Girls who Cut: Treatment in an Outpatient Psychodynamic Psychotherapy Practice with Adolescent Girls and Young Adult Women

LOUISE RUBERMAN, M.D.

The observation of deficits in the capacity for mature emotional self-regulation in girls who cut is noted in the literature (Daldin, 1990; Novick & Novick, 1991; Nock et al., 2008). The acquisition of the ability to respond in a healthy manner to stress and challenge, either from outside or inside the self, is one of the most important tasks of early development; girls who cut have not accomplished this developmental task or are seriously compromised in their efforts to do so. The connection between this observation, the psychosexual developmental antecedents of this deficit, and psychodynamic approaches to treatment are explored in the literature and in case reviews.

KEYWORDS: cutting, non-suicidal self-injury, self-abuse, self-regulation, skin

REVIEW OF LITERATURE

In adolescence the risk of engaging in nonsuicidal self-injury (NSSI) ranges from about 13.0% to 23.2% (Jacobson and Gould, 2007), which is even higher than it is in adults (estimated to be 4% by Briere & Gil, 1998). Given that the 12-month prevalence of NSSI is as high as 2.5% to 12.5% (Muehlenkamp & Gutierrez, 2007 as referenced in Miller, 2007, as many as 2.1 million teens self-abuse (Miller et al., 2007). Deeply disturbing are the statistics on the relationship of NSSI in teens and suicide attempts; in a recent study, 70% of teens who had engaged in recent NSSI reported having made, at a minimum, one suicide attempt. And 55% reported two or more such attempts (Nock et al., 2007). The average age of onset of NSSI is usually between ages 12 and 14 years (Muehlenkamp and Guti-

Bronx Children's Psychiatric Center & Montefiore Medical Center, Department of Psychiatry, NY. ***Mailing address:*** Montefiore Medical Center, Office of Residency Training, Department of Psychiatry, 3331 Bainbridge Avenue, Bronx, NY 10467. E-mail: *lruberma@montefiore.org*

errez, 2004), with an even higher risk for young adults between 18 and 25 (Whitlock et al., 2006), which may reflect the potential for contagion in "nontreatment" groups, such as college students (Muehlenkamp et al., 2008). There is literature emerging that reports on behavioral subtypes of adolescents who cut, and that while most engage in only a few episodes of cutting (Nock et al, 2006; Whitlock et al., 2006), Whitlock and colleagues (2008) find that gender, number of episodes, and severity of damage vary in different subsets, and this may affect assessment strategy and treatment.

Having a psychiatric disorder is associated with nonsuicidal self-injury in teenagers. A study evaluating adolescent psychiatric inpatients who had engaged in NSSI during the year prior to admission found higher rates of internalizing disorders (including major depression and post-traumatic stress disorder), externalizing disorders (including conduct disorder and oppositional defiant disorder), and elevated substance abuse compared to youth that do not self-mutilate (Nock et al., 2006). The association between self-injury and borderline personality disorder is well known in both adults and adolescents with NSSI (Shearer, 1988, 1994; Stanley & Brodsky, 2005; Nock et al., 2006). In a controlled study of a group of self-destructive teens with NSSI and suicidal behavior, only bipolar disorder distinguished adolescents with NSSI from those that were not self-destructive (Jacobson et al., 2008). A recent study of adults (Foote et. al, 2008) points to the association between dissociative disorder, self-harm and suicidality, and though the symptom of dissociation is reported (Kisiel & Lyons, 2001; Miller et al., 2007), the relationship of a dissociative disorder to NSSI has not been studied in adolescents to date.

The most serious aspect of concern in these cases is co-occurrence with suicidal behavior and the risk of completed suicide (Miller et al., 2007), and authors note that patients with *both* NSSI and suicidality represent a more disturbed, at-risk group (Cloutier et al., 2010). Within a group that self-injures, the statistics do not differ on whether boys or girls are more likely to attempt suicide (Jacobson et al., 2008). Miller et al. suggest that because the motivations of the adolescent who cuts to manage her dysfunctional emotional state differ from the patient who is suicidal and wants to die, treatment approaches need to be specific (2007).

Individuals engage in NSSI impulsively, typically without the concurrent use of substances or reports of pain (Nock and Prinstein, 2005). Consistent with the idea of impulsivity as an aspect of the self-injury, a group of adolescents and young adults were assessed for their ability to generate solutions to a distressing scenario. The study authors stated that although the NSSI group had more deficits in problem solving, the real

issue in the group was that they were impulsive and *did not wait* to select the most adaptive solution to a problem (Nock & Mendes, 2008). In addition, adolescents with NSSI have a lower physiological threshold for stress and greater difficulty in stress management than those who do not self-injure (Nock and Mendes, 2008); the authors suggest treatment strategies and family education to improve techniques for responding to stressful situations. They further note that in those with NSSI higher arousal in response to stress is associated with a subgroup whose self-destructive thinking is less related to others and more "intrapsychic" (Nock et al., 2009).

In adult women, many of whom have Borderline Personality Disorder, motivations for nonsuicidal self-injury include the expression of anger, the wish to punish oneself, the desire to feel normal and the need to distract oneself from disturbing emotions (Brown et al., 2002; Gunderson & Hoffman, 2005). Skin self-mutilation is the most common means of self-injury (Rodham and Hawton, 2007). Particularly salient is the function the self-injury provides as a "validation" to the person of how terrible he/she feels; the cut or scar provides "concrete proof of (his/her) emotional distress" (Linehan, 1993 as reported in Gunderson & Hoffman, 2005, p. 49). The behavior feels like a solution to a problem, particularly one in the interpersonal realm:

> In the face of their emotional and interpersonal difficulties, many of these individuals report that their behavior is designed to provide an escape from what, to them, seems like an intolerable and unsolvable life (Linehan, 1993, p. 15).

In addition to sexual abuse and physical neglect, there has also been found an association with emotional abuse in childhood; adolescents who cut may react to stress by engaging in NSSI behaviors in order to self-punish in a manner that reflects a self-critical mode of thinking (Glassman et al., 2007). Herman (1992) points to the role self-injury plays in an effort both to cope with unbearable emotional states in cases where child abuse is part of the history, thus allowing the victim to survive in her family without disclosing her pain and disrupting the family. Sarnoff reports a case in which very early physical abuse by a sadistic father led a teenage boy to self-cutting, producing orgiastic feelings (Sarnoff, 1988).

Finally, the relationship between self-injury and forms of body decoration or "body art" has not been explored in the peer-reviewed literature. While our culture accepts (as have many through history) a certain amount of body piercing or tattooing for the purpose of making a statement or

beautification of the body, girls who cut themselves or otherwise self-mutilate do not do so to enhance their appearance. Interestingly enough, despite not being able to parse out the fine "cuts" between the phenomena, psychoanalytic authors have made reference to the deeper meaning of "body art". They propose its meaning as sublimation for an impulse to smear the skin with feces, which might represent a compensation for the "deprivation of objects" during periods of developmental stress and growth and as an "eroticization" of the skin in an attempt to make it "lovely" (Hárnik, 1932, p. 235).

DEVELOPMENTAL THEORY, PSYCHOSEXUAL DEVELOPMENT AND THE FUNCTION OF "SKIN"

Psychosexual development forms the ground upon which mental health grows. Knowledge and awareness of one's gender is a crucial acquisition accomplished very early in childhood and it forms a significant component of the development of a sense of self. With her girl child, a mother has multiple deep and powerful identifications with herself as a little girl as well as to her own mother who had cared for her (Brazelton & Cramer, 1990); a mother is reborn in the little warm, fleshy person that is her daughter. The power of this feeling is such that a mother may fantasize that she and her baby girl are even inside one skin, a concrete image that corresponds to Mahler's idea of symbiosis (Mahler et al., 1975). As infants grow, they "like to venture and stay just a bit of a distance *away from the enveloping arms of the mother* [my emphasis]" (Mahler, et al., 1975, p. 55). Mother's job is to tolerate her daughter's psychological birth as she grows without unduly acting out her own separation anxiety, rage at being left, or disappointment that the girl self she has brought into the world might mimic her own self-doubts. When any of these conditions are in the forefront, however, it presents a risk factor for the girl.

The young girl needs, in particular during the Oedipal period, to identify positively with and to "idealize" the mother for her to be happy in her gender and femininity (Ornstein, 1985 as referenced in Sands, 1989). A healthy, well-developing daughter feels, mirrored in her mother's gaze, the sense of satisfaction in that which "envelopes" them (Brazelton & Cramer, 1990). According to Bick (1968), the skin, which in early life functions as a "boundary" that holds together the personality, is "introjected" as a containing object (the mother) that is experienced as a "skin."

> This description ... retains the notion of actual separateness. It also conjures up the use of wrapping, a membrane, a skin, while simultaneously evoking images of containment and mothering" (Biven, 1977).

The very little girl's relationship with her mother through her skin is unconsciously tapped into in the adolescent or young adult girl who cuts; she may respond to future demands, particularly ones that stem from moments of separation, by symbolically cutting into the "envelope" that once held them both. It may be that the battle she has in regard to her impulses is symbolically acted out in the cutting.

In writing about the development of masochism, Novick and Novick (1991) note a lack of growth in feelings of competence that are typically found in the normally developing infant-mother pair. This competence is typically generated from countless hours of experience that provide an infant with the confidence that not only can she elicit a caring, loving response from her mother, but also, should there be a rift, the relationship can be mended (Brazelton & Cramer, 1990; Noshpitz & King, 1991). The absence of these experiences affects reality-testing and is marked by a lack of feeling of effectance in the toddler period; not only does the child have deficits in her self-confidence and sense of joy in the physicality of the developmental period, but also, her efforts to separate and individuate are mislabeled and distorted. For the female patient, the experience of disappointment and frustration in early relationships is particularly challenging when the source of the frustration is the same-gender parent—the mother—with whom she cannot identify positively. She associates her most intimate relationship with dysphoric feelings (rather than comfort and pleasure), as lacking empathy, and in desperation, she turns to masochistic defenses as a way to rage at her mother (Galenson, 1988). In essence, the above describes one aspect of the development of anxious attachments in infancy (Bowlby, 1977; Sroufe, 2000; Main, 2006).

> There is increasing evidence that borderline patients, particularly those who have been hospitalized and/or are suicidal and/or chronically self-injurious (parasuicidal), have failed to integrate or resolve attachment traumata, particularly sexual and physical abuse by caretakers (Diamond et al., 1999, p. 839).

Particularly salient to the discussion of self-abuse is the lack of pleasure, the vulnerability of self-esteem, the blurring of boundaries and omnipotent fantasies of the child described by authors as a "pathological source of self-esteem" (Novick & Novick, 1991, p. 322). These are patients for whom causing pain, and in the cases in question, self-inflicted pain, serves as a pathological means of self-regulation and as a remedy for the desperation of feeling alone, abandoned, or empty (Linehan, 2003).

Psychoanalytic authors have written on the subject of "early symbiotic

relations" that imbue the skin with particular significance (Raine, 1982 as referenced in Daldin, 1990, Schur, 1955). Biven (1977), in his paper on a disturbed adolescent boy with a history of extreme neglect and violence, describes the role of skin as "an organ of contact, vulnerability, protection, and power" reflecting his patient's wish to return to an ambivalently remembered, early relationship with his mother. Literature on anhedonic teenage girls speaks to the role of self-abuse to avoid feelings of depersonalization, especially when aggressive feelings are mounted (Asch, 1971). Some describe that their patients cut because they are reassured that "I bleed, therefore I am alive" (Rosenthal et al., 1972, p. 1367); the self-injury counteracts their feelings of lack of control and poor reality-testing and helps them to feel "normal." Similar themes are seen in the development of masochism; infants are seen as having "turned away from their inborn capacities to interact effectively with the real world and instead began to use the experience of helpless rage and pain magically to predict and control their chaotic experiences" (Novick & Novick, 1991, p. 313).

Self-injurious behaviors, often emerging just after puberty, may be seen to develop as a reaction a young girl has to her changing body; she is faced with the reality of her changing shape and identity as she biologically matures into an adult female. Many of these young girls deny masturbatory activity and feel that the act is disgusting; others have difficulty keeping their masturbatory fantasies contained and "act out" their fantasies in masochistic attacks on the body (Novick & Novick, 1991). Female patients who self-abuse by cutting are reported as being afraid of their own menstruation (Rosenthal et al., 1972), of remembering the bleeding of older sisters and mother as being frightening (Daldin, 1990), and of unconsciously associating their self-injury with mutilation of the genitals (Friedman et al., 1972; Daldin, 1990). Girls who self-injure by cutting choose their skin as a canvas on which to carve an opening and draw blood, but in reality are afraid of their body openings. In cutting they attempt to gain some measure of control over a body from which they feel they cannot derive normal pleasure (Rosenthal et al., 1972; Daldin, 1990).

CASE MATERIAL

Polly

Polly began to cut herself following the death of a relative, who, during Polly's early years, had been a surrogate mother while mother worked. During her early years with this relative, Polly was given nurturance and unconditional acceptance, which had been all but impossible in Polly's relationship with her mother. When Polly began to have more contact with

her mother, the already ambivalent relationship between the two became inflamed.

Polly's depressive feelings and feelings of depersonalization began; she would fantasize that she heard a voice hypnogognically at night, she had frightening dreams, and she started self-cutting. She said the cutting behavior reminded her of losses (so she would not forget), was a response to feeling "nothing" (at times she craved and wanted to "disappear"), and counteracted a desperate and urgent sense of guilt. The worst times for Polly typically followed feelings of abandonment by one boyfriend or another—in these tortured relationships bouts of cutting and occasional suicidality followed feelings of abandonment. When a rejection or some form of abandonment (even slight) occurred, Polly was prone to feeling that she did not know who she was. She had difficulty when she looked in the mirror, questioning if it was really herself she was looking at; when she imagined herself, she really did not know what she looked like. At times she felt as if there were two personas within her; at times she felt there was NOTHING in her, that she was a sack of skin. Although attractive, she did not feel beautiful at all and wanted to cover herself in loosely fitting garments that covered her (as well as her scars); she felt that various body parts, including her skin, were ugly. She felt truly "uncomfortable" in her own skin. Polly's dysphoric feelings tended to range between constant anxiety and feelings of paranoia—she felt easily judged and "looked at"; drug use allowed her to numb these feelings and to function as best as she could. In addition to drug use, she developed a restrictive eating disorder that occasionally bordered on anorexia. The cutting, drug use, and eating disorder were used to manage her turbulent inner life. She was convinced that she would never grow up and have a normal life, family, or happiness.

Heather

In treatment during late adolescence, Heather remembered being depressed even as a very young child. She had an extremely close relationship with her mother, who she said was the only one in her family who understood or truly cared about her. As a young child she always felt cast aside by father and siblings who demeaned and did not accept her. She found it difficult to trust others: Her mother was the only person that she truly trusted. She felt guilty if a friend had a problem and she did not take care of the friend, just as her mother had taken care of her; she surrounded herself with disturbed and needy friends.

Heather began cutting as a mid-high school student; she said that the pain she experienced was a way of exerting control. For Heather, pain was

direct, not controlled by others, and reassuring; when she cut she did not need a relationship, in fact, she had no need for anyone at all. She went from one quick relationship to another: if a boy got too close, she would move on. It seemed as if when a relationship began, she already had an exit strategy. She wondered if she was "too comfortable" in her own skin with boys, and was concerned that she did not feel much in her relationships. Like Polly, Heather had a low-grade eating disorder.

Treatment

Treatment of self-destructive patients is extremely challenging to patients, therapists and families alike. Because adolescents are focused on the here and now, interesting them in the past—in particular, on their relationships with their parents during their younger years and how their character was formed around those relationships—is a challenge that not every adolescent (or every therapist) is ready to meet. As in any therapy, even in manualized cognitive therapies, the personality and skill of the therapist is paramount. In psychodynamic therapies described in this and other papers (Ruberman, 2009), it is particularly important that the therapist's personality, experiences, and point of view fit well with those same factors in the patient. In fact, the relationship between the patient and therapist is likely the mutative factor in any psychotherapy. Marsha Linehan, who writes about dialectical behavioral therapy (DBT) in suicidal or parasuicidal patients suggests that

> the relationship with the therapist is at times what keeps her alive when all else fails . . . similar to many schools of psychotherapy, DBT works on the premise that the experience of being accepted and cared for and about is of value in its own right, apart from any changes that the patient makes as a result of therapy (Linehan, 2003, p. 9).

Treatment of these two young women has been complicated and immensely rewarding. Neither was raised in psychologically sophisticated families—initially, family members were hesitant to have their daughters engage in a treatment that seemed foreign to them. Neither was self-referred or referred by a mental health practitioner; Polly was referred by her pediatrician and Heather, by her school. In the experience of this writer, referrals that come in this manner can tend to be challenging, the families less knowledgeable about inner psychological processes. But frequently, if the young women can be engaged in a patient, meaningful psychotherapy, these treatments sometimes are rewarding in a way that "more experienced patients" are not and families feel that, for the first time, their eyes are opened to the meaning of their children's behavior. The

beginning of treatment becomes a shared educational experience of learning to understand inner cues and beginning to recognize the impact of the unconscious in daily life, choices and psychopathology. The beginning of treatment is a time when a therapist can educate a family if one is patient and goes at the speed the family can manage so that they can integrate both a new presence in their lives (the therapist) and the idea that their daughter has an emotional life of which they may have been unaware.

Treatment of both Polly and Heather involved periodic contact with family members, especially in the beginning of treatment and at moments of acting-out. Therapeutic contracts with both young women included their right to privacy unless their health was at great risk. When they self-mutilated, they were encouraged to tell their parents rather than having the therapist call to relay the information. It was explained to both girls that if their parents felt listened to, this would lead to trust of the treatment and to even more privacy and trust in them by their parents. (See Ruberman, 2009 for a discussion of treatment of parents).

In the treatment of both of these girls, the transference was a maternal one. Among this writer's experiences of treatment of girls who engage in NSSI, the transference here stood out as particularly fragile and vulnerable to feelings of being intruded upon or misunderstood. The therapist had to be careful not to be drawn into the protective, at times paranoid, features of the transference to either a hostile/rejecting mother or to an all-knowing and accepting mother. Polly was more vulnerable, raw at times and self-condemnatory. The therapeutic relationship faltered at moments of severe stress, when she felt misunderstood; her impulsivity at these moments seemed designed to rectify the world's mistreatment of her. She raged at her mother for caring only for herself. A (seemingly) unempathic comment by the therapist could also produce enormous rage that would have to be tolerated and understood. Fonagy (2000) described the interplay of anticipation of care and the reality of an inadequate caregiver response to distress in an infant with disorganized attachment.

> It is as if the infant's emotional expression triggered a temporary failure on the part of the caregiver to perceive the child as an intentional person. The child comes to experience his own arousal as a danger signal for abandonment (Fonagy, 2000, p. 1136).

In the case of Polly, one could see, in retrospect, the difficulty a high-strung small child must have placed on HER mother, the role another caregiver played to relieve the stress of the mother-child relationship, and the despair that it must have caused Polly to feel not only grief but also

unprotected by her mother from this and other intense feelings. Novick and Novick (1991) capture this "intense helpless rage" stemming from difficult early relationships that lead to the "omnipotent solution" of the masochistic attack.

When Polly cut, there was a dual identification, as she felt that she was both punishing her mother and being punished by the mother within her. In marking herself she would avoid ever making a particular mistake again (often related to failed relationships).

Heather was superficially more resilient; dreams and associations pointed to the rage she had at family members for not caring about her. In her mind, only her mother cared about her; she cut at herself in a solipsistic gesture that may have attempted to cut her mother away from the "envelope" that enclosed them, but this only served to keep her mother enthralled, worried, and engaged. She remembered feeling depressed and "left out" as a young child, which resembles masochistic patients described by Novick and Novick:

> [they have] no cushion of self-esteem . . . these children remained exclusively and anxiously tied to their mothers, with the feeling that safety and survival depended solely on their mothers (1991, p. 314).

With Polly there was less despair of being capable of a relationship, but her relationships were shallow. She was always her mother's girl.

These girls shared an ambivalence about their femininity. Neither had developed the sense of comfort in her own "skin" as an emerging, fully competent female adult, at ease with her sexuality. For Heather, the pleasure she felt was in being in control; there was no age-appropriate relationship to afford her this level of pleasure. For Polly, restrictive eating was a conscious result of wanting to keep herself from being girlishly curvy (see Daldin, 1990, p. 4 for a description of a girl with NSSI and anorexia in which the latter was "understood as an identification with the mother as well as an attempt to starve her developing sexual body"). For Heather, bulimia was a way to maintain the interest of a boy in the only part of her that she believed might be appealing to him—her figure. She did not feel that someone might be attracted to the whole of her. Chen et. al. (2009) noted the co-occurrence of bulimia with suicidal behavior and anorexia with self-injurious behavior. They feel that eating disorders in the borderline population convey additional risk for suicidal and parasuicidal behavior. Claes (2003) found that self-injury in the eating- disordered population was a marker for more disturbances in the clinical picture. Muehlenkamp et al. (2009) explored the function of self-injurious behavior in patients

with bulimia, finding a similar emotion-regulatory function of NSSI to that of bulimia; the authors noted the increased severity in patients with co-occurrence, and cautioned that one behavior may substitute for the other if aspects of treatment did not include skill sets to increase tolerance of distress. The eating-disordered adolescent can be seen as turning to the ritual of the eating to help with "problems with tension regulation" in an attempt to replace the mother or "idealized selfobject" with food: "Patients often describe what sounds like a passionate love affair with their favorite foods." (Sands, 1989, p. 87). Thus, both behavior patterns (cutting and eating disorders) respond to deficits and disappointments in the early relationship with mother; it may be that the specific responses are dictated by the characteristics of the mother-infant pair. For both of the cases reviewed, mature object relationships were not possible, and whether the relationship with mother was gratifying or not, it was the only one that mattered.

For both of these patients, the treatment represented an oasis of caring and acceptance; in both, the therapist was exquisitely aware of boundaries and counter-transference reactions involving wanting to "mother" these girls and help them grow, unscathed, to maturity. It was important to accept them for who they were, but vest both their difficulties and their willingness to get help within *them*, not within the therapist. Ultimately the choice to be helped is the patient's. Bromfield (2005) writes, "Only by withholding our judgment and permitting our wonder can we convince the adolescent child to do the same, maybe enabling her to come out from the dark" (p. 47). Notably, both families became extremely cooperative and supportive of treatment of their daughters. Both young ladies began to reconsider their roles in how the story of their lives had unfolded. With time, they even began to develop, in the case of Polly, some empathy for a mother with whom it had been tremendously challenging to co-exist. Heather began to convey in sessions that there were probably other sides to the story she had told about her life. Both young women needed to learn, as pointed out in the work of Nock and Mendes (2008), how better to respond to the stresses in their lives, though no doubt this will continue as a challenge, particularly at moments of greater developmental demands.

In the literature, the gold standard of treatment of girls (and boys) who demonstrate pathology such as outlined above is DBT (Miller et al., 2009). When available, and with interested young women (and their families), psychodynamic psychotherapy allows for growth and development of their mature female selves. Given the inherent risks of suicidality posed by cases such as these, being able to acquire pleasure from themselves as mature

females is a critical goal that will—it is hoped—serve as a protective envelope.

DISCUSSION

These young women confirm observations in the behavioral and psychoanalytic literature about difficulties in the capacity for emotional regulation in patients who self-abuse. For the first patient discussed, Polly, the devastating loss of a major caregiver coupled with her feeling that her mother did not understand her contributed to self-abuse to quiet the internal turmoil she felt. She cut, as well, to punish herself both for her needs and her aggressive impulses towards her mother, whom she both identified with and raged against. This was concretized within her in the feeling that she had two identities—one that felt abused and one that was abusive. The final meaning of her cutting was as a memorial to all the bad decisions she had made but did not want to repeat. She felt these needed to be inscribed into her flesh rather than thought about and worked through. For Heather, who had a relationship with her mother but felt alone and abandoned without her, self-abuse represented a retaliation and railing against the rest of her family, who, she felt, did not appreciate or love her. For Heather, cutting helped her to feel in control, the lack of which she found unacceptable.

These two cases have several features in common. Their psychopathology and object relations had direct connections to relationships with mothers, on the one hand, rejecting and on the other, excessively close. The second feature was the importance of performing an action that would cause bodily pain; they both needed the pain to ward off truly terrifying feelings of loss and rage. Neither young lady had mature object relations. Their true relationships were with their bodies. However, that relationship was not primarily based on pleasure, but on pain, whether directly experienced or not (in the opinion of this author this pleasure is more the motivation and province of the eating disorders, though the eventual torture of the body through the eating disorder is similar). Polly felt pain when she cut, which helped her calm the storm of racing thoughts and disturbed perceptions. Heather felt numb, which calmed her and allowed her to not feel insecure that, in particular, her father did not love her. Similarly, in a paper on *The English Patient*, a novel about a spy burned beyond recognition, the author refers to the skin as the "first border, as well as first place of contact between baby and mother" (Doidge, 2001, p. 290, referring to Anzieu's discussion of Freud's infamous observation that the ego is "first" and "foremost a body ego" [Freud, 1923]). In the

paper, Doidge analyzes the damaged skin of the hero as representative of the ambivalent state of the impaired schizoid personality wanting both to be in contact with a significant other (via the skin), alternatively, being terrified of the contact and how it could do damage, and in parallel, the wish (seen as well in patients who cut) to be united inside the mother—"buried alive" being the fantasy alluded to by Doidge (2001, p. 304).

Neither girl could take pleasure in her own body; both were promiscuous during later adolescence without deep feelings for their partners. Because of a warm relationship with her mother, Heather identified with the desire to give to those in need, and was able to freely help others, particularly needy and troubled friends. Polly, because of a more ambivalent relationship with her mother, had deeply disturbed, at times, abusive relationships. Their primary attachments remained to their mothers, but, as anxious attachments tend to do, were not able to allow for the free expression of love and trust in others. Polly and her mother held each other in "thrall" because of their constant fighting and ambivalent relationship. Heather and her mother lived in a cocoon that Heather would try to emerge from in her relationships with boys but which felt "fake" to her; ultimately her mother was the only person she trusted. Ornstein (1991) writes about the importance of appropriate parenting in the development of normal narcissism and the difficulties faced by the developing child in its absence:

> The fate of these infantile narcissistic structures depends on the availability of an empathetically responsive selfobject environment, an environment that is expected to be responsive to the infant's and child's developmental needs for affirmation and validation. When these needed responses are not forthcoming, or not reliably so, we witness the emergence of behavior that indicates the presence of low self-esteem, narcissistic vulnerability, poor impulse control, and other signs of a poorly consolidated self. Complex defense organizations as we see them in self-defeating behavior are unlikely to become established in relation to the anger and guilt the child may feel toward the *ordinarily* (my emphasis) frustrating parent (p. 395).

Finally, Polly was ambivalent in her sense of herself as female, though through treatment she was able to show off more of her feminine appearance. Heather liked to exhibit herself more, but wondered how superficial her sense of her feminine self was. She felt her body might be there to attract boys rather than as a secure part of herself. Neither Polly nor Heather experienced their female bodies in an integrated fashion that would allow for mature pride in their femininity, but used them as a template to express their rage, loneliness, and limited relationships to

others. Their primary absorption was with themselves and in causing themselves (their bodies) pain. For them, their bodies had remained the seat of the ego, and they were not prepared to take good enough care of themselves.

REFERENCES

Asch, S.S. (1971). Wrist scratching as a symptom of anhedonia: a predepressive state. *Psychoanalytic Quarterly, 40*, 603–617.

Bick, E. (1968). The experience of skin in early object relations. In David E. Scharff (1996) *Object relations theory and practice: an introduction*. NY: Jason Aronson.

Biven, B.M. (1977). A violent solution—the role of skin in a severe adolescent regression. *Psychoanalytic Study of the Child, 32*, 327–352.

Bowlby, J. (1977). The making and breaking of affectional bonds: 1. Aetiology and psychopathology in the light of attachment theory. *British Journal of Psychiatry. 130*, 201–210.

Briere, J. & Gil, E. (1998). Self-Mutilation in clinical and general population samples: Prevalence, Correlates, and Functions. *American Journal of Orthopsychiatry, 68*, 609–620.

Brausch, A.M., Gutierrez, P.M. (2010). Differences in Non-Suicidal Self-Injury and Suicide Attempts in Adolescents. *Journal of Youth and Adolescence. 39*, 233–242.

Brazelton, T.B., Cramer, B.G. (1990). The earliest relationship. Reading, MA: Addison-Wesley Publishing Co., Inc.

Bromfield, R. (2005). Teens in therapy: making it their own. NY: WW Norton and Company.

Brown, M.Z., Comtois, K.A, & Linehan, M.M. (2002). Reasons for suicide attempts and nonsuicidal self-injury, in women with borderline personality disorder. *University of Washington Journal of Abnormal Psychology,*111, 198–202.

Chen, E.Y., Brown, M.Z., Harned, M.S., & Linehan, M.M. (2009). A comparison of borderline personality disorder with and without eating disorders. *Psychiatry Research, 170*, 86–90.

Claes, W, Vandereycken, W., Vertommen, H (2003). Eating-disordered patients with and without self-injurious behaviors: a comparison of psychopathological features. *European Eating Disorders Review, 11*, 379–396.

Claes, W., Vandereycken, W., Vertomme, H. (2007). Self-injury in female versus male psychiatric patients: A comparison of characteristics, psychopathology and aggression regulation. *Personality and Individual Differences, 42*, 611–621.

Cloutier, P., Martin, J., Kennedy. A., Nixon, M.K., & Muehlenkamp, J.J. (2010). Characteristics and co-occurrence of adolescent non-suicidal self-injury and suicidal behaviours in pediatric emergency crisis services. *Journal of Youth and Adolescence, 39*, 259–269.

Diamond, D., Clarkin, J., Levine, H., Levy, K., Foelsch, P., & Yeomans, F. (1999). Borderline conditions and attachment: a preliminary report. *Psychoanalytic Inquiry*. 19, 831–884.

Doidge, N. (2001). Diagnosing the *English Patient*. Schizoid fantasies of being skinless and of being buried alive. *Journal of the American Psychoanalytic Association, 49*, 279–309.

Fonagy, P. (2000). Attachment and borderline personality disorder. *Journal of the American Psychoanalytic Association, 48,* 1129–1146.

Foote, B., Smolin, Y, Neft, D.I, & Lipschitz, D. (2008). Dissociative disorders and suicidality in psychiatric outpatients. *The Journal of Nervous and Mental Disease, 196*, 29–36.

Freud, S. (1923). The Ego and the Id. The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIX (1923–1925): The Ego and the Id and Other Works, 1–66.

Galenson, E. (1988). The precursors of masochism: protomasochism. In Glick, R,A, & Meyers, D.I. (Eds.), *Masochism: current psychoanalytic perspectives* (pp 189–204). Hillsdale, NJ & London: The Analytic Press.

Glassman, L.H., Weierich, M.R., Hooley, J,M., Deliberto, T.L., & Nock, M.K. (2007). Child maltreatment, non-suicidal self-injury, and the mediating role of self-criticism. *Behaviour Research and Therapy. 45,*2483–2490.

Gunderson, J.G. & Hoffman, P.D. (2005). Understanding and treating borderline personality disorder—a guide for professionals and families. Washington, DC: American Psychiatric Publishing.

Harnik, E.J. (1932). Pleasure in disguise, the need for decoration and the sense of beauty. *Psychoanalytic Quarterly, 1*, 216–264.

Herman, J. (1992). *Trauma and recovery: the aftermath of violence—from domestic abuse to political terror.* NY: Basic Books.

Jacobson, C.M., Gould, M. (2007). The epidemiology and phenomenology of non-suicidal self-injurious behavior among adolescents: A critical review of the literature. *Archives of Suicide Research, 11*(2), 129–147.

Jacobson, C.M., Muehlenkamp, J.J., Miller, A.L., & Turner, J.B. (2008). Psychiatric impairment among adolescents engaging in different types of deliberate self-harm. *Journal of Clinical Child & Adolescent Psychology, 37*, 363–375.

Kisiel, C.L. & Lyons, J.S. (2001) Dissociation as a mediator of psychopathology among sexually abused children and adolescents. *American Journal of Psychiatry, 158*, 1034–1039.

Klonsky, E.D. & Muehlenkamp, J.J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology: In Session*, 63, 1045–1056.

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

Ornstein, A. (1991). The dread to repeat: comments on the working—through process in psychoanalysis. *Journal of the American Psychoanalytic Association, 39*, 377–398.

Main, M. (1966). Introduction to the special section on attachment and psychopathology: 2. overview of the field of attachment. *Journal of Consulting and Clinical Psychology, 64*, 237–243.

Mahler, M.S., Pine, F. & Bergman, A. (1975). *The psychological birth of the human infant: symbiosis and individuation.* New York: Basic Books.

Miller, A.L., Rathus, J.H. & Linehan, M.M. (2007). *Dialectical behavior therapy with suicidal adolescents.* New York: The Guilford Press.

Miller, A., Muehlenkamp, J.J. & Jacobson, C. (2009). Understanding nonsuicidal self-injury: Origins, assessment, and treatment. In Nock, M. K. (Ed.) *Special issues in treating adolescent nonsuicidal self-injury*, xiii, pp. 251–270. Washington, DC,: American Psychological Association.

Muehlenkamp, J.J. & Gutierrez, P.M. (2004). An investigation of differences between self-injurious behavior and suicide attempts in a sample of adolescents. *Suicide and Life-threatening Behavior, 34*, 12–23.

Muehlenkamp, J.J. & Gutierrez, P.M. (2007). Risk for suicide attempts among adolescents who engage in non-suicidal self-injury. archives of suicide research, 11, pp. 69–82.

Muehlenkamp, J.J., Hoff, E.R., Licht, J-G., Azure, J.A., Hasenzahl, S.J. (2008). Rates of non-suicidal self-injury: A cross-sectional analysis of exposure. *Current Psychology, 27*, 234–241.

Muehlenkamp, J.J., Engel S.G., Wadeson, A., Crosby, R.D., Wonderlich, S.A., Simonich, H. & Mitchell, J.E. (2009). Emotional states preceding and following acts of non-suicidal self-injury in bulimia nervosa patients. *Behavior Research and Therapy, 47*, 83–87.

Nock, M.K. & Prinstein, M.J. (2005). Contextual features and behavioral functions of self-mutilation among adolescents. *Journal of Abnormal Psychology,114,* 140 –146.

Nock, M.K., Joiner, T.E., Gordon, K.H., Lloyd-Richardson, E. & Prinstein, M.J. (2006). Non-suicidal self-injury among adolescents: diagnostic correlates and relation to suicide attempts. *Psychiatry Research, 144*, 65–72.

Nock, M.K. (2009). Why do people hurt themselves? New insights into the nature and functions of self-injury. *Journal of Consulting and Clinical Psychology, 76*, 1–8.

Nock, M.K. & Mendes, W.B. (2008). Physiological arousal, distress tolerance, and social problem-solving deficits among adolescent self-injurers. *Journal of Consulting and Clinical Psychology, 76*, 28–38.

Nock, M.K., Prinstein, M.J. & Sterba, S.K.,, (2009). Revealing the form and function of self-injurious thoughts and behaviors: A real-time ecological assessment study among adolescents and young adults. *Journal of Abnormal Psychology, 118*, 816–827.

Noshpitz, J. & King, R. (1991). *Pathways of growth. essentials of child psychiatry. vol. 1. normal development.* New York: John Wiley & Sons.

Novick, J. & Novick, K.K. (1991). Some comments on masochism and the delusion of omnipotence from a developmental perspective. *Journal of the American Psychoanalytic Association, 39*, 307–331.

Rodham, K. & Hawton, K. (2009). Epidemiology and phenomenology of nonsuicidal self-injury, xiii,

pp. 37–62. In Nock, Matthew K (Ed.) *Understanding nonsuicidal self-injury: origins, assessment, and treatment.* Washington, DC, US: American Psychological Association.

Rosenthal, R.J., Rinzler, C., Wallsh, R. & Klausner, E. (1972). Wrist-cutting syndrome: The meaning of a gesture. *American Journal of Psychiatry, 128*, 1363.

Ross, S. & Heath, N. (2002). A study of the frequency of self-mutilation in a community sample of adolescents. *Journal of Youth and Adolescence, 31*, 67–77.

Sands, S.H. (1989). Eating disorders and female development: a self-psychological perspective. *Progress in Self-Psychology, 5*, 75–103.

Sarnoff, C.A. (1988). Adolescent masochism, pp. 205–224. In Glick, R.A. & Meyers, D.I. (Eds.). *Masochism: Current Psychoanalytic Perspectives.* NJ: The Atlantic Press.

Schur, M. (1955). Comments on the metapsychology of somatization. *Psychoanalytical Study of the Child, 10,* 119–164.

Shearer, S.L. (1994). Phenomenology of self-injury among inpatient women with borderline personality disorder. *Journal of Nervous and Mental Disease. 182*, 524–526.

Shearer, S.L., Peters, C.P., Quayton, M.S. & Wadman, B.E. (1988). Intent and lethality of suicide attempts among female borderline inpatients. *American Journal of Psychiatry, 145*, 1424–1427.

Sroufe, L.A. (2000). Early relationships and the development of children. *Infant Mental Health Journal, 21*, 67–74.

Stanley, B. & Brodsky, B.S. (2005). Suicidal and self-injurious behavior in borderline personality disorder: a self-regulation model. In Gunderson, J.J & Hoffman, P.P. (Eds.). *Understanding and treating borderline personality disorder: a guide for professionals and families.* Washington, DC: American Psychiatric Publishing.

Whitlock, J., Eckenrode, J. & Silverman, D. (2006). Self-injurious behaviors in a college population. *Pediatrics, 117,* 1939–1948.

Whitlock, J., Muehlenkamp, J. & Eckenrode, J. (2008). Variation in nonsuicidal self-injury: Identification and features of latent classes in a college population of emerging adults. *Journal of Clinical Child and Adolescent Psychology, 37*, 725–735.