mercy and healing.

We know all too well that sometimes man, like the other animals, preys upon his own species, and sometimes man, like the other animals, takes his own body

as the object of prey and preys upon himself, creating his own blood rites and sacrificing his flesh to his own internalized demonic gods. While the popular "inner child" concept often helps people develop a sense of empathy for themselves and their needs, which they have denied, what is lacking but equally needed to complete the picture is the concept of the "inner predator," that destructively demonic part of the self that resides in all of us, that can come to prey upon and take over the self. We also need a sense of empathy for the dark impulses to do so and greater understanding of the spiritual dimension of our patient's lives, whether within the confines of organized religion or not. Bollas (1997) has said, "Perhaps we need a new point of view in clinical psychoanalysis, close to a form of personal anthropology" (p. 7). Whether the reader practices psychoanalysis, psychoanalytic psychotherapy, or family systems therapy, understanding the concepts of the prey-to-predator transformation and sacrifice can enrich the treatment of those who harm themselves.

Given the recent findings of biological psychiatry in understanding the psychobiology of trauma, we must consider how psychobiology and neuropsychology can help us to understand self-harm. Given the findings of evolutionary psychology about the evolutionary origins and functions of anxiety (Marks and Nesse 1994), we must consider how self-harm may have evolved in the life of an individual as a means of defending against extraordinary anxiety. We must also ask how self-harm can be understood in relation to suicide and in relation to sadomasochism, either the wish to inflict pain and harm on another or the wish to inflict pain and harm on oneself.

Self-harm can be best understood by the idea that psychological symptoms are caused by more than one factor and can serve multiple functions in the psyche (Waelder 1936). Various forms of self-harm can be understood as compromise formations (Brenner 1982), solving conflicts among and between the psychic apparatus (ego, id, superego), the repetition compulsion, and the demands of the outside world. In this era of Freud-bashing, those who have been quick to dismiss Freud's theories of the instinctual drives and the etiology of trauma will need to reconsider Freud's contributions in order to understand the origins of self-harm.

Various forms of self-harm—drug and alcohol abuse; compulsive sex, gambling, shopping, or spending; shoplifting; and the quest for danger and near-death experiences—can also be understood as attempts at self-medication. That is, they are the attempts of desperate people to interrupt or terminate an intolerable mood or emotional state, or more simply put, to feel better. As with the self-medicating use of drugs or alcohol, these attempts at self-medication can develop into an addictive cycle.

The developmental point of view requires that we explore self-harm in the context of how it developed throughout the phases of childhood, adolescence, and adulthood, considering what led up to it, what came after, what has continued, what has fallen by the wayside, and what has been transformed. Child therapists know that the task of treating the child is to remove the stumbling blocks

that impede healthy development. Because the developmental point of view helps us to identify how these obstacles developed and the developmental tasks that should be achieved when they are removed, it is invaluable in pointing a direction for both the clinical treatment of self-harming children and adults and the preventive early intervention or developmentally informed later interventions with self-harming infants and children.

The universality of self-harm may be difficult to consider because its primitive nature tends to evoke considerable anxiety in civilized people. We need to look at the apparent increase in self-harm in relation to the dramatic shifts for both sexes in terms of body image and gender role expectations brought about by the sexual and cultural revolution of the 1960s. At the same time, we need to acknowledge that self-harm is not peculiar to contemporary Western culture, but has existed in diverse cultures and religions, and in mythology from the beginning of history.

While certain forms of self-harm are acknowledged and discussed in our culture, others are not. But we must consider that self-harm not only may be far more common than has been acknowledged but also may be universal in human beings. Accepting its possible universality allows us to relinquish the artificial and defensive "us" and "them" categories that marginalize our patients and keep us from understanding them in ways that can be truly healing.

The concepts of adaptation and attachment theory are key to understanding the universality of self-harm as they offer the potential for integrating into psychoanalysis concepts from other disciplines. They serve as valuable bridges to object relations theory that can be used to understand how human self-harm is related both to self-harm in other animals as well as to our need for a feeling of connectedness to others.

Heinz Hartmann brought together concepts from biology, anatomy, psychology, and sociology to inform his understanding of how human infants adapt to their environment (Blanck and Blanck 1974). Adaptation is "primarily a reciprocal relationship between the organism and its environment" (Hartmann 1939, p. 24). To adapt, the infant must discharge instinctual drive energy outward to the exterior of its body and must develop instincts for protecting and caring for the body self. Hartmann, however, was referring to an "average expectable environment," in much the same way that Freud's theory of neurotic conflict assumed that the environment of the person with the neurosis was both average and expectable. And today more and more of the people seeking treatment present with borderline personalities, dissociative disorders, and posttraumatic stress disorders. Many have had to adapt, not to average expectable environments, but to human jungles in order to survive, and they have come to prey upon others so that others cannot prey upon them. From poor families and affluent ones, these children have adapted to their environment abusively and violently. Others of their ranks are wild and savage only to themselves, preying upon their own bodies in an adaptation that is steeped in pain, violence, and sadomasochistic experience. Un-

fortunately, Hartmann's obtuse theory of adaptation did not include the clinical material necessary for bringing it alive for clinicians. This book should serve to fill that gap.

What is the difference between man and the other animals? Until recently we have thought that the distinguishing features are man's ability to use language, to make and use tools, to have a sense of consciousness about himself, and to have the ability to transmit culture. Each of these distinctions has crumpled and we have come to understand more and more that what may be thought to be unique about human beings is also characteristic of other animals (Candland 1993). Ethology, the scientific study of animal behavior, has produced a body of knowledge on animal self-harm and the nature of early attachments that can be applied to understanding human self-harm. For example, hair pulling, head hitting, head banging, face slapping, eye and ear digging, self-biting, and skin scratching are seen in confined monkeys and other animals, and are comparable to mutilative behaviors in humans. Animals, like humans, are known to refuse to eat after being separated from their mothers. Animals manifest their response to separations and disorders of attachment much as humans do. Understanding how animal self-harm evolved will provide further understanding of how human beings can come to prey on their own bodies like the most savage of animals, thus helping clinicians better understand how profoundly deep is the ego regression in the act of self-harm.

Like the concept of adaptation, the greatest contribution of attachment theory is that it offers a rich potential for integration of concepts from other disciplines, including evolutionary biology, ethology, psychoanalysis, cognitive psychology, chaos science, and nonlinear dynamics. Attachment theory is a systemic theory, seeing the individual not in isolation but in reciprocal relationship, initially to a primary attachment figure, then to secondary attachment figures within the family, and then to the larger society (Holmes 1996). The key premise of research-based attachment theory is that there is a biologically based attachment system characteristic of each species that attaches the offspring to its caregiver in order to protect it from predators in the environment (Bowlby 1969) and to promote the development of self-regulatory functioning (Hofer 1995). Intimate behavior, especially intimate touch, is at the heart of the attachment system and is central to the existence of all animals (Morris 1971). It is intimate touch that attaches the infant securely to his mother and the mother to her infant, making her a secure base for him. With a secure atttachment the child can come to tolerate separations and develop a basic sense of trust. The theory provides a firm psychobiological framework for appreciating the importance of the mother–child relationship in ensuring that the child survives and thrives, not only in the attachment to the mother or caregiver but also in other future attachments. Man needs to touch and to be touched, to love and be loved. Whether we use Fairbairn's concept that infants are not only instinctually driven but object seeking, Melanie Klein's theory of the interface of very early developmental events and

primitive cognitive mechanisms, Winnicott's conclusion that the infant cannot be understood apart from its interaction with the mother, Mahler's observationally based theory of separation-individuation, Stern's concept of interactive attunement mechanism's in the mother–infant relationship, or Kohut's theory of self-object relations, what we really are talking about are the ways in which human beings become attached after birth to their caregivers and subsequently to others. Attachment theory can help us to understand self-harm by illuminating what goes wrong in the attachment system that predisposes human beings to forming strong attachments to repetitions of trauma, to internalized violent and pain-inflicting objects, to painful affect, and to somatic pain.

The research and clinical literature on attachment theory has provided a great deal of food for thought. Especially exciting has been the work of Jeremy Holmes (1996) and Peter Fonagy and associates (Fonagy 1997, Fonagy et al. 1995, Fonagy and Target 1995) in using attachment theory in adult psychotherapy and violence. The work of Felicity de Zulueta (1994) in using attachment theory to understand the increasing violence in our society, Barbara Ehrenreich (1997) in tracing our attraction for war and violence to prehistoric man's fear of powerful animal predators, and Reid Meloy (1992) in using attachment theory to understand the violence of the most bizarre homicidal acts have been both evocative and provocative in helping to clarify, inform, and differentiate my own ideas about the violence in self-harm. Especially important in the development of my ideas about attachment has been Hans Loewald's seminal paper, "On the Therapeutic Action of Psychoanalysis" (1960), which continues to inspire my theoretical and clinical thinking.

Hofer's (1995) synthesis of neurobiological concepts from ethology with psychoanalytic concepts has provided a unified psychobiological theory for understanding human attachments and emotional and physical responses to separations and losses. Hofer's theory also provides a valuable lens for understanding the psychosomatic processes underlying disorders of self-regulation, illness and self-harm. I am indebted to Graeme Taylor, whose integrative book, *Psychoanalytic Medicine and Contemporary Psychoanalysis* (1987), introduced me to the concept of attachment theory and its relation to physiological regulatory processes, thus enabling me, without the benefit of medical training, to understand these and countless other concepts in psychosomatic medicine. Discussions of such concepts with the psychosomatic study group of the Psychoanalytic Association of New York, guided by C. Philip Wilson, has taught me a great deal as well about psychosomatic processes. The International Federation on Psychoanalytic Education's 1998 conference was an extraordinary event that brought together individuals interested in psychoanalysis to consider the question: "How Will the Body Speak in the 21st Century?" Allan Schore's (1997) exciting integrated theory of the imprinting of early mother–child interactions on the brain not only illuminates how earliest attachment experiences shape the child's regulatory processes in the brain but also provides a conceptual model for understanding how

subsequent secure attachment experiences can alter the earlier imprinting. Similarly Bessel van der Kolk's (1994, van der Kolk and Fisler 1994) research in integrating the neurobiology of trauma and self-destructive behaviors with attachment theory has been exciting and inspiring.

While we may know through our clinical work that a strong and secure attachment to a therapist can change our patients' "wiring," Schore's work has demonstrated that psychotherapy can produce changes in the brain as significant as those produced by psychotropic medication and perhaps even longer lasting. In this era of managed care and quick fix solutions, Schore's work provides the empirical support needed for psychoanalytically informed psychotherapy in general and in its treatment of self-harm. Schore (1997) has said that the regulatory processes that get disrupted in infancy can get repaired in psychotherapy. Schore's work also highlights the importance of expanding our vision and thinking across a spectrum of other disciplines.

Like other animals, we human beings are capable of violence to others and ourselves. However, we are quite different in that we are "as a species, quite alone in our capacity to murder in cold blood, to torture one another and to threaten our species' very existence" (de Zulueta 1994, p. vii), by means of killing off others of our species or ourselves. We must recognize our primitive and violent inclinations if we are to become capable of restraining them in ourselves and understanding them in others. Physical violence is the language of those who, lacking the ability to use metaphor or symbol to express emotion or unspeakable pain, use the body to speak for them. In those who tend toward self-harm, these acts serve to narrate that which their words cannot say or their minds cannot remember. In the acts of self-harm they are more like feral animals, living primitively and viscerally in the bodily experience of bared fangs, tensed muscles, and bloody talons.

The fields of ethnology and anthropology provide a cross-cultural perspective from which one could understand the adaptive aspect of self-harm in diverse cultures the world over. For example, if bloodletting could be used by indigenous people of New Guinea and was routinely prescribed during the American Revolution for yellow fever among Washington's troops, the claim of self-cutters that they feel healed by their cutting places their self-harm in a tradition of healing that spans history and cultures. The members of snake-handling churches risk getting bitten by poisonous snakes to achieve a state of religious ecstasy. Similarly, seeking out pain, starvation, and mutilation was in the medieval Christian tradition that continues today far more than is usually thought. Religious self-harm is similar to the disordered eating and self-mutilating behavior of those who use such behavior to purify and cleanse themselves of the continuing aftereffects of severe childhood physical and sexual abuse and other trauma. Today we are seeing a multitude of young people in industrialized cultures all over the world with tribal-like markings, "modern primitives" who have had their bodies pierced, branded, tattooed, and scarred by others or who scar their own bodies themselves

or create their own home-made marks. Why do they mark and harm themselves in these ways? How do these practices relate to tribal practices? Are they, in fact, the new tribal practices of contemporary global tribes? The tribe of the disenfranchised and alienated? The tribe of the freak? The tribe of the traumatized and abused?

ORGANIZATION OF THE BOOK

Part I, "The Mysterious Borderland of Self-Harm," serves as a map of new territory, introducing the reader to the self-harm concept, its spectrum, paradoxes, and universality. Part II, "Neglect, Violence, and Traumatic Attachments," explains the origins of self-harm in experiences of violence, abuse, and neglect. Attachment theory explains how such experiences and the psychosomatic nature of the trauma response promote an addictive-like attachment to pain and suffering. The perspectives of evolution, religion, mythology, and contemporary culture are presented so that those who prey on themselves can be understood within a larger context as having been transformed from the status of being prey to the status of predator.

Part III, "The Body Speaks," explains the creative power of the unconscious in directing the construction of symptoms that can perform so many functions, and introduces the concept of self-harm as gestural articulations of trauma. The language of self-harm as articulated by patients and those who participated in my study is presented. It explains how various kinds of self-harm can become forms of self-medication, the specific kinds of self-harm serving as the drug of choice uniquely suited by the individual to what ails him. It explains what self-harm can do for someone, how it can regulate moods, affect states, relationships, and self-esteem, express unthought and unspoken emotion, and reenact earlier trauma. Gender differences in self-harm behavior are discussed, including the apparent tendency for self-harm behavior to be more common in women. The phenomenon of symptom substitution is addressed—when one self-harm behavior is given up or renounced, often another form of self-harm crops up to substitute for it. The body modification culture and the culture of the "freak" will be discussed in light of what is known about self-harm, attachment theory, and self-medication.

Part IV, "Clinical Implications," presents the implications for this understanding to the diagnosis, assessment, and treatment of those whose emotions bypass their mind and are expressed through bodily self-harm. The influence of my training with Gertrude and Rubin Blanck, who developed and taught a model curriculum for training in psychotherapy at the Institute for the Study of Psychotherapy (G. Blanck 1998), is profound. Their psychoanalytic developmental ego psychology is a model that does not see either conflict or deficit as an all-or-nothing proposition, but is based on the concept that building ego functions increases the structuralization of the ego, which can ultimately make a patient with ego

deficits more capable of sustaining the demands on the ego made by a more intensive psychotherapy. The work of treatment will be to provide an environment in which a safe and secure attachment relationship can grow, and to hold and contain the patient while undertaking the work of decoding their bodily enactments. The aim is to transform the harmful bodily enactments by building in patients a capacity to reflect upon their experience, a symbolic leap from the body to the mind. Inspired by Loewald's (1960) "On the Therapeutic Action of Psychoanalysis," a concept of how this is accomplished by means of the therapeutic process is proposed. The relationship of enactments on the body and enactments in the transference/countertransference matrix is discussed, with special considerations for helping clinicians deal with countertransference issues and avoid becoming secondarily victimized by the treatment. Handling group contagions of self-harm is discussed as well. In addition to implications for the treatment of those who self-harm, there are implications as well for early intervention and prevention in schools, medical practice, social service agencies, and mental health programs.

The appendix, "The Study and Transitional Space," is devoted to a description of the study, with emphasis on it as a transitional space, an intermediate area of experience between the researcher and the subjects. It provides readers with an interest in research an understanding of the study to which I refer throughout the book. For those not usually interested in research but who are considering working with these patients, it provides an understanding to other clinicians of what I have learned in the study's transitional space so that they too can, as I did, come to feel less afraid of working with these challenging and often fearful individuals who require lots of transitional space.

The voices you will hear in this book are those of patients, of people who participated in my study, of theorists, clinicians, researchers, and writers. The words of patients are not always verbatim, having been altered at times for instructive purposes, and some case vignettes are composites, created also for instructive purposes.

PART I

THE BORDERLAND OF SELF-HARM

To seek out in a world full of joy the one thing that is certain to give you pain, and hug that to your bosom with all your strength— that's the greatest human happiness.

Jean Giraudoux, *Ondine*

1

The Mystery of Self-Harm: Concepts and Paradoxes

Symptoms belong to the realm of semiology; they are signs that suggest a mystery.

Hamburg, "Bulimia: The Construction of a Symptom" in Bemporad's and Herzog's (1989) *Psychoanalysis and Eating Disorders*

Many patients come into treatment complaining of an endless sense of aloneness and psychic deadness. They want to get back to the land of vibrant living where life has meaning. Those who can articulate this pain are the fortunate ones because they know what it is to feel alive and are troubled by the loss of their spirit (Bollas 1997, interviewing Michael Eigen). By entering treatment they turn to another human being in the hope that their spirit can be rekindled. It is the unfortunate ones who often do not know or remember what it is like to be alive in body and spirit. They may feel like the walking dead but may not even be able to say that they feel dead inside; instead, they may harm themselves in one way or another.

Those who harm themselves have received ongoing messages—from family, peers, and the media—about their worth or lack of it, about pain, pleasure, violence, power, death, sex, God, and beauty. Self-harm is a particular kind of masochism, the embodiment of a determination to punish, castrate, or annihilate the self, but it is more than that.

For some who are deadened by depression, feeling bodily pain is to be jolted momentarily out of a depressed state and to come alive once again. For those who are deadened by dissociation, inflicting bodily pain on themselves is like turning

on the switch that makes them feel real once again. For those who live with a constant anxious hypervigilance that deadens them to pleasure and joy, inflicting pain to their bodies can provide them with a release that is as close to joy as they will get. To feel pain in the body is to experience the body as alive and vital, a very welcome relief that mitigates the severity of the physical pain.

As clinicians, we have values that we take for granted and bring implicitly to our work—that life is to be preserved, to be bettered, to be lived. These values may conflict with the ways that some of our patients live their lives. We want to help our patients find the freedom to live their lives more fully. Food is meant to sustain life and bring pleasure, not torture by self-starvation, vomiting, or laxative abuse. Blood is meant to flow through our veins, nourishing our cells and sustaining our lives, so the thought of someone deliberately shedding his or her blood may make us cringe in fear and revulsion or may make our own blood boil. People who make suicide attempts, mutilate their bodies, have eating disorders, or are dependent on alcohol or drugs disturb and frighten us, shaking up our assumptions about human nature. Although the term *self-destructive* is more familiar and is usually used for such people, it seems to presume that the destruction of the self is the person's primary intention. It is not nearly so simple. The term *self-harm* is a more neutral term to designate a continuum of behavior that results in harm to the self. It does not presume a primarily self-destructive intention, which makes it preferable to the term *self-destructive*. It may be more accurate to say that both self-destructive as well as life-affirming impulses exist in all of us, in different balances and at different times.

THE DEATH INSTINCT REVISITED

Some self-harming patients are attracted to self-destruction in a strangely erotic or romantic dance. Freud's (1920) theory of the life and death instincts explains certain fundamental attitudes in relation to life. In Freud's theory of the death instinct, the person withdraws from human connections and retreats into a narcissistic position, silently driving him- or herself toward death. Freud emphasized that it was only through the activity of the life instinct that this death-like force was projected outward as destructive impulses to objects in the outside world. He assumed that the life and death instincts—or the constructive and destructive aspects of the personality—are in constant conflict and interaction. As Menninger put it, "To create and to destroy, to build up and to tear down, these are the anabolism and catabolism of the personality, no less than of the cells and the corpuscles—the two directions in which the same energies exert themselves" (Shneidman et al. 1994, p. 18). This conflicting interaction is an unstable fusion, that is, the "erotic [life] instincts and the death instinct would be present in living beings in regular mixtures or fusions, but 'defusions' would also be likely to occur" (Freud 1920b, pp. 258–259). No one of us evolves completely free from

the upsurge of self-destructive tendencies. Some of us manage to balance the conflicting tension between the constructive and destructive tendencies, acting only occasionally on the self-destructive wishes, and others establish a very different kind of equilibrium, in which the self-destructive impulses prevail.

Steiner (1996) formulated how the conflict between the life and death instincts has deepened and supplemented the mental conflict theory, the central theory of classical psychoanalysis. The early mental conflict theory stressed the conflict between unconscious impulses and drives and the demands of reality. Then with the introduction of the structural theory, the conflict between the ego and forces from the id and from the superego became more important. Ultimately, however, the conflict was formulated as one between the life and death instincts, and innate destructiveness was seen to set limits on what psychoanalysis could achieve (Freud 1937).That is, each individual must negotiate the conflict. When he cannot, he develops symptoms as a compromise and uses maladaptive mental mechanisms to defend himself and his objects. These mechanisms become embedded as permanent personality features and may give rise to illness or to serious character disorders. With Freud's discovery of transference and resistance, a theory emerged in which the conflict can be worked through in the analysis because during treatment it is relived in relation to the analyst (Freud 1914b). The goal of treatment was to help the patient understand his unconscious processes in order to resolve the conflict in healthier ways, in particular through the use of insight. Both self-knowledge and control over his impulses are part of these goals, as suggested by the adage, "Where id was, there ego shall be" (Freud 1933, p. 80).

PURGING, BLOODLETTING, AND EXORCISING THE DEMONS

Until the beginning of the nineteenth century, treatment of the physically or mentally ill in the Western world involved getting rid of something evil that was foreign to the individual—a spirit, demon, or toxic substance—that had invaded the body (Rizzuto 1985). Or it was thought that the four basic humors or temperaments—sanguine, phlegmatic, melancholic, and choleric—had become unbalanced and could be rebalanced by bloodletting, blistering, purging by vomiting or anal purgatives, or other potions that would cleanse the body. George Washington was one of the most famous victims of this kind of healing. Physicians trying to save him from a high fever hastened his death by blistering his arms and legs, purging him with laxatives, and bleeding him repeatedly, withdrawing around half of his blood. These same practices were believed to rid the body of the demons that were thought to dwell within the ill individual. Even today when we say "God bless you" or "gesundheit" to someone who has sneezed, blessings are invoked because of the belief that sneezing expels the demons. In some Eastern cultures, tattoos with religious significance are thought to banish

the demons. So what we might regard as our contemporary afflictions—excessive exercise, self-starvation, self-induced vomiting and diarrhea, self-mutilation, and body modifications (tattooing, body piercing, etc.)—fit within a long and established tradition of health and healing.

Freud wrote about demons and states of possession (1923b) and told us that sometimes neuroses "emerge in demonological trappings" (p. 72). He told the story of a painter who had made a pact with the devil, promising to belong to him body and soul, and who was redeemed from the pact by the Virgin Mary. Nonetheless, the demonic and the sacred are concepts that psychology, especially psychoanalysis, tends to discount. But many of these patients do seem possessed, if not by demons, then by monsters, and at times may even verbalize this. "It's as if there's a monster inside me, telling me to do these things, and I can't resist." Today we are seeing increasingly larger numbers of people who are trying to heal their broken souls and spirits with the help of vomiting and other purging, bloodletting, tattoos, body piercings, and other contemporary exorcisms.

THE FEAR OF MADNESS

Many clinicians tend to avoid understanding those with such problems as eating disorders, substance abuse, self-mutilation, compulsive gambling, stealing, shopping, and compulsive sexual behavior. In addition, those whose physical illness has a large psychogenic component are not the kind of referrals we tend to welcome, nor do we tend to welcome patients with dissociative disorders, who can evoke a great deal of anxiety and threaten to overwhelm our emotional resources. They can intrude into our lives, fantasies, and dreams in ways that can make us want to shut them out of our lives. For the past twenty years or so, using the label "borderline" has been an easy way to create a defensive distinction between self and other. When these patients are treated it is usually primarily by medication or behavioral modalities that do not require truly understanding these patients. Sometimes such treatment is ineffectual, and often may even be destructive and traumatizing.

It is very difficult to treat patients who court death. It is challenging to connect empathically with them, so we tend to resist the complex attachments that must develop if we are to treat these patients. It is much easier to see them simply as the sum of their symptoms, and to collude unconsciously with them in maintaining their symptoms and the sense of identity that is bound up in them. Understanding the mystery of self-harm, like understanding the mystery of schizophrenia (Karon 1992), means getting in touch with the darkest, most violent, and primitive aspects of ourselves, a venture into unknown territory that evokes fear. It means bending toward the patient's unconscious to face the monsters and demons in them and in ourselves. It means facing truths about ourselves, our families, and our society that we do not want to face. Trying to understand self-harm means

entering into our patients' darkest states of being, to tolerate dwelling there for a time, confident in one's ability to emerge from it. "Mysteries—if we reinvest the concept with something of its ancient prestige—designate a truth *necessarily* closed off from full understanding. They remain always partly veiled in silence . . . they introduce us to unusual states of being which, for a time, we enter into and dwell within. . . . Mysteries disturb the world we take for granted" (Morris 1991, pp. 23–24).

THE BODY

The body has become the locus of subjectivity, and is linked to language, feeling, pleasure, pain, power, and history. And so what we do to and with our bodies, what and how we eat, how we dress, how much space our bodies occupy, the daily rituals through which we attend to our bodies, are all part of our unconscious individualism. The body provides a home for the self.

> What is it—this thing, this flesh, this cabin of our consciousness, this sailboat of our soul?
>
> The body: we stuff it, starve it, expose it, cover it, excite it, drug it, destroy it. It is the source of our lust, and its object. It sates and is sated. It is the house of our appetites. In the body is our idea of pleasure.
>
> And our idea of pain. It smells, it swells, it stretches, it sags, it decays. It will never again be what it was before. It is our personal metaphor of time—and death. [From the back cover of *Granta*, 39, Spring 1992]

We have polarized our images of the body, portraying it in art and literature as either wholesome or diseased, unified or fragmented, a sacred temple or a hungry monster. The mind-body split has existed not only in medicine but in Western culture in general. More recently, our culture, even more than psychoanalysis, has seen a dramatic return to an interest in the body, holistic health, and an effort to heal the mind–body split.

The human body stands as a symbol of society and its values. The "body politic" is divided into left and right, while the "social body" is compartmentalized into upper, middle, and lower segments which are governed by a disembodied "head" (Polhemus 1988). We describe behavior in ways that are both corporal and social: A person may be upright, uptight, straight, bent out of shape, tight-assed, twisted, loose, upfront, hard-headed, soft-hearted. At the same time, inside and outside describe both physical and social boundaries, and so a popular song of years ago referred to love as "getting under one's skin" while ending a relationship may be called "cutting her loose." Anthropologist Mary Douglas has analyzed the symbolic interface of the physical body and the social body: "The physical experience of the body, always modified by the social categories through which it is known, sustains a particular view of society. There is a continual exchange

of meanings between the two kinds of bodily experience so that each reinforces the categories of the other" (Douglas, *Natural Symbols*, p. 65, quoted in Polhemus 1988, p. 12).

Despite the efforts of Freud and the early psychoanalysts in understanding how libido and aggression had become trapped in the body's symptoms, the importance of bodily experience has been largely neglected until the recent focus on the intersubjective and interrelational has made psychoanalysis begin to turn its interest to the body as the subject of experience.The ascetic view of the body has become woven into the landscape of Western culture. According to the ascetic writers (Saint John of the Cross, Saint Catherine of Siena, etc.), the "body of desire," with all its cravings excited by the phenomenal world, must be mortified or obliterated (Podvoll 1969). Self-cutting and self-starvation mortify the flesh on a major scale, while the most common and even ordinary self-harm—picking at one's skin, overeating, chewing on one's cuticles—does it on a minor scale. It is most intriguing, then, that self-harm has neither been well defined nor understood in the clinical or research literature. Clinicians and researchers have not explored the mysterious aspect of human experience that, more than any other, bridges the chasm between "us" and "them," and allows us to see people who harm themselves as less human than ourselves. This chapter introduces the concept of self-harm and discusses the spectrum of human self-harm behavior, which may encourage readers to become more acquainted with their own individual repertoire of self-harm behavior, certainly not an easy or welcome acquaintance to make. It does, however, promise to be a fascinating one that can help us to better understand our patients and engage them in a treatment that is "experience-near."

SYMPTOMS AND LANGUAGE

To navigate the terrain of self-harm, one needs to understand the mysterious language spoken by the symptoms.

> Symptoms . . . are signs that suggest a mystery. . . . The symptom is necessarily ambiguous. . . .
>
> We can welcome symptoms as clues to an underlying process. Naturally we are first impressed by the pain of the symptom itself, yet we are also confronted by uncertainty, mystery, and the possibility of many meanings. . . . The psychiatric symptom is at once a source of distress to the patient, a complex assortment of unconscious meaning, a form of communication, and a cause for our own discomfort as we seek to unravel its interweavings. . . .
>
> Symptoms can be seen as complex acts of communication. . . . A symptom, then, is a clue to multiple contexts of communicated meaning. It reveals and conceals simultaneously. [Hamburg 1989, pp. 131–134]

The language of self-harm is the language of violence spoken on the body. Learning the language means having a tolerance for seeing the essential unity in opposite ends of the pole, for tolerating contradictions, dualities, and paradox. It means developing an appreciation for the resourceful creativity of the unconscious in constructing the symptoms.

THE PROBLEMATIC CONCEPT OF SUICIDE

The term *self-harm* is now used differently from the way it had been used in the older literature, in which it was synonymous with attempted suicide and parasuicide, a suicide-like activity such as self-mutilation or suicide gestures (Hirsch et al. 1982, Kreitman 1977). These synonyms are problematic.

We know that among borderline patients, the rate of completed suicide among those who engaged in parasuicidal behavior is twice the rate of those who do not engage in this behavior, which suggests that parasuicidal behavior is the best predictor of subsequent suicide (Stone et al. 1987). In addition, borderline patients who frequently mutilated themselves have significantly higher mean scores on the Beck scale for suicidal ideation, are more likely to have attempted suicide, and are more likely to have attempted suicide more often than a group of infrequent mutilators and a group of nonmutilators (Dulit et al. 1995). Certainly, these findings compel us to understand the relationship of self-mutilation and other parasuicidal behavior to completed suicide. These acts of self-harm result in the deliberate infliction of harm upon the individual's body. The harm may cause injury to body tissue, may or may not cause pain, and may or may not be life threatening.

The word *suicide* has too many unclear and contradictory meanings to be scientifically or clinically useful (Shneidman 1993, Schneidman et al. 1994). Suicidologist Edwin Shneidman's (1973) early definition is "Suicide is the act of self-inflicted, self-intentioned cessation" (p. 383). Yet how can we know with any certainty that a person who has caused his own death had the intention of doing so? How can we know that even if the individual leaves a suicide note stating his intention, he is not imagining that at the very last moment, someone or something will come along to rescue him? How accurate can we be in assessing the degree to which a person has the intention of ending his life? Many individuals are suicidal only for a brief period, so the person who actively seeks his own death on Monday may find himself quite glad on Tuesday that he was not successful.

There is no agreed-upon definition of actual suicide, and there is no way to know with certainty any individual's intention to commit suicide (Ivanoff 1991). Realizing the problems with his earlier definition, Shneidman implored clinicians to abandon terms like *suicide attempt* or *gesture* and restrict themselves to evaluating the lethality of the act and the psychic pain of the individual contemplating death. To reduce the level of lethality, the clinician must view suicide as a

multidetermined act aimed at decreasing the level of psychological pain. That is, the patient suffers from a "psychache" and wants relief from pain and resolution of conflict. Choosing death is a quick, uncomplicated resolution of the tension between living and dying, and so despairing patients who cannot tolerate ambiguity and who are impulsive are at special risk. We need to understand the individual's basic orientation toward death, that is, the role of the person in his own demise (Shneidman et al. 1994). Does he play a direct and intentional role in his own death? Does he play a more ambivalent indirect, partial, covert, or unconscious role in hastening his demise? Or does he play no significant role in his own death?

When we think about self-harm in relation to suicide, then we think of the more severe and dramatic forms of self-harm such as self-cutting. Cutting has been aptly called "a bright red scream" (Strong 1998) and is the stuff of drama. Drops of blood oozing from self-inflicted cuts excite our emotions and bring to mind acts of violence and "the sameness of all living creatures under the skin" (Ehrenreich 1997, p. 25). Self-harm can be directed at the body's external surface, the skin, as in most forms of self-mutilation, or can be directed in various ways to the deeper recesses of the body's interior, to the fat, nerves, and guts.

PAIN AND SUFFERING

> *The Stoic split between body and mind, like the Christian split between body and soul, indicates how ancient the desire is to assign pain wholly to the flesh.*
> David B. Morris, *The Culture of Pain*

To understand the pain and injury that a human being inflicts upon his body means to understand the depth of emotional pain that requires such expression. We think that pain is either physical or mental, reflecting the dichotomous thinking inherent in the traditional medical model of illness. "These two types of pain, so the myth goes, are as different as land and sea. You feel physical pain if your arm breaks, and you feel mental pain if your heart breaks. Between these two different events we seem to imagine a gulf so wide and deep that it might as well be filled by a sea that is impossible to navigate" (D. B. Morris 1991, p. 9). Yet the gulf between the two is not so wide at all. There is no limit to the means by which human beings can harm themselves. Bodily self-harm can cause pain and suffering, but sometimes this pain is welcome because it can divert one from one's emotional pain. Inflicting pain upon oneself can also give rise to pleasure, and so some come to seek and embrace pain. Sexual masochists get erotic pleasure from physical pain, and moral masochists create their own emotional suffering. When we talk about pain, we are not on solid ground. The suffering of self-harm, like the suffering of passionate love, has to do with mystery, with the pursuit of

that elusive something that constantly escapes one's grasp, with illusion, with the forbidden, the secretive, and with danger (Viederman 1988).

Pain is more than the result of a biochemical process in the brain involving nerve pathways and bodily reflexes (D. B. Morris 1991). Suffering implies a type of damage that has gone beyond the body to afflict the mind and spirit as well (D. B. Morris 1991). The taste for suffering has something to do with sadomasochism, but can take human behavior far beyond the exotica of sadomasochism. Lingering emotional distress afflicts the body just as chronic bodily pain takes its toll on the emotions and spirit. "A deep sorrow or grief that does not begin with pain very quickly produces it. Loss and isolation can cut like a knife" (D. B. Morris 1991, p. 247). Grief or anger can be stored in the muscles of a tense neck or in unrelenting headaches. "Pain, no matter what its cause, is a strange and difficult phenomenon. Its hardness and horrors collapse normal life: pain . . . is the 'unmaking of the world.' . . . Our normal lifeworld dramatically does recede when pain is intense" (McLane 1996, p. 108). What most matters about pain may well be the personal and social meanings with which we and our surrounding culture endow it (D. B. Morris 1991).

SELF-HARM AND PAIN IN THE CONTEXT OF CULTURE

Although the mental health professions have considered all self-injurious behaviors in terms of pathology, most societies sanction some of these behaviors. A valuable way of understanding self-harm is by identifying which of these behaviors receive social approval and which receive social disapproval. There are at least four basic constellations of social attitudes to these behaviors (Kroll 1993). In the first, the self-injurious behaviors express positive social values, and the self-harming person, for example the person who goes on a political hunger strike, is accorded a great deal of social approval. Public self-harm is, above all, a protest of the weak against the powerful as well as a means of honoring and appeasing the weak and the powerful (Kroll 1993). The second constellation consists of those self-injurious behaviors that appear to have no social value and are publicly condemned, and the self-harming person is regarded as having a mental disturbance, such as in eating disorders, self-mutilation, and substance abuse. Paradoxically, self-starvation and bulimic behavior are devalued socially even though their apparent goals—weight loss and slimness—are socially approved. The third constellation is an ambiguous range of self-injurious actions considered to be pathways to socially valued performances, but are met with disapproval when disclosed publicly, such as professional ballerinas who starve themselves or competitive athletes who abuse exercise and steroids. The fourth constellation is "lifestyles" that are associated with a higher than usual risk of illness or accidental harm, for example cigarette smoking and use of other mood- or consciousness-altering sub-

stances, unusual exercise training, unhealthy diets, sexually related social behavior, and body modifications (piercing, tattooing, scarification). In the cases that come to the attention of the mental health professions, an important component of the self-harm behavior consists of some degree of public demonstration of one's "wounds," with an expectation of evoking a response from others.

In most cultures throughout history there have been socially acceptable forms of self-harm within the context of religious and healing rituals, cultural rites of passage, social stratification, and self-adornment and beautification. The Western healing traditions of bloodletting, vomiting, and anal purging continue to the present day, transformed and shaped by the forces of history and culture. For example, the self-starvation and abuse of laxatives that are common in what is today called eating disorders can be traced back to the last quarter of the nineteenth century, when physician John H. Kellogg and his brother invented Kellogg's Corn Flakes and established the Battle Creek sanatorium, where colonic purging, exercise machines, and low-calorie and high-fiber regimens were the rule. The message was that weight loss and keeping one's colon clean with large quantities of bran and herbal laxatives purified and cleansed one's soul, bringing one closer to God. This is not so dramatically different from what is predominant in our culture today: a sense of moral and spiritual self-righteousness and goodness achieved by strict dieting, weight training, and aerobic workouts. So it is just a bit of a leap to understand the logic of bulimics, who persist in trying to rid themselves of the badness within through vomiting and the use of laxatives. We see it in the Overeaters Anonymous groups, whose doctrine has members believing that if they place their faith in God or a power higher than themselves and stick to their food plan, the evidence of their faith will be apparent in the resulting weight loss.

As eating disorders increase in prevalence in the Western countries, they also increasingly affect immigrants who have become Westernized. Interestingly, large numbers of people with anorexia and bulimia have been reported in Japan (Hsu 1990), an affluent nation that has become Westernized. While a strong African-American cultural identity may afford black women a tolerance for a body size larger than the anorectic or tubular-shaped feminine ideal as well as some protection against a preoccupation with slimness, as more black women become upwardly mobile they tend to adopt the feminine ideal of the dominant culture, which puts them at risk for eating disorders in at least equal proportion to whites (Chandler et al. 1994, Pumariega et al. 1994). The same is true for Hispanic women (Thompson 1994). In the Southwest, Native-American subjects were found to be more prone toward disordered eating than Hispanics and Caucasians (Smith and Krejci 1991), possibly influenced by the unusually high rates of alcoholism found in Native-American culture (Holderness et al. 1994). Contributing influences may be traditional practices, specifically fasting among the Pueblo for ceremonial cleanliness (Benedict 1934) and the use of emetics, bleeding, purging, and sweating (Vogel 1970).

To What Lengths for Beauty?

Across cultures, men are attracted to women with narrow waists and full hips, busts, and lips, all of which are signs of fertility. From an evolutionary perspective the attraction ensures that sufficient pregnancies result for the survival of the species *Homo sapiens*. What is advantageous from an evolutionary perspective has become an aesthetic preference that certain cultures have exploited. Despite this, the feminine physical ideal has oscillated throughout history depending on whether woman's reproductive capacities were or were not being celebrated. In the past several decades the feminine ideal of beauty has undergone radical transformations, from an ideal that glorified a bottom round and broad enough to carry a fetus to term and full breasts for nursing, to an elongated tubular emaciated body. Historically, it has been expected that women be willing to endure far more pain and suffering for the sake of their appearance than men, whose attractiveness was not so dependent on their physical appearance. A heavy man with power and money might be called portly and considered attractive, while a heavy woman is simply called fat.

Today the expectations are converging in a unisex standard. Women tweeze their eyebrows; remove facial or body hair by shaving, waxing, or electrolysis; diet or exercise stringently to reduce the size and shape of their bodies; chemically bleach, curl, or straighten their hair; and have expensive cosmetic surgery. In 1921 the first Miss America was soft and plump; today's Miss America is quite thin, has "buns of steel," and may well have had cosmetic surgery. For women, the body ideal has shifted radically from curvy to tubular, at least in the lower body, appearing more like a prepubertal asexual lower body, which is attached to a grotesquely bosomy top. Similarly, increasingly greater numbers of men are spending hours in the gym, dieting stringently, and having cosmetic surgery, all in the quest for health and fitness. Many men style or replace their hair with permanent waves, hair coloring, or hair replacement surgery, while some shave, wax, or use electrolysis to make their bodies and their heads virtually hairless.

Marking and Mutilating the Body

Self-mutilating practices have been sanctioned for centuries in many cultures, from male ritual nose bleeding in New Guinea that is thought to be a protection against illness and a form of male menstruation, to the finger amputations common to some Polynesian, African, North American Indian, and New Guinea tribes, to the head slashing of a Moroccan cult, to the self-flagellation and other self-mutilation endemic in Christianity. The latter includes flagellant Christian cults from the eleventh century on (Favazza 1987), numerous nuns and saints of the Middle Ages who were known to starve, purge, flagellate, and scar themselves (Bell 1985), and even in the self-flagellation of today's Roman Catholic Opus Dei movement.

We regard permanent markings on the body as belonging to primitive people, not to the civilized being that is Western man.

> From Africa to Asia, the Arctic to the South Pacific, tribal peoples cut, shave, dyed or decorate their hair; paint, tattoo, scar or pierce their flesh. . . . Some bind the heads of their infants, stretch their necks or compress their waists. Most groups attach feathers, shells, bones, flowers, leaves or ornaments made of metals or some material to their bodies. No group of which I am aware does all these things but—what is more important—*no group does none of them.* [Polhemus 1988, p. 31]

No culture accepts the body in its natural state. Makeup, body paint, war paint, tattoos, body piercings, and scarifications have existed throughout time in cultures everywhere. The marks tell stories, personal history written on the body. Cultures everywhere use the body to inscribe messages about the society and about the place of the individual in the society, and to define human nature (Polhemus 1988). While the tendency is universal, the particular way each group decorates itself is the result of cultural factors. Tattoos are more prevalent among people whose skin is light enough to display a tattoo, while scarification is more prevalent among darker-skinned peoples whose skin forms darker keloid scars when cut. Tattooing has been a universal practice, reaching its height in the Pacific Islands, where they have had religious meaning, then decreasing under the influence of Christian missionaries. In Japan, however, the tattoo folk art of *irezumi*, associated with the lower social classes, geishas, and criminals, is still practiced. *Irezumi* artists cover the client's entire body with very colorful designs of fish, dragons, flowers, snakes, gods, and famous lovers, designs that have been described as "subtle, repulsive, magical, seductive, sensuous, three-dimensional, thought-provoking and macabre" (Ackerman 1990, p. 100). Japan has a particular fascination with the perverse, erotic, and sadomasochistic aspect of tattoos (Favazza 1996). For example, a Japanese wearing the work of a grand tattoo master may donate his skin to a museum or university upon his death. Tokyo University has three hundred of these bizarre framed "masterpieces." Czar Nicholas II of Russia and George V of England were tattooed by a famous Japanese artist, and a number of fashionable people in London had patriotic tattoos done at the royal coronation in 1901 (Favazza 1996).

In Western culture tattoos and other permanent markings have identified groups with unconventional or antisocial subcultures: bikers, skinheads, English punks and Teddy boys, prisoners, gang members, prostitutes, and homosexuals. A tattoo was the mark of a street tough who might start a barroom brawl and was a common initiation ritual of a sailor on leave. It was a mark of aggression, of those whose masculinity was measured by physical prowess and ability to withstand pain. Incarcerated Hispanic males developed a convention, since adopted by non-Hispanics, of having a small tear tattooed at the corner of the eye for each year spent in prison. However, nipple and genital piercings were fashionable among royalty in Victorian England. Prince Albert reportedly had his penis

pierced in a way that allowed him to tether it to his leg so that he could fit into the tight pants that were customary. Today the "Prince Albert," as it is called, is one of the most popular genital piercings (Vale and Juno 1989).

From prostitutes to aristocrats, tattooed women have always been regarded as subversive (Mifflin 1997). The height of subversion was the development of a small cadre of tattooed female tattoo artists. A woman's tattoo, whether so public that all the world can see it or private so that only a spouse or lover can see it, is a way of making public what is private, an illicit compromise between the wish to exhibit one's body and the constraint to keep it private. Once again, the British aristocracy had the privilege to go beyond the social boundaries, and many upper-class ladies, including Winston Churchill's mother, were tattooed. Middle- and upper-class women flirted with tattoo in the suffragist 1920s and then again at the birth of the women's movement in the 1970s.

Tattoos were usually done by a man of working-class background (Sanders 1989). Common designs were crude pictures of nude women, predatory animals, or symbols of death. The hippies popularized body painting in the 1960s and early 1970s, and even today face painting for children is a popular feature at church sales and suburban fairs. For a growing subculture within evangelical Christianity, religious tattoos have become an expression of individuality, identity, and faith. In the 1970s the punk movement's practice of inserting safety pins into their faces was a forerunner of the tattoos and piercings of sadomasochists and disaffected young people. These signs of affiliation to a marginal subculture are becoming more socially acceptable and normative, indicating that once again the borders dividing socially acceptable self-mutilation from deviant self-mutilation are changing, as is clear in fashion trends and the practices of young people. Researchers for the First Collegiate Body Art Project at Rutgers University (Greif & Hewitt 1996) launched a study of collegiate body art through the Internet, obtaining data from 766 students in twenty universities (nineteen American and one Australian). Almost every student with a tattoo or body piercing had arrived at college without it but had acquired one or more body modification in college. They represented all racial, religious, and ethnic groups, and included those who were academically outstanding and those who were marginal. Myrna Armstrong, a nurse at Texas Tech University, advocates for health education programs to inform students about the risks inherent in obtaining a tattoo, while Clint Sanders, a tattooed sociologist at University of Connecticut and expert on the sociology of tattoo, serves informally as campus tattoo consultant.

Today, almost half of all tattoos are done on women, many of them career and professional women (Armstrong 1991). The designs are usually small and feminine, and tend to be placed on parts of the body usually covered by clothing, to be viewed and enjoyed by those with whom they are intimate. Bolder women may have a tattoo that is meant to be openly displayed, such as a floral design on the wrist, or a tribal-like bracelet on the upper arm or ankle. Many current tattooists

were artists originally, have had formal art training, and regard themselves as artists working on human canvas.

What is a culturally acceptable form of self-mutilation in one era shifts with time, and we are in the midst of a transition. In the 1960s a man's pierced ear signified his homosexuality, while the particular ear pierced signified his sexual availability or commitment to a partner. In this country in the first half of the twentieth century, girls and women wearing earrings in their pierced ears were readily identified as foreigners, Mediterranean gypsies, or other "undesirables," while "real Americans" (e.g., white Anglo-Saxon Protestants) wore clip-ons. Whereas thirty years ago, middle-class parents might be horrified if their 18-year-old daughter came home with her ears pierced, her adolescent "declaration of independence," today it is not unusual for parents and children to have piercings in various parts of their faces and bodies and parents sometimes even accompany their adolescent child to the tattoo or body piercing studio.[1]

All cultures have rites of passage into adulthood. In Western culture they have traditionally had to do with male drinking, while today binge drinking is expected of male and female students in high school and college. Fraternity hazing rituals often include tolerating the pain of tattoos, beatings, and cutting rituals, and drinking toxic quantities of alcohol. Binge eating and purging parties for women are reported in many boarding-school and college dormitories. We cannot assume anything at all about what any self-harm behavior means to any individual or what role it plays. What is socially acceptable, even desirable, within a subculture, may be repugnant to the larger mainstream culture. The social acceptability of the behavior itself says not very much about the person performing the behavior, the presence or absence of psychopathology, or the nature of any existing pathology. Two different individuals may perform similar behavior for very different intrapsychic, interpersonal, social, and cultural reasons. All such contextual factors must be considered together in attempting to understand the self-harm behavior of any individual.

THE LANGUAGE OF PAIN AND VIOLENCE SPOKEN ON THE BODY

Pain speaks of our bodily existence when spoken language cannot. Pain speaks and writes on and through the body, signifying what words cannot say. If

1. When I was conducting my study on the relationship between bulimic and self-mutilating behavior, I visited a few body-piercing and tattoo studios to enlist the help of the proprietors in recruiting subjects for the study. Sitting in the waiting area next to a table displaying magazines about body art, nipple and genital piercings, and sadomasochism, was a middle-aged couple. They were waiting for their 16-year-old son, who was in one of the cubicles getting his septum pierced.

the language of pain fails to communicate, if it cannot be heard or read by another, it becomes woven into the fabric of the "speaker's" existence. Pain "unweaves the self until the self is nothing but pain" (D. B. Morris 1991, p. 254).

> What does matter then is: How can I get the pain to end, and when? Why do I hurt? Will it ever go away? . . .
>
> Pain *refers* to the disintegration of the wounded person and to her need for reintegration, and *expresses the value* of the persons harmed, her wholeness, and her wished-for unwounded connection to the world. Even the cries, screams, moans, grasping of wounds, rocking back and forth of physical pain are sounds and movements which are part of the gestural basis of language. [Merleau-Ponty 1962, pp. 185–187]

> But if these expressive aspects of pain are hindered . . .—if the wounding is not communicated . . .—pain reiterates. It is not resolved, but becomes part of the lived structure of the human being suffering it. [McLane 1996, p. 108]

Those who harm themselves are speaking a language we must try to understand. They make gestures—pushing food away, picking or scratching at their skin, slicing into their flesh, sticking a finger down their throat to vomit—that signify who they are, how they have lived, and the pain about which they cannot or will not speak. Throughout this book, self-mutilation and disordered eating are considered in depth. These behaviors express and regulate pain and cause pain, injury, and death. The pain and signifying of those who harm themselves through self-mutilation and disordered eating provide a template for understanding the pain and signifying found in the broader continuum of self-harm.

THE SPECTRUM OF BODILY SELF-HARM

Self-harm is not limited to self-cutting, probably the most dramatic form of physical self-harm and the one that evokes the most anxiety in us. Identifying the spectrum of self-harm is helpful in removing some of the veil of mystery about the more extreme forms of self-harm such as disordered eating and self-mutilation, and places them in a continuum.

Self-Mutilation

Mutilation is associated in our minds with both the demonic and the divine. In 1969 the world was stunned by the gruesome murders of actress Sharon Tate and her houseguests and Leno and Rosemary LaBianca committed by the Manson Family. Ever since "Charlie's girls" Leslie Van Houten, Susan Atkins, and Patricia Krenwinkle appeared in court with crosses carved into their shaved heads, cut-

ting has been associated in the mind of the public with the demonic. "No one with a heart and a soul could have done what these defendants did to these seven victims. . . . These defendants are human monsters, human mutations," said prosecuting attorney Vincent Bugliosi (Conway and Siegelman 1995, pp. 219–220). However, the pain of a bleeding, mutilated martyr is at the center of both the Oedipus myth and the story of Christ. In Christian countries, the story of Christ's martyrdom occupies a central position in the minds and hearts of the people, consciously, unconsciously, or both, and is reflected in themes of sacrifice and atonement that are heard in the words of many self-harmers. Were it not for the discomfort many clinicians feel with religious imagery, the story of Christ might have come to occupy the same central position the Oedipus myth has occupied within psychoanalysis (Grotstein 1997). The Oedipus story of a tragic forbidden unconscious male sexual yearning for his mother, is the Passion Play of psychoanalysis. Yet until recently there has been relatively little written about the actual act of self-mutilation, which is as intrinsic to the myth as incest and patricide.

> Near the conclusion of *Oedipus Tyrannus* the chorus and two messengers speak alone before the closed doors of the palace. Inside, hidden from view, King Oedipus has just learned the terrible truths he so stubbornly pursued: that he unknowingly killed his father and married his mother, the queen Jocasta. One of the messengers explains what happened next inside the palace. Just moments before, we are told, Jocasta hanged herself. Oedipus then tore the brooches from her dress and plunged them deep into his eyes. "No sluggish, oozing drops," the messenger reports, "But a black rain and bloody hail poured down." The flood of gore from his ruined eyes, the messenger says of Oedipus, even now runs down his face and stains his beard.
>
> Only after this terrifying verbal preparation do the doors of the palace open. We behold the once mighty king now blind, broken, soaked in his own blood, and anguished with the guilt he feels for a crime he committed unknowingly. When Oedipus finally speaks, what we hear is not words but only a single, repeated cry of agony: speech rolled back into mere sound and torment. This is the stark revelation toward which every act and speech of the entire drama have been relentlessly aiming: a frozen moment of pain that contains nothing except the mutilated human body and its wordless suffering. [D. B. Morris 1991, pp. 247–248]

For medieval Christians, pain served as a sign and means of contact with the divine, inspiring many saints to shed their blood as martyrs and inspiring numerous others to mimic them. Both Oedipus' and St. Lucy's acts of self-enucleation makes us cringe in horror, as do other major acts of self-amputation, such as cutting off the penis, hand, fingers, or toes. These acts occur with sudden violence, involve a great deal of tissue damage, and are found primarily in psychotic states or in those who are acutely intoxicated (Favazza 1987, Walsh and Rosen 1988, Winchel and Stanley 1991). Patients' explanations for this behavior often refer to biblical texts and to sexual themes (Favazza 1987, 1996).

Then there are acts of stereotypic self-mutilation—head banging, eyeball pressing, finger biting—that have fixed, often rhythmic patterns, and are thought to be without symbolic meaning. They are most commonly seen in institutionalized mentally retarded individuals and may be associated features of autistic disorder, acute psychotic states, schizophrenia, Lesch-Nyhan and Tourette syndromes, and obsessive-compulsive disorder.

Although others who have studied self-mutilation have defined it as the nonlethal infliction of injury upon one's body that results in tissue damage, (Favazza 1987, 1996, Kahan and Pattison 1984, Pattison and Kahan 1983, Russ 1992, Walsh and Rosen 1988, Winchel 1991, Winchel and Stanley 1991), it is best that it not be defined according to lethality, which is the outcome and not necessarily the intent. It is preferable to define it descriptively as the infliction of injury upon one's body that results in tissue damage or alteration, without inferring assumptions about intent. Some superficial to moderate acts of self-mutilation might strike one initially as being startlingly pathological, while others are so common and ordinary that it may seem odd to refer to them as self-mutilation. Other forms of self-mutilation include burning oneself, peeling off layers of skin, sticking oneself with needles or pins, scratching oneself, cutting oneself, picking at one's skin or blemishes, popping pimples, interfering with wound healing by attacking scar tissue or pulling off scabs, pulling out one's hair, rubbing away layers of skin with erasers, and severe nail and cuticle biting. Most people who self-mutilate do so in several different ways. A survey of 250 self-mutilators (Favazza and Conterio 1988) found that 78 percent used multiple methods, the most prevalent of which was cutting (72 percent), followed by burning (35 percent), picking at wounds or otherwise interfering with wound healing (22 percent), hair pulling (10 percent), and bone breaking (8 percent).

While cutting may strike us as violent and dangerous, this is often an emotional reaction to the drama surrounding it rather than to the actual danger to the person doing it. It is important to distinguish between wild and out-of-control slashing and the "delicate self-cutting" (Pao 1969) more commonly known to clinicians—superficial controlled cuts typically to the wrist or arm that usually require little or no medical treatment. Cutting is prevalent in patients with personality disorders, posttraumatic stress disorder, and dissociative disorders, who report experiencing little or no pain or a localized pain that is far more tolerable than their more diffuse emotional suffering. Some cutters cut their thighs, abdomen, breasts, or even lacerate the vaginal canal. The cuts may be simple lines or a word, name, or symbol engraved in the skin. The location and appearance of the scars often allude to some veiled meaning.

A chilling practice among groups of adolescents is sharing cutting instruments, with possible exposure to the risk of infection including human immunodeficiency virus (HIV) and hepatitis. For example, among seventy-six adolescents hospitalized in psychiatric facilities 46 reported cutting themselves and 50 percent of them shared their blades with others (DiClemente et al. 1990).The risk

is even greater in gangs of intravenous drug users, in whom the knowledge of the risk they are taking increases the thrill. The use of drugs or alcohol may precede the self-cutting, diminishing inhibitions, judgment, and the degree of pain felt, and giving the person greater courage to cut more deeply and violently.

Body Modifications

Those who have a penchant for permanent markings may employ someone else to tattoo, pierce, cut, or otherwise mark their bodies, which is a passive form of self-mutilation. Often they bridle at the term *self-mutilation* because of the connotation of psychopathology, and prefer the term *body modifications*. They may be ignorant of the real or potential dangers or find the pain and danger to be exciting. (Most body modifications are done without anesthesia.) Physicians and dentists have seen an increase in problems associated with body modifications, which is not surprising since piercing is really a form of minor surgery involving the insertion of a needle into a body part supplied by major nerve centers and blood vessels. Studio piercings and tattoos are done by unlicensed personnel who may have minimal or no knowledge of anatomy. A Mayo Clinic study found that nearly 25 percent of people with congenital heart disease who had their bodies pierced developed endocarditis, a potentially life-threatening heart-valve infection. Tongue piercing, done with a needle with a diameter seven times greater than that used for dental anesthesia, can cause puncture infection, chronic pain, soreness, chipped teeth and broken fillings, permanent numbness, loss of taste, and interference with speech, chewing, and swallowing.

There has been little consideration of the risks involved in introducing permanent ink into the body or of transmitting blood-borne pathogens through the inks or needles. Tattoo pigments are laden with mercury or chromates, are neither standardized nor approved by the Food and Drug Administration for intradermal use (Armstrong 1991, Armstrong and McConnell 1994), and can, along with unsterilized needles, be tainted with the hepatitis C virus. An outbreak of hepatitis was traced to a tattoo parlor in New York City in 1961, leading to a ban on tattooing that remains today. Oddly enough, New York City is home to many body-piercing studios even though piercing carries many of the same risks as tattooing as well as some additional ones. While there have been no reported cases of HIV infection traced to tattooing or body piercing, studies of "body art" among students (Armstrong 1991, Armstrong and McConnell 1994, Greif and Hewitt 1996) found that some piercings did not heal and some students had become infected with hepatitis. Traditionally, girls and women from certain ethnic groups have pierced each others' ears, which is far less risky than piercing other parts of the body. Earlobes consist of mostly fatty tissue and few blood vessels or nerve endings that can be damaged. More risky are the homemade tattoos and piercings, some made by children as young as 8 who use pins, needles, or pens to insert colored India ink, carbon, charcoal, soot, or mascara into the skin.

As the shock value of tattoos and piercing wanes, branding, a mark traditionally denoting ownership of animals, is gaining popularity. Branders heat thin slivers of steel to extremely high temperatures and apply it to the skin. Blood vessels are cauterized on impact and the tissue heals to form keloids or scar tissue that is usually raised. The greatest danger is caused by branders who may not get the brand hot enough for branding but hot enough to cause serious burns and infections. While most of us are pleased when our wounds heal without causing scarring, there are those who have designs cut into their skin expressly for the purpose of leaving permanent raised dark scars, a practice called scarification. As the cuts begin to heal naturally, the healing process is deliberately thwarted by rubbing alcohol on the wound and igniting it, rubbing vinegar into the wound, rubbing ashes or ink into the wounds to color the tissue, and picking off the newly formed scabs.

Certain kinds of self-mutilation are meant to enhance sexual pleasure. Some individuals have their nipples or genitals pierced to increase their own excitement, while some have their tongues pierced and a "barbell" inserted for the purpose of providing greater sexual stimulation to the partner during oral sex. Others may frequent clubs where they are likely to find "vampires," people who enjoy bloodletting and bloodsucking (Ramsland 1998).

Mutilating Surgery

Some individuals manage to get doctors to perform intrusive medical procedures or unnecessary surgery on them. These may at times be cases of Munchausen's syndrome or sex-change surgery, but the majority are cosmetic surgeries—tummy tucks, face lifts, rhinoplasty, breast enlargement, breast reduction, penile enlargement, eyelid surgery, liposuction—that have become increasingly common in both sexes. With newspaper ads for penile enlargement surgery, it should be no surprise that the newest development on the cosmetic surgery horizon is a procedure called "aesthetic labioplasty," or surgical "beautification" of the labia. As for facial surgery, the injection of animal collagen to make lips fuller has become a popular procedure despite the fact that it can result in a disease of the connective tissue (Lappe 1996). Although most reputable hospitals require intensive training for their residents, board certification is not required to perform plastic surgery. In fact, in New York and California there are no regulations regarding who can perform tumescent liposuction, which is the most popular cosmetic surgery in the country and more risky than is commonly known. Unfortunately, too many people are more concerned about the before and after computer imaging they see during a consultation for cosmetic surgery than they are about the physician's qualifications.

For centuries male infant circumcision has been a common religious practice among Jews and in the twentieth century was the most frequently performed operation in the United States, performed primarily for nonreligious reasons despite

medical controversy about whether this operation affords health advantages. Pulitzer Prize–winning author Alice Walker helped expose to the Western world the practice of female genital mutilation in Africa in her 1992 novel, *Possessing the Secret of Joy*, sparking an international debate on the issue. African midwives have been traditionally trained to perform these mutilations on young girls for the purposes of providing a "chastity belt" for women until marriage, and to contain their sexual appetites. Women with mutilated genitals experience unusual pain during intercourse and childbirth and medical complications in childbirth.

Female genital mutilation is currently practiced openly in central Africa and the Middle East. According to the United States Centers for Disease Control and Prevention, there are an estimated 168,000 women in this country, mostly from central Africa, who have undergone female genital circumcision or are at risk for having it. Although it is not openly acknowledged, some American doctors currently perform the operation on the daughters of African emigrants when they or their parents request it (Abel 1996). What is also not so well known is that the mutilation of women by means of gynecologic surgery such as genital circumcision and unnecessary hysterectomy has been practiced throughout the history of medicine, and continues today in "civilized" and Third World cultures (Shorter 1992). In fact, clitoridectomies have been practiced in England, Europe, and the United States as remedies for chronic masturbation, nymphomania, and hysterical seizures; the *American Journal of Obstetrics* published numerous papers from 1869 until World War I praising and reporting clitoridectomy (Shorter 1992). The procedure became so institutionalized as a panacea that some women requested it.

Fighting Fat: The Desperate Quest for the Magic Bullet

Although obesity is an enormous American health problem, the number of overweight adults and children continues to increase because of overeating and under-exercising. It is very easy to become fat in the Western world because human beings continue to prefer food dense in calories that was an adaptive preference when we were evolving prehistorically in an environment where food was scarce (Logue 1986), a preference that is now maladaptive. The increase in obesity parallels the increasing cultural obsession with weight, dieting, and exercise and the increase in eating disorders, providing those with anorexia and bulimia with a culturally acceptable rationalization for their illness. For the first time in recorded history individuals are dieting and exercising excessively in the name of self improvement, suffering from too much of a good thing (Yates 1991). This is less a problem in Europe where people are not so fat-phobic. They eat smaller portions but savor their food more, maintaining lower body weights and suffering less with eating disorders.

In America, miracle diets, drugs, surgeries, and other "magic bullets" prevail, leading Americans down a desperate and often dangerous path of weight loss and health regimes.

The Keys study (Keys et al. 1950) during World War II is the classical study of the mental and physical effects of semi-starvation that led to the recognition that severe and prolonged dietary restriction can lead to serious physical and psychological complications. Many of the symptoms once thought to be primary features of anorexia nervosa were found to be symptoms of starvation (Wooley and Wooley 1985). The experiment involved carefully studying young, healthy, psychologically normal men while restricting their caloric intake. For the first three months the volunteers ate normally, and in the next six months they were restricted to half their former intake and lost, on average, 25 percent of their former weight. At the same time hypochondriasis, depression, and hysteria increased.

The caloric intake in the Keys study was at a level that is greater than many weight loss programs permit. What makes the Keys study so important is that the 25 percent rapid weight loss of the subjects is paralleled by a 25 percent rapid weight loss by those who meet *DSM-IV* criteria for anorexia nervosa. Many of the experiences observed in the study volunteers are the same as those experienced by patients with anorexia nervosa: dramatic increase in preoccupation with food, decreased interest in sex and activity, increased hunger, episodes of binge eating, obsession with food, and bizarre and secret food rituals. The study showed that tormenting and obsessive thoughts about food are an inevitable result of starvation and the semi-starvation that characterizes most weight loss diets, predisposing one to develop the ravenous "ox hunger" that defines bulimia, to binge, to lose control of eating, and to purge. It explains why many who became anorexic after experiencing rapid weight loss on a restricted diet began to experience bouts of bingeing and purging. For many these bulimic episodes alternated with severe dietary restriction, sometimes called bulimarexia, or anorexia nervosa, bulimic type. For others the bulimic episodes continued. Thus, many bulimics envy the control over the impulse to eat exerted by anorexics and consider themselves to be "failed anorexics." In the rarely discussed eating disorder status hierarchy, anorexia reigns as "queen" while binge eating or compulsive overeating is of the lowest status, one of the seven deadly sins (gluttony).

Fat has gone from being a symbol of health, prosperity, and well-being to a sign of moral, psychological, and physical disorder. "Fat" has become the new "F-word" or dirty word, and "fat-free" has become a national mantra, with children as young as 5 or 6 becoming phobic about consuming any fat. The compulsion to exercise excessively and to develop perfect fat-free bodies is especially intense among those involved in careers or sports that have stringent weight requirements, such as ballet dancing, figure skating, swimming, cycling, gymnastics, running, modeling, and wrestling. Gymnasts present with the highest rates of eating disorders found in any sport; 20–25 percent become bulimic. Wrestling competition, like boxing and the martial arts, is conducted in weight classes, and many high school and college wrestlers use vomiting, diuretics, and excessive exercise to lower their weight. Recently three college wrestlers died within six weeks of

each other during strenuous weight loss workouts (Litsky 1997). Male and female body builders are as obsessed with ridding their body of fat as much as anorectics and bulimics. They will go to grotesque lengths to achieve huge striated muscles and the "cut" or "shrink wrapped" look, stripping themselves of all subcutaneous fat to reveal the full definition of their muscles. "Cutting" involves strenuous dieting, often with nutritional additives or fat solvents, a process of intentional dehydration to minimize the amount of water retained in the hypodermis. The dehydrated skin cannot maintain the correct body temperature, and so despite their bulk, body builders are often cold. Someone with a well- 'cut' body will have less than 4 percent body fat, a level reached only among starvation victims (Lappe 1996). Although the body must look vital and youthful, one Mr. Universe commented on a television documentary, "By the time we are on stage, we are more dead than alive."

In the 1960s and 1970s, diet doctors dispensed dexamphetamine diet pills freely and a generation of women walked around tolerating heart palpitations, anxiety, and sleeplessness, even risking drug-induced psychosis in order to lose weight. In the 1980's the very popular liquid protein diets were associated with gall bladder disease and hair loss.

The fen-phen phenomenon has been extraordinary. On the basis of one study of 121 obese patients who had lost an average of 30 pounds on a combination of fenfluramine (an appetite suppressant related chemically to the amphetamines) and phentermine (a serotonin regulating drug), and despite the fact that it was not approved by the Federal Drug Administration, the word spread about fen-phen and doctors were inundated with requests for the drugs. A huge industry in diet "pill mills" was spawned, exploiting the 30 percent of their female clients with diagnosable or subclinical eating disorders and depressions, who suffer from magical thinking, convinced that if they simply become thinner their lives will be transformed. They have the obsessional "diet head," living lives of yo-yo weight cycling, going from weight loss from the latest diet to reinforced obsessional thinking about food and compulsive binge eating, to the newest diet, and on and on. Even after extensive media coverage of the linkage of fen-phen and Redux with serious heart-valve damage, sales of these drugs nearly tripled from 1995 to 1996, and many enraged dieters demanded that their doctors prescribe the pills despite the recall. Weight loss centers that had done a big business in fen-phen did an about face, advertising their concern for their patients' well-being by promoting the "natural" way to weight loss with dangerous herbal remedies and other diet drug substitutes.

Those desperate to lose weight may turn to street drugs like cocaine and amphetamines. Metabolife, one of numerous "fat burners" containing ephedrine, an adrenaline-like substance that speeds up metabolism and increases heart rate and blood pressure, has become extremely popular, selling as well as Prozac and Viagra. People have been demanding products made with Olestra, a fat substitute, even though Olestra may interfere with the absorption of necessary vitamins and minerals and can cause a condition euphemistically called "intestinal leakage" as

well as diarrhea and gas. Many have been taking Xenical (orlistat), a prescription fat blocker that can result in the same difficulties associated with Olestra.

Overeating and Obesity

People who eat so compulsively that they become morbidly obese put their health at great risk. Morbid obesity may decrease longevity and aggravate the onset and development of cardiovascular difficulties, hypertension, high cholesterol levels, diabetes, sleep apnea, or other pulmonary problems, gallbladder and other digestive diseases, trauma to the bones and joints, and certain cancers, specifically prostate and colorectal cancer in men, and gallbladder, breast, cervix, endometrial, uterine, and ovarian cancer in women (Bray 1986). The frequency of abnormal labor and delivery is higher in obese women.

Anorectic Behavior

The image of a bleeding and mutilated Christ is also an image of an emaciated and dehydrated Christ. The anorectic operates under the assumption that she can transcend the flesh and not need what other human beings need in order to live.

The physical complications of anorexia and bulimia can be life threatening, yet it is disturbing to know that many psychiatrists, non-medical therapists, and primary care physicians overlook and fail to diagnose eating disorders (Hornbacher 1998, Sharp and Freeman 1993). Many anorectics have an intense obsessional fear of being fat and an encapsulated delusional inner representation of their body as fat and grotesque. Others are compelled to punish themselves by starving themselves, purging their bodies violently and painfully, and exercising to the point of pain and injury and beyond. They progressively and rapidly lose more and more weight, allowing their emaciated bodies to feed off themselves, thus cannibalizing their own muscle tissue, including cardiac muscle. Aptly, the earliest account of the anorexia nervosa syndrome in 1694 was called "Nervous Consumption" (Morton 1694).

Although anorexics often minimize their difficulties, nonetheless some die suddenly from heart arrhythmias, renal malfunctions, circulatory failures or suicides. According to the American Anorexia Bulimia Association, each year 150,000 American women die of anorexia. Some anorectics improve enough that their medical risk ceases to be an immediate concern, but nonetheless torture themselves with diet, weight, and body image preoccupations, remaining chronically ill throughout their lives. There are many kinds of anorectic behaviors, some that might strike one as being startlingly pathological and others that are very common in our culture as ordinary culturally acceptable weight control practices.

Anorectics are often irritable and depressed and may have difficulty concentrating, thinking clearly, and making decisions. Their moods are often labile,

going from the manic exhilaration that comes with losing weight to crashing depression and self-loathing. Endocrine and metabolic abnormalities include yellowing of the skin, impaired taste, and hypoglycemia. Other common symptoms are constipation, bloating, abdominal pain, cold intolerance, lethargy, hyperactivity, low blood pressure, dizziness, dry skin, and pitting edema. Often there is the growth of a fine downy hair (lanugo) that covers the limbs and face, the body's adaptation to hypothermia in much the same way as fur is the body's adaptation for animals in cold climates. Anorectics may suffer from leukopenia, low white blood cell count, non-menstrual bleeding or the loss of menstrual function (amenorrhea), and loss of libido. Often, there is bone loss. Even the brain may undergo structural changes such as loss of brain tissue and enlargement of the ventricles, which may be reversible when weight normalizes.

In her 1998 memoir, Marya Hornbacher described compellingly the medical and mental toll taken by anorexia. She had become ugly, like a monster. Her hair had fallen out; her skin was "the color of rotten meat." Her brain would not work and she felt "like an ice cube." Where there once was flesh, there now was space, and the spaces were growing larger and larger. "I put toilet paper in my shoes so the ground wouldn't slam back at the bones of my feet when I walked, jarring me and making me dizzy . . ." (p. 267).

Those Who Purge to Binge

Marya, old and wasted beyond her 23 years, speaks: "Bulimia is linked . . . to periods of intense passion, passion of all kinds, but most specifically emotional passion. Bulimia acknowledges the body explicitly, violently. It attacks the body but does not deny. It is an act of disgust and of need . . . the bulimic impulse is more realistic than the anorexic because, for in its horrible nihilism, it understands that the body is inescapable" (Hornbacher 1998, p. 93).

The word *boulimia* means ox-hunger in Greek and has been defined in terms of binge eating, the consumption of what most people would regard as large amounts of food, usually over a concentrated period of time (American Psychiatric Association 1994). There are problems with this definition because it does not take into account the subjectivity factor; what one person might consider to be a large amount of food might be regarded as small by another. The binge is usually ended by a purge, which serves the purpose of allowing individuals to continue to binge without fear of weight gain, popularly expressed as "having your cake and eating it too." These are the individuals who seek the experience of satiety and fullness. For them the purging is a necessary evil, a means to an end. They may account for approximately 85 percent of those who meet criteria for a *DSM-IV* diagnosis of Bulimia Nervosa. Bulimia can be more dangerous than is usually thought because it can go undetected for a long time by family members and physicians, as the bulimic can maintain a normal body weight and appearance even while putting her life at continual risk.

"I Purge, Therefore I Am"

Cardiac arrest is the most common cause of death among bulimics and among anorectics who binge and/or purge. Some anorectics starve themselves and if they eat so much as a spoonful of food, feel compelled to purge several times immediately. Because so much of the literature on bulimic behavior focuses on binge eating, the severity of the physical and psychological problems of the person who starves and purges or who binges in order to purge are easily overlooked (Farber 1995a, Garner et al. 1993, Tobin et al. 1992).There are those who binge so that they have something to purge, a significant group barely even mentioned in the literature (Hall and Beresford 1989). This group, whether they binge or whether they starve themselves, seeks the experience of the purge, the violent cramping and pain, and will induce severe purging to a life-threatening degree. They use multiple means of purging and will purge very frequently. In fact, laxative abusers have an increased probability of making suicide attempts or other self-injurious behavior and have a higher rate of prior inpatient treatment for depression (Mitchell et al. 1986). Further, much of the morbidity and mortality in patients with eating disorders may be a consequence of purging behaviors (Sharp and Freeman 1993).

Those who purge very frequently and severely tend to be an extremely masochistic group who seek the violent and intense experience of pain, cramping, and injury and the resulting emptiness, dehydration, and internal bleeding (Farber 1995a). Their purging is a literal form of self-mutilation from the inside out, as it lacerates organs and causes internal injuries and bleeding. They attack their bodies internally in much the same way that self-mutilators attack their bodies externally. They might consume a large amount of food so that they can have the experience of vomiting or anally evacuating it. To make sure they get rid of every last morsel, they may consume foods of only one color, or may binge on foods organized by color and eaten in a certain order, a ritual called layering.[2] That is, they may mark the beginning of the binge with orange foods, progress to green, then white, and so on, and when they see they have vomited food in the reverse order, they can be certain they have rid themselves of all of it. This process may be marked not by one but by many purges for each binge, even resulting in several waves of dry heaving. Some patients may purge as many as 40–100 times during any discrete binge period which might last as long as two or three hours (Hall and Beresford 1989). For them, the binge might be a necessary evil, or it may be the experience they seek along with the violent purge.

The pain and serious complications of bulimic behavior are more often the result of the purging rather than the binge itself (Johnson and Connors 1987). Chronic purging may result in menstrual irregularities and other endocrine difficulties, and has been associated with peripheral nervous system changes. Vomiting

2. While I knew of this ritual involving food of different colors, it was Star Qualter, M.S.W., a student in my eating disorder seminar, who introduced me to the term *layering*.