



## THE BODY AS TESTAMENT: A PHENOMENOLOGICAL CASE STUDY OF AN ADULT WOMAN WHO SELF-MUTILATES<sup>†</sup>

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### Introduction

There are few words in our language that adequately express pain. To express emotional or physical pain to another human being we often rely upon metaphor. Self-mutilation is generally an unspoken expression of an internal and intangible experience. This behavior makes the unseen experience concrete. In some cases the process and outcome of self-mutilation is an explicit metaphor for the mind of the individual. Self-mutilation, the cuts, burns and scars represent fragmentation and woundedness in a graphic and pictorial fashion. The act is about pain, emotional and physical. The act is a reflection of the internal world of those who hurt themselves. This internal world represents the collective whole of each individual's life.

The act of self-mutilation often draws blood, symbolic of life and energy. As the blood crosses the broken skin barrier, the act of self-mutilation communicates pain and alienation . . . During the talking cure of a therapy session, the client expresses feelings verbally. The client "gets it all out." In an act of self-mutilation gesture replaces language. What cannot be said in words becomes the language of blood and pain. Although the gestures are often performed clandestinely, they are potent expres-

sions all the same. (Hewitt, 1997, pp. 55-56, 58)

How can self-mutilation be understood when pain is difficult to communicate in meaningful language? Scarry (1985) discusses this very problem in the quote below. Her thoughts may be applied to physical and emotional pain.

When one hears about another person's physical pain, the events happening within the interior of that person's body may seem to have the remote character of some deep subterranean fact, belonging to an invisible geography that, however portentous, has no reality because it has not yet manifested itself on the visible surface of the earth (p. 3) . . . To witness the moment when pain causes a reversion to the pre-language of cries and groans is to witness the destruction of language. (p. 6)

Miller (1994) discusses the problems of communication experienced by client populations who are most likely to self-harm.

Their power of speech has been so distorted that they are often communicating in a language of fragments, self-abusive behaviors, or painful si-

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lence. The narrative may be fragmented to the point of incoherence, confusing both the therapist and client. (p. 187)

The identification and treatment resolution of self-mutilation is exacerbated by problems of communication. This is a population that communicates what seems to be the unspeakable with a behavioral act rather than words. Again, acts of self-mutilation may represent a literal metaphor, sometimes a remarkably accurate metaphor, for an internal experience or history that is hard to embrace, has been disavowed and cannot be seen.

The verbal self is that self which links us to the world of people and ideas, the self which makes us comprehensible to others by making us comprehensible to ourselves. And yet our preverbal self remains, made up of all our "disavowed" experiences (those thoughts, feelings, perceptions, and sensations which resist encoding in language or contradict the reality of our emerging verbal subjective selves). But the use of the word "self" here is not exactly right since our disavowed experiences and emotions are fragmentary and elusive, often inaccessible to language, and lacking the coherence and continuity of a self. (Young, 1992, pp. 93–94)

Considering the fact that we have cultural and linguistic limitations in our ability to communicate physical or emotional pain, it should not be a surprise that we have many disagreements over the definitions, meaning and efficacy of treatment for self-injurious behaviors. It is a very complex, multifactorial and multidimensional topic.

## Methods

### *Description of the Research Participant*

For the larger research study, five women were interviewed. One of the five case studies is presented here. Criteria determined for the research participants in this study were: (a) female, (b) age 21–65, (c) with a history of the behavior of self-mutilation and (d) the research participant must be willing and able to describe her experience of self-mutilation. It was also a consideration that the research not impede the recovery of the individual. For this reason referrals from the primary therapist or medical professional to the

research study were sought. Pre- and postinterviews were given to each participant. An informed consent was presented to the research participant (for the verbal interview as well as the art and poetry) and signed by each individual. In a few cases, when the research participant was in outpatient therapy, a release of information to primary care takers was signed in case of abreaction or potential relapse. Research participants and referring therapists were warned of the potential triggering effects of an open-ended interview such as this one. Local referrals for emergency care were offered, but not needed.

### *Description of the Theory of Phenomenology*

It is due to the fact that the literature reveals conflicting definitions and meanings for the experience of self mutilation that a qualitative study was determined to be appropriate for this research study. For example, Pattison and Kahan (1983) reviewed 56 individual case studies that reported "deliberate self-harm of low lethality" (p. 867). They excluded studies involving children and those with chronic alcoholism, drug use and eating disorders. "We located 56 individual index cases with sufficient clinical description to allow data comparison. Even so, comparability of data was problematic" (p. 868). The case studies they found were lacking in sufficient psychiatric case detail, there was confusion between low-lethal deliberate self-harm behavior versus highly lethal suicide attempts and the labels given to these events were unreliable. Another reason for the problems of doing a comparison study with this data was described, "... deliberate self-harm has not been widely defined as a syndrome, the concomitant target signs and symptoms are not uniformly or systematically recorded" (p. 868). Their justification for avoiding psychiatric diagnostic labels was that:

... psychiatric diagnosis varies with theoretical orientation and has low interrater reliability, and diagnostic labels have changed with psychiatric fashions over the past 20 years ... However, we assumed that if we found a set of characteristic symptoms, they would be likely to be significant, although we can not rule out variables that were underreported or unnoticed. (Pattison & Kahan, 1983, p. 868)

It is for this reason that the research participants in this study were chosen based upon their behavior, not

a previous diagnosis. Another reason for avoiding selection based upon prior diagnosis is that many adult women who chronically self-mutilate have received numerous, sometimes contradictory, diagnoses over time.

During the early stages of planning this dissertation, quantitative research was considered. "Quantitative measures are succinct, parsimonious, and easily aggregated for analysis; they are systematic, standardized, and easily presented in a short space" (Patton, 1987, p. 11). These positive attributes of quantitative research were appealing when contemplating a research project of great depth.

Yet, in 1994, when the methodology for this project was determined, the literature review revealed a missing link in current research on self-mutilation. What was missing was a thorough, systematic, qualitative study that presented the perspective of those who suffer from the behavior of self-mutilation. A primary goal of this study was to provide an opportunity for women who self-mutilate to describe their experience in their own words.

. . . the open-ended response permits one to understand the world as seen by the respondent. The purpose of gathering responses to open-ended questions is to permit the evaluator to understand and capture the perspective of program participants without predetermining their perspective through prior selection or questionnaire categories. (Patton, 1987, p. 11)

After further contemplation, a qualitative phenomenological methodology was chosen. It is a philosophy that blends well with the theoretical beliefs of this author. In addition, it is a research method that is respectful of those being studied.

Over the past two decades, "minority" and feminist scholars have sought to challenge traditional disciplinary paradigms of social research. "Research for whom?" we have asked. "How is it conducted?" "Whose voice is privileged?" "Don't the 'researched' also interrogate the 'researcher?'" The concern to develop socially responsible research has forced us to question continually the relationship between investigation and the needs and rights of people. It has also forced us to rethink our research practices and our own motives for engaging in this activity. (Benmayor, 1991, p. 159)

The phenomenological approach used for this study is one that is based upon a method of analysis refined by Moustakas (1994). His methodology is structured, systematic and it incorporates intuition, as well as self-reflection. The process of phenomenological analysis includes determining meaning units, themes, clustered themes and then a synthesis.

Meaning units are statements by the research participant (co-researcher) that are pertinent to the object being studied. It is a complete thought, sentence or even paragraph that can be clustered according to theme. In this process there are two types of themes, descriptive or prescriptive. The descriptive themes are determined by the researcher based upon the research findings and the prescriptive themes are predetermined by the phenomenological protocol. This process of creating themes and writing about them is done from these two different perspectives for each interview. After the meaning units are clustered each clustered theme is contemplated by the researcher. The final synthesis, for each individual, is an integration of these two clusters of themes. This final synthesis is entitled, Individual Composite Textural-Structural Description. Due to the typical length of a journal article, only the final synthesis of one co-researcher of the five is presented. In the larger study, themes across all five participants were clustered to determine commonalities among the five co-researchers. The case study portrayed here embodies many of those common themes.

Douglass and Moustakas (1985) offer a description of phenomenological research.

Through disciplined focus on the structure of experience (e.g., time, space, materiality, causality, interpersonal factors), the phenomenological investigation attempts to reveal the actual nature and meaning of an event, perception, or occurrence, just as it appears. Rigorous analysis transforms the subjective data (in the form of direct reports and observations) into objective accounts of reality. This requires an initial stepping back from the various suppositions and prior beliefs that the researcher holds. In other words, analysis of data must be unbiased. Phenomenological reduction (analysis) is complete when themes or patterns have been distilled from the data and when the essence of the phenomenon is fully disclosed through textural and structural descriptions. (p. 43)

Wiener (1998) in her article on therapy with “psychiatric survivors” illustrates the need for professionals to enter into the realm of what is real, as well as what is imagined, without judgment. Although her article is about therapy, not research, her comments are important and supportive of phenomenological research philosophies.

If we assume that one of the goals of the therapeutic process, whether working with the psychotic or non-psychotic, is to help the client safely enter into his psychic processes in order to promote healing, then this entry must not only include an examination of universal mythological systems, but the individual mythologies that clients may use to protect themselves and bridge communication with others. (p. 180)

It is the wish of this author that a phenomenological synthesis of self-mutilation will create a bridge of communication between those who hurt themselves and the world of professional counselors. Issues of professional countertransference with this population are often discussed in the literature. While insight and understanding alone may not be curative for mental health issues, it can help professionals develop rapport with isolated or alienated clients. Understanding may even help a therapist successfully navigate a potentially disruptive therapeutic impasse or double bind.

This method of research reveals the very complex behavior and internal experience of those who engage in self-mutilation. The task of this study was to understand the experience of a behavior or event (self-mutilation), the sensations and perceptions (including physical pain) associated with that behavior, as well as related thoughts, emotions, motivations, urges and triggers. The study of, “Phenomena include visible, touchable, and audible things in the world around us, as well as thoughts, feelings, dreams, fantasies, and all that stems from the human mind and spirit and belongs in the realm of mental experience” (Betensky, 1987, p. 149). Cohen (1994) delineates a short overview of phenomenology below.

Phenomenology as a research method is based upon the philosophies of Husserl, Heidegger and others. It is a qualitative, as opposed to quantitative, method of systematic scientific inquiry. The aim of the researcher is to describe the human experience and understand it, not

quantify it. As it is philosophically understood that meaning exists through mutually experienced encounters between individuals and the world . . . Phenomenology is research at a pre-experimental level. Sample sizes are small and purposeful because the purpose of the research was to obtain subjective depth in the data, not objective or quantifiable data. The sample size is considered sufficient when the data are saturated or the same patterns recur with each new participant interview. (p. 38)

Garai (1987) makes a comparison of our tendency to focus, in Western culture, our explorations to the outer regions of space rather than our inner beings.

It appears paradoxical that man has been able and willing to extend his most intensive exploration into the outer spaces of planets and the solar system, but he has been unable or unwilling to explore the vast uncharted territories of his own “inner space.” (p. 190)

If we are reluctant to explore our own “inner space,” then how much more resistant are we to explore the inner space of another, especially another who is different or labeled with a diagnosis? Betensky describes her attraction to the philosophy and method of phenomenological research in direct terms: “Its opposition to the restriction of psychology to behavior and behavior control, and to mechanistic, associationistic views as well as to reductionistic tendencies in the study of man, was what I was looking for” (p. 150).

Briere (1992) encourages therapists to embrace a phenomenological therapeutic approach when working with those who self-mutilate. His reasons and justifications for a phenomenological therapeutic approach with adult survivors of childhood trauma are compatible with the reasons why a phenomenological methodology was chosen for this research project.

A phenomenological therapeutic stance is necessarily empathic, since one of the therapist’s most powerful tools becomes his or her ability to inhabit partially the survivor’s inner world, and to perceive indirectly what the survivor perceived. This endeavor not only allows the therapist to offer accurately empathic statements, but assists with the process of treatment. By monitoring the survivor’s internal state, via

questions and attempts to understand his or her experience, for example, the clinician is less likely to move faster or slower in treatment than the client is able to go, and is more able to communicate in a manner most congruent with the client's subjective understanding of self and others. Further, to the extent that the clinician is attuned to the client's phenomenology, he or she is more likely to focus on issues most critical to the survivor, rather than being distracted by less important themes or dynamics. (p. 85)

The question posed by the larger research study follows, "What is the meaning and the experience of adult women who self-mutilate?" The questions written for the interviews were open-ended, to encourage dialogue. They were designed to explore, reveal and honor the experience of the co-researcher. During the interviews the primary researcher chose to put all theoretical concepts aside, to be as present to the research participants' experience as possible. "Although the doubt of Descartes was transformed into the Epoche of Husserl, both philosophers recognized the crucial value of returning to the self to discover the nature and meaning of things as they appear and in their essence" (Moustakas, 1994, p. 26).

The open-ended prompts were:

1. Recall a vivid time of self-mutilation and describe it.
2. What dimensions of the experience stand out for you?
3. What bodily feelings were you aware of having?
4. What emotions were you aware of having?
5. What thoughts were you aware of having?
6. How was your life affected by this experience?
7. How did this experience affect others in your world?
8. Did you notice any difference in your experience of time, of other people and/or yourself?
9. How does your adult experience relate to your childhood experience?
10. What has been most beneficial to your healing process?
11. Is there anything else in the experience that was important which has not been presented or covered?

Art and poetry were collected as part of the phenomenological interview. The research participant was asked to bring art and poetry, to the interview, that most represented her experience of self-mutila-

tion. The art and poetry is included in the final synthesis of the phenomenological analysis with a discussion of the meaning and relevance to the disorder. For the purpose of accurate documentation, each interview was tape recorded (by two machines) and then typed by a professional transcriptionist. The art work was photographed and the poems were photocopied from the original to be sure of accurate punctuation.

#### *Description of the Art Method of Inquiry*

Many who self-mutilate struggle with the ability to express themselves verbally. This fact and the nature of self-mutilation itself as a form of implicit communication was the justification for creating a visual method of inquiry. The instruction for the life-sized silhouette protocol (art method of inquiry) was, "Show me, as accurately and with as much detail as possible, where you physically hurt yourself." For the purpose of this study, the life-sized silhouette was used to determine where and how the co-researcher hurt her body. Each participant had their body traced upon large white 3' x 6' paper and were given the same set of 12 magic markers. No other directives were given. This author chose to use a life-sized silhouette, rather than a smaller version, because gross motor movements seem to access implicit, imagistic memory better than fine motor movements.

The life-sized silhouette was completed after the verbal interviews. The whole interview, verbal and visual, lasted approximately 4 hours. In the case study presented here, the silhouette drawing brought up new information that had been left out of the verbal interview. It appeared that different memories were more easily accessed by different methods of research. Using a verbal and a visual method of collecting data accessed declarative/explicit memory and nondeclarative/implicit memory. This individual remarked that until she drew the silhouette, some of the information she wanted to access was not easily available to her. In addition, during the art method of inquiry, this individual looked at her scars as a reference.

A reproduction of the life-sized silhouette is included in this article.

#### *Description of the Assessment of Memory*

The research protocol was to seek those who self-mutilate. There was not an effort to enlist those who had a certain diagnosis. Yet, memory was an impor-

tant issue to assess in relationship to the phenomenon of self-mutilation. It was the desire of this researcher to employ a psychometric instrument that was valid, reliable and not too intrusive, respecting the role of the co-researcher.

The assessment instrument used in this project, the Dissociative Experiences Scale (DES), was developed and published by Carlson and Putnam (Carlson et al., 1993). This short assessment scale measures several important constructs including amnesic dissociation, depersonalization, derealization, absorption and imaginative involvement. This questionnaire, a self-report measure, consists of 28 questions about experiences one might have in daily life. The questionnaire is concerned with how often these experiences happen when the client or patient is not under the influence of alcohol or drugs. Each question has a scale of 0%–100%. The 0% means “this never happens to you” and the 100% means that “this is always happening to you.”

“A total score is determined by calculating the average score for all items (add all item scores and divide by 28)” (Carlson & Putman, in press, p. 3). The administration of this test and the scoring takes an average of 15–20 minutes. Results of reliability studies of the DES suggest that the DES has good test–retest reliability and internal reliability. Carlson et al. (1993) indicated that a DES cutoff score of 30 resulted in 74% of dissociative identity disordered (DID) subjects correctly identified, and 80% of not-DID correctly identified in a clinical sample of 1,051 subjects. The authors of this study concluded that their data supported the construct validity of the DES.

It should be noted that scores do not necessarily reflect the level of psychopathology since many DES items ask about nonpathological forms of dissociation (such as daydreaming). Consequently, DES scores may have different meanings across clinical and nonclinical populations. For example, late adolescents score relatively high on the DES, but they tend to endorse mild to moderate experiences of dissociation. (Carlson & Putnam, in press, p. 4)

The author chose the DES as a psychometric instrument for this research project due to the fact that (a) it is valid and reliable, (b) it is short and simple to administer, (c) the verbal interview and art method of inquiry were time consuming and (d) the scoring of the DES is rather basic and takes only 5 minutes.

The results of this instrument were to be tabulated and reported for the group of five research participants, and not each individual. This decision is compatible with the philosophy of psychological phenomenology. Yet, each research participant described herself as DID during the interview. This self-report was supported by the psychometric testing.

Not one co-researcher had difficulty understanding the directions or objected to the test. Each one seemed to agree with the wisdom of including such an instrument. A few had some testing experience. For those familiar with the test, this author asked them to think of their recent experience and try to answer the test as honestly as possible. The research participants were reminded that they may score differently than in the past, depending upon whether or not they have been involved in therapy.

#### *A Brief Overview of the Case Study for Co-Researcher A*

Co-Researcher A, is a divorced, 41-year-old single mother with two children. One daughter lives with her and the other child, a son, lives with his father. Co-researcher A has completed a Master of Science degree in Sociology and is now working on her doctorate full-time. She volunteers, as a counselor, at a local mental health center and she receives disability payments which supplement her income. She describes herself as a poet–artist.

Although she has hurt herself since childhood, her first “intense” episode of self-cutting occurred in 1988. This episode was precipitated by at least three coincidental events; her work at a child abuse intervention unit, a separation from her abusive husband and a planned trip to a family reunion. She does not know why she began cutting her wrist on this occasion but once she started she began making multiple slices on her wrists with a knife. She did not feel any death urges but felt that no one was concerned about her. She felt numb, isolated and overwhelmed. Even so, she called both the crisis helpline and her therapist during the episode. She remembers that the blood on her arms drew her attention and made her feel drugged.

Although her arms were bandaged, the next day she went to work as if nothing was wrong. She was hospitalized straight from work. She does not perceive the cuts to have been deep. She remembers that both wrists had “lots of raised texture” and that most of the cuts were both up and down the length of the



I'd know maybe what was connected to it. I don't know.

Her silhouette represents where and how she cuts, scratches, burns and hits herself on various parts of her body. The most common locations of self-harm represented by her silhouette are her face, head, neck, shoulders, chest, stomach, arms, wrists, inner thighs and vagina. The burns are represented by dots, the cuts by lines and the hitting by fists. Her cutting and burning patterns shown here are a blend of two styles of self-mutilation (a) systematic and geometric and (b) impulsive and random. In the larger study, one other participant exhibited a blended pattern similar to the one shown here, a third revealed a rigidly systematic and geometric pattern and the fourth and fifth revealed patterns of self-mutilation that were random in form.

Co-researcher A expressed satisfaction that her silhouette accurately represented her experience of self-mutilation, which for her feels like living in the middle of a tornado.

### Findings

#### *Individual Composite Textural-Structural Description*

This individual has abused her body since early childhood. "I think I've always done some sort of self-harm like punching or scratching. Feeling like I always needed to attack my body or cut something out." Over the years she has hurt her own body with her bare hands, cigarettes, sharp instruments and hot water. She acknowledges specific ways of hurting herself such as hitting, punching, pinching, scalding, scratching, binging and purging food and verbal abuse. In her opinion these behaviors have run in stages or cycles, independently and concurrently with other acts of self-harm.

In the course of her interview she expresses many etiologies and motivations for her behavior of self-mutilation. Some of these etiologies and motivations seem to be primary, others secondary, but all are important. ". . . it seems like I always had this urge to hurt myself. The only memory I have before 8 is sitting in the hall hitting my face real hard saying, 'bad, bad, bad' . . . it connects directly back there."

Her disorder began in childhood. Her earliest episodes of self-mutilation were described as a "help me, I'm hurting act." These acts were efforts to get help

and professional care. The later stages of her self-mutilation cycle seemed to be propelled by self-punishment and markation. Self-punishment is one of her greatest motivations for self-mutilation. She will hurt herself for having "acted out, had bad thoughts."

According to her, the self-mutilation quiets the voices in her head and pushes back the memories of childhood. She believes that the extreme acts of self-harm "protect the secrets" or keep her from knowing the truth of her childhood history. Yet, her very acts of self-mutilation may be telling the story she wishes to deny. She states that she has urges to annihilate herself to protect those who harmed her.

For example, she has had urges to mutilate her genital area since she was 18 years old. In one point in the interview she admits to hitting her vagina but denies other methods of self-mutilation in that area. In another part of the interview she admits putting knives into her vagina. Here she makes a comment that she hits her vagina and that other people hit her when she was growing up. For her there is a link between how she was treated and how she treats herself. In her own words, the link between her childhood experience and her adult behavior appear to be a form of reenactment. "Now you need to remember the pain. Some hook back to what I felt before or something, anger, urges to cut deeper and deeper and deeper."

Figure 2, by Co-Researcher A, is an image of her, eyes closed, with a hand coming out of her mouth. This image portrays sensations of pressure she feels in her mouth and on her neck.

Sometimes its a pressure on the outside of the neck. Often it's a feeling almost, either a block in the neck, or hands coming out the mouth, trying to pull something out of my throat. I was wanting to let that escape.

She acknowledges that some of her self-harm is motivated by neck or stomach pains (also see Figure 1). These body pains or pressures may be induced by extreme stress, illness, body memories of childhood trauma or all three. Nonetheless, they motivate her to hurt herself. "My stomach pains are definitely connected to the really massive self-mutilation, fisting. I hit myself hard. It's also connected to the few flashbacks or bridge backs I've had." Again, she describes the stomach pains as somehow connected to flashbacks she has had of trauma. When she has flashbacks she sees small, brief, intrusive images of childhood



Figure 2. Silenced in Hungered Pain.

trauma that she refers to as “blips.” She also experiences triggers. Triggers are contemporary experiences in life that remind her of earlier trauma and the associated feelings.

According to this individual, self-mutilation is sometimes precipitated by a desire to control or contain the disturbing physical experience described above. The desire to pull something nebulous out of the throat is not an uncommon experience expressed by sexual abuse survivors who were orally abused.

Every time I feel like like I’m gonna go away, like I’m gonna have a flashback, like I’m gonna remember something or something like that, it seems like those urges (to self-mutilate) come up. It seems like the urges, the self-harm, the cutting, the burning, the more massive thoughts of doing it seem to be voiced by certain alters who also seem like they don’t want me to know the who or the what exactly, or the where (of the original trauma).

When looking closely at the self-portrait shown in Figure 2, one can see another, smaller profile of a face portrayed on the upper left hand side (from the viewer’s left) of the cranium. This image of another self portrays her self-described experience of split multiple selves.

There are times when she perceives her physical body to be a metaphor for her inner world—as if her body is a metaphor for her mind versus her mind representing a metaphor for her body. “Ever (sic) once in a while a thought gets blocked and I have to get it, like if I just slice down it will be let loose,” as if she could slice down (split) her body, then her thoughts and pain would be released. More recently, this feeling or thought has intensified and, “some of the self-harm feels like if I can just cut down my stomach, I can reach inside and pull out everything that is in there because we can’t touch it.” Her inability to connect with herself, aspects of herself or others in an emotional way seems to push her to try to connect in a very concrete or literal fashion. Her damaged and scared body is an accurate metaphor for her mind. She can not touch her body pain or memories that trouble her so deeply. It may be that those who self-mutilate feel as if they need to touch their inner experience to fully understand it.

Her metaphor for the containment of her inner world and feelings is a tarp. This tarp covers her terror and anguish. It provides a boundary but it also blocks any connection to her inner self or selves. She may have conflicts regarding intimacy with her inner world. In one sense she wants to touch her inner experience and yet desires distance at the same time. She doesn’t feel as if she can communicate to her alter ego-states who are beneath the tarp to sooth them; nor does she feel as if she can feel the full expression of her feelings through the tarp. Figure 3 reveals the tarp on the right side of the image. The right side of the image shows a spiked wall. Again, this is her representation of, “The Tarp,” her metaphor for that which covers her emotions, sensations and memory, making them inaccessible to her.

Everything is beneath the tarp. I should explain the tarp. The tarp is what is over the parts. I feel the terror. I feel the anguish. I feel screaming. I feel running around. I feel everything but its like under a tarp. Its like having a wound on your hand, really deep wound, you’ve got this glove on and you can’t get the glove off and you can feel the pulsing of it but you can’t get

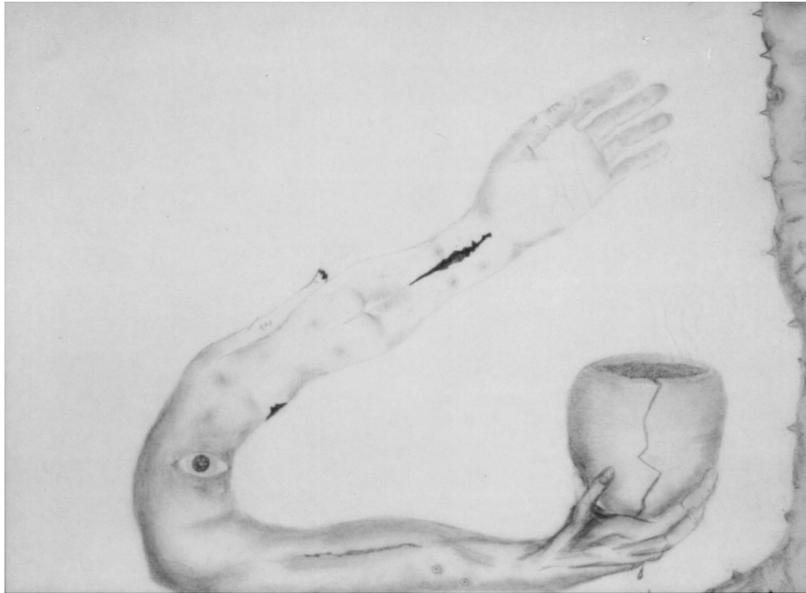


Figure 3. Holding Patterns: Walls and Crevices.

to it. But it blocks any connection from anything about who or what and where so I can't get past that tarp to soothe them (the alters) and to feel the full expression of feelings. It's like ice covers my skin.

Figure 3 is a representation of her experience as one who self-mutilates. Artistically it is a representational image that is also surreal at the same time. Her floating, disembodied arms and hands represent the totality of her being. It is possible to see the back of a naked woman's torso superimposed upon her forearm. Attacking her arm is a substitute for self-annihilation. In the literature this is referred to as "partial sacrifice." On this same forearm there is a large gaping wound, in this image the gaping wound also represents the space between the naked woman's legs. There are double meanings here.

One hand seems to be reaching out to an unseen viewer. The other holds a cracked vessel, again another representation of herself. A vessel, is an ancient symbol for womanhood. Her hand is holding the cracked vessel, herself, together as she leaks fluid, or blood. Blood or fluid has literal and figurative meanings.

As her self-mutilation increased she began to see herself as DID. For this individual, the relationship to herself is complicated by her fragmentation. She ac-

knowledges having alter ego-states but sometimes the boundaries are blurred or rigid, "Some of it is me, all is me, but some of it feels very alter-oriented." She refers to her behavior of self-punishment as if it were a disembodied voice, a separate entity or an external perpetrator. One aspect of her personality feels compelled to punish another part of herself.

"I mean I physically can feel myself battling them not to do something when I can recognize the different in voices inside my head." The act of self-mutilation seems to ground her to reality, "It was like all I could do was just cut and see the blood and know that that was real even though all was unreal in my head."

Her experience of switching from one alter ego-state to another is very physical. When Diana (an alter ego-state) tries to gain executive control, the host can feel the struggle. The host, when she has executive control, can feel Diana pressing down on her body or circling into her head. One time after fighting Diana she felt dizzy and she couldn't walk for the next hour. Sometimes during these episodes when she expends effort to control switching she feels as if she is spinning, hanging upside down or drugged.

This one, Diana (alter ego-state) it's almost like she can press down into my body and so it's up and down. I feel many of them come in this way

circling into my head, into my body. I wasn't really even aware of this till I got up and for the next hour after fighting her (Diana) not to cut my neck, I was like dizzy, I couldn't walk. There's sometimes spinning involved with fights, before the cutting, sometimes feeling upside down. I'm aware of feeling like I'm going to jump out of my body, anxiety, feeling like glass is shattering, my whole body is buzzing. I try to race ahead of it but there is this floating trance draw, almost a drug-like feeling. Sometimes like . . . exactly . . . hands crawling all over me to get to something.

There are times when she is able to control certain types of self-mutilation for a period of time. There are other times when she would have control of a behavior and then relapse. For example, head punching and scalding are two methods of self-harm that have returned in the last year after a period of abstinence. As her alter ego-states compete for control, her definition of control changes. The ego-states voraciously compete for control of the body with different goals in mind, some want to hurt the body, others want to protect it. "That was always very trance based, just like I was drawn into doing it, although I'm in control of things but it just felt like I just was on this path to do that." Sometimes self-mutilation was the last line of defense. If purging did not quiet the internal dialogue or push "back memories voices," then self-mutilation or scalding would follow.

She has recently identified a new set of alter ego-states who seem intent upon her death and destruction. These "new strange death oriented alters," called the Triad, cut and burn feelings. They are homicidal and seem oblivious that this is a form of self-annihilation/suicide. She fights these urges to annihilate herself. On New Years she experienced a desire to punish herself for, "passing another year, for being alive, . . . for being in the hospital again, for abandoning my children." These acts of self-punishment were motivated by her deep feelings of guilt and self-hate. For her, self-punishment is a personal and private act.

"Part of it is a well hidden voice at times that seems to be saying that I should be marked for all that I've done, the pain that I've given people." This self "markation" is a method of communication to the world, to let us know the nature of her true character, that of a monster. This seems motivated by the desire to show others who she perceives herself to be "a fake, a facade, who is pretending" to be something

she can't be. It is not clear if she is seeking judgment or forgiveness from the unidentified "they."

I do feel like a monster that does all these bizarre things to their body and that is feeling the most recent urges to cut on the face. Cause I see my face as monstrous and if I had scars all over it then that would be perfect . . . They'd see the real me. I mean, they would see scars. My face reminds me of my Dad. That fuels it sometimes, but mostly just that it's a monster.

She has enormous feelings of disgust, "that I'm just a bizarre creature that wants to cut their body all over the place." These acts of self-mutilation are to make herself physically ugly. This makes manifest her feelings of shame. This would make her inside experience match her outside reality for all to see. Yet she says, "I don't want to have to cut apart my body. Body, which is my life." She says, "my experiences of self-mutilation have changed greatly, it frightens me."

During her episodes of self-mutilation her sense of time varies. "Time, it's almost like it is frozen, like everything around me is stopped except for me." She feels as if she is present but then she is surprised at how much time has passed. For her time may be frozen/stopped (constricted) or sped up (expanded), both experiences are common to trance. She says that she is losing more time now. She believes that she is experiencing more periods of dissociation, since beginning therapy.

The following poem reveals her experience of de-personalization, isolation, relationship to time and despair. The theme of death is prominent in her poetry.

### The Writer—I

(For Sylvia Plath 1932–1963)

No Date

ONE

Kitchen clock, ice white,  
watches her like a historian,  
its worn hands wearing time away  
as she sits writing another birthday poem.

Twenty-five or forty years have gone by.

It makes no difference.

Leather arms of her dreams keep getting stabbed.

Time doesn't shield scars from the  
blade's plunging.

Time doesn't heal, only conceals scabs

that secretly raise their hands  
 ready to be lifted  
 so blood may flow again,  
 flow into the shaft of her pen.

Sometimes she engages in destructive behaviors other than self-mutilation, such as bingeing and purging. Her acts of self-mutilation decrease during these episodes of bingeing and purging, but return when they stop. When she refrains from self-harm and purging she finds that her episodes of dissociation, switching and memory blips increase. As her dissociation increases “strange sexual thoughts” come into her head. She has difficulty accepting these thoughts. “Some of them had to do with things that I just could not accept that I thought were just awful . . .” Here she is struggling with a physical reenactment such as the self-mutilation and reenactment fantasies. Both seem to be traumatic for her. Her life seems to be a juggling act, balancing her internal angst and one or more self-harm behaviors at a time.

“It seems like I never masturbated until I self-mutilated and then this voice tells me that I have to remember the pain, the knife and that I wanted the pain, as I masturbate.” As described earlier, she experiences a feeling of pressure in the vaginal area (or other areas) that starts the masturbation or self-mutilation. There are significant experiences of arousal attached to her self-mutilation/masturbation ritual. “Whenever I had these (sexual) thoughts, I would then cut or burn. I mean that was standard.” It seems as if her self-mutilation was part of the arousal process and part of her self-punishment for feeling sexual feelings. She describes herself as frigid except for these feelings.

She has had thoughts of committing violence, obscene phone calls and exhibitionism. “I didn’t really ever do that, think about doing it, but not do it.” She believes that she puts herself into trance and then a command voice surfaces that tells her what to do, “that was take a razor and cut myself inside (vagina) and destroy the parts.” It seems as if she is speaking literally and in metaphor at the same time. She takes action to destroy a part of her body and at the same time it appears that she is trying to destroy an alter ego-state named Southern, who holds her feelings of sexual arousal. Southern contains feelings and thoughts that are not acceptable to her and she concretely attacks the part of her body that is most associated with him and her arousal, her vagina. “It was

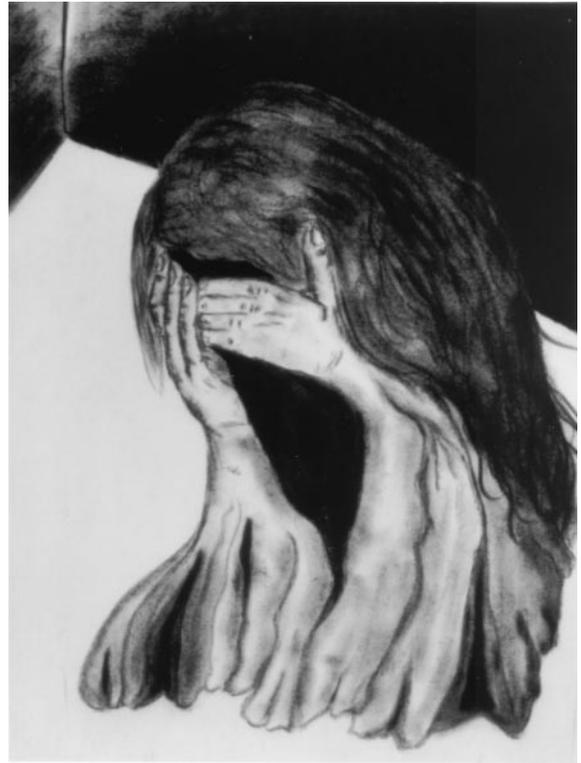


Figure 4. Faceless into Black.

that point that I just started thinking that my sexual organs did not need to live anymore.” She seems to anthropomorphize her body parts. She holds them, her body parts, responsible for her sexual urges or fantasies. After feelings of arousal and violence surface she feels feelings of “terror, stark terror.”

She has noticed that over time the little acts of self-harm are no longer satisfying “. . . cutting deep enough to draw blood but not long cuts . . .” just doesn’t bring her to the same level of relief. In general, few acts of self-mutilation are as satisfying as in the past. “For a while it did numb things. It doesn’t have that capacity now.” Self-mutilation used to help her concentrate and focus her thinking. This no longer works either. So she escalated the self-mutilation, “The burning was that I felt like I was frozen in feeling and I had to feel and that was a much more intense pain.” There were times when she was so numb that she couldn’t feel people touching her in certain places. Burning created a more intense pain than cutting. The following poem and art work (Figure 4) describe her feelings of frozen hollowness.

**Thoughts of Self-harm  
(Beginning for a poem)  
No Date**

Eyes moan in silence,  
imprisoned screams  
curl deep inside,  
words long frozen  
are held back  
by aching fingers  
clamped tightly around shoulders.  
Shield the hollowness.  
Protect from touches that burn.  
Don't look toward horizons  
that rumble with night storms  
sometimes so black they ache.  
Hold the faces and feelings out of reach.  
Yet their pulsing calls  
and you try to find a way inside  
thinking the pain will open portals  
instead of close doors.  
For the pain, numbs no more  
like a drug that has lost its effect  
And a silent voice inside  
whispers promises that  
it is in the more expansive cuts,  
the body on fire  
that the truth be known.

She does not want to traumatize others with her self-mutilation if at all possible. Yet this is a set-up for her to keep secrets and she does keep secrets. "Many people don't know about it other than my therapeutic circle. My daughter doesn't know about it, although she has seen scars a couple of times and I've lied to her about infections." Secret keeping may be maintained by avoidance or out right lying.

She has reasons for keeping her behavior private. Until recently her school was not affected by her self-mutilation behavior. When her supervisor at school heard that she self-mutilates, he suggested that if her behavior continued she would have to leave graduate school. He was supportive and kind, but firm. He wants her to finish her doctorate but he doesn't feel as if he can enable her self-mutilation behavior. He set limits. She understood his compassion but did not miss the "undertone" of his message. He did say, "don't make me ask you to leave the program." This was devastating to her. In her mind she could lose all that is important to her life. One of her primary motivations to survive and recover is her

work with women who have a similar issues. If she were forced to leave her doctoral program, this could sabotage her *raison d'être*. She expressed frustration when she said, "I think he thinks I can 'just' control it." Working with women has been a driving force behind her wish to recover.

I have fought so hard for this and I'm gonna lose everything I've fought for and what has kept me alive for so long is this work, is this compelling compulsion to work with women similar to me. I'm tired of dealing with it. It (the self-mutilation) is invading what I've worked so hard for.

She describes her interaction with the behavior of self-mutilation as, "control, not control." She can usually contain her behavior while at work or school but the minute she leaves it becomes a fight within herself. "It's like I'm always fighting." At times she does not feel as if she can control her behavior. In a literal way she understands how her clients struggle, which she finds useful as a therapist, but she takes their problems home with her. She says that, "it takes away from my life. I am tired of carrying the baggage home, I pay for it." Sometimes the burden of being a caregiver is too much. While she has empathy and understanding for her clients paradoxically, she experiences this work as energizing and draining.

Prior to this time she had been able to manage her problems during a few extended breaks from school. She has fought hard for her life and recovery and she has accomplished more than she expected. This success has been especially difficult while "dragging all this along," her childhood history and her self-destructive behaviors. She realizes she has achieved a lot and yet at this time it doesn't seem to matter to her.

Her therapist has clearly stated that she is no longer willing or able to rescue this individual from her suicidal path. This has meant that some of the more superficial "see me" self-harm has stopped. Spelling out this reality was helpful for this individual and gave her a chance to be more responsible. It also makes her more lethal. She states, "I think that that really gave me a chance. That also makes me more lethal in that any thoughts of suicide would be real pure and I wouldn't tell anyone."

Cognitively she knows that self-mutilation doesn't work for her anymore. She finds that she can control her urges better if she can catch them early, especially those related to anxiety. Today she uses painting and

drawing as a substitute for self-harm. She attributes her willingness to listen and honor the voices in her head as a helpful intervention. Painting and drawing provides her a safe vehicle for listening to her inner selves.

Often when I'm feeling the urge to do something or feeling the body compelled to, I will sit down and paint. Sometimes it'll be an alter saying, 'I have to draw, I have to draw, I have to draw.' And much of my art has come from that urge to cut.

It has been most important and helpful to her to understand what is behind the urges to cut—to understand what was feeding the self-harm.

I think finally accepting or allowing the voices to come up (helped), finding the right people especially the art therapist, those have been the things that have been most beneficial. Just stopping, at least altering the self-harm, of course there have been other ways to talk.

At the end of the interview she reports that she is in a dangerous place in her recovery process. Her feelings of shame and hopelessness are enormous. She feels as if she is lying and that she hasn't really healed. She feels as if she is screaming inside. There is great sadness.

Dammit I put in a lot of time for this (recovery). I've done everything I can. There's a kid inside saying, "I don't want to be here. I'm tired let me go. I've been good. I hurts too much (in a child-like manner). I've tried everything. Let me go please."

In the second section of her poem entitled, "The Writer," she continues the theme of hopelessness and death.

**The Writer—II**  
(For Sylvia Plath 1932–1963)  
No Date  
TWO  
4:45 A.M.  
Blue light slips  
through squinting windows  
onto the cluttered table

filled with tulips and veils,  
a mug full of curdled hope  
and crumbled paper dreams  
that tried to fly, to sing  
before being put to bed  
beneath her wintered covers.

Minutes move like the last spasms of night moths  
as the sunlight reaches towards her eyes.

she looks down and sees  
her hands floating  
over another epitaph.

### Conclusion

One characteristic that is constant within the experience of self-mutilation as described by those in this study is that motivation, sensation, perception, emotions and cognition may all change, even during one event; or that the individual parallel processes the same experience, differently, simultaneously. It is noteworthy that the alter ego-states that inflict self-mutilation are least likely to be the ones who feel the pain. This rigidity of ego-state roles is a factor of the dissociative identity process.

In the quote below Walsh and Rosen (1988) lament that the psychoanalytic studies have revealed "highly divergent explanations of the same behavior" (p. 182). They attribute these results to the fact that the explanations were idiosyncratic to each individual studied. *Yet, what if the experience or explanations of self-mutilation are not only divergent among individuals, but within individuals?* In this study it was determined that the experience of self-mutilation is divergent for each research participant and even each episode. That is the greatest commonality.

Since psychoanalysis is idiographic in nature, it is neither surprising nor contradictory that the psychoanalytic reports regarding SMB (self-mutilation behavior) have provided highly divergent explanations of the same behavior. Each of these reports has been based upon the intensive study of a single person, or, at most, several individuals. The fact that these explanations differed markedly from case to case indicates only that the determinants of the SMB were idiosyncratic to those individuals. Until commonalities can be identified across cases (i.e., beyond the issue of loss already men-

tioned), a more generalized psychoanalytic explanation of SMB is not possible. (pp. 182–183)

One of the primary threads of self-mutilation that weaves itself through all other themes is that of paradox and double binds. These themes of paradox and double binds contribute greatly to the complexity of the disorder and our lack of understanding. This is where therapists and clients can become blind-sided or lose control of good therapeutic direction. By paradox I mean that there are often two (or as in this study, even more) seemingly contradictory motivations for self-mutilation, when in fact both have meaning. To confound the issue, both seemingly contradictory motivations may answer important intrapsychic needs. Of course the theme that most closely follows paradox is one of double binds. By double bind I mean that the individual who self-mutilates is confronted with two or more seemingly contradictory demands, expectations or outcomes from the behavior (or the avoidance of the behavior), and whatever action they make will appear wrong or feel wrong. This is something like a, “damned if you do and damned if you don’t,” theme. Awareness of these complex contradictions help clinicians while working with those entrenched in this behavior. Labeling the paradoxes and the double binds is the first step to finding a way out of it. For example, it may take a map to find the way out of a labyrinth. These contradictions, and the power they have to keep an individual stuck in their patterns of behavioral acting out, are discussed but not clearly or fully explained in contemporary literature. In the larger study I counted a minimum of 17 motivations and 9 double binds and paradoxes.

The paradoxes and double binds explain why many researchers have a good understanding of one or more aspects of self-mutilation, but not the whole. They are looking at one side of the coin or one side of the paradox. What became clear is that the many motivations and experiences of self-mutilation usually attributed to different individuals with different diagnoses may be attributed to one individual or even one experience of self-mutilation. In general, as researchers, we have been like the blind men touching the elephant. Like the dissociative disordered women in this study, we are fragmented in our understanding. We are accurately describing the part of the elephant we are touching, but for the women in this study, the phenomenon of self-mutilation, even within one experience, is as diverse and varied as the body of an elephant.

Most themes that were revealed in this particular

case study were similar to or exactly the same as those in the larger study. A systematic synthesis of the five verbal interviews was completed, which revealed 12 themes. The descriptive themes of the larger study follow: (a) dissociation; (b) variable experience of pain: emotional and physical; (c) losses due to behavior; (d) control issues; (e) reenactment; (f) shame and guilt; (g) hopelessness; (h) triggers, motivations and urges; (i) sexuality; (j) self-punishment and/or intrapsychic punishment; (k) interventions, both positive and negative; and (l) disclosure. The only apparent differences between this case study and the commonalities among all five are that she had an additional category entitled Cognition due to her extensive discussion of fantasies and flashbacks. In addition, she was the only one in the study who discussed feelings of sexual arousal associated with self-mutilation. Yet, all in the study discussed issues of appearance and sexuality related to the behavior of self-mutilation.

In summary, I believe that self-mutilation, as described by the research participants in this study, is a metaphor for the internal splitting of a dissociative disordered client. In addition, it may actually reinforce the internal splits by suppressing the memories of dissociated traumatic material. This woman said that self-mutilation pushed back memories’ voices. Keeping the memories suppressed reinforces the fragmentation/dissociation and the need for rigid boundaries between alter ego-states, those that know about the trauma and those that don’t. This study suggests that the body is a metaphor for the mind. For that matter, their adult lives may be a metaphor . . .

For survivors of childhood sexual abuse, chronic self-injury is both a sequelae to and a behavioral container for unintegrated traumatic stress . . . acts of self-injury sometimes reenact early traumatic abuse; at other times, they act as a way to show exactly what happened without breaking the abuser’s injunction of silence. (Calof, 1995, May/June, p. 16)

Most in the study stated that no one had ever listened to their detailed descriptions of self-mutilation without judgment, even though they had been in therapy for years. Although this study was not designed to be therapeutic, it was described as therapeutic by all, even if it was a painful experience. Thank you notes were received from four of the five co-researchers.

Dear Erica (sic),

You gave me a gift by your kindness and acceptance . . .

THANK YOU POEM

Life is a momentary  
touch  
Found when taking a chance  
To be vulnerable is to accept  
Both gift and loss—  
the back and forth dance of life  
Because of this time together . . .  
I dance a little longer.

Co-researcher A, 1997

The intensity of this research was rewarding and difficult. This research challenged the author to the core, emotionally, spiritually and even physically. As the co-researchers literally scraped their skin down to blood, tissue and bone, she was figuratively scraped to the bone as well. There were times when she thought she had taken on too great of a task. Ultimately, she used this challenge, to go deeper within herself.

At one point the author painted a portrait of herself as if she were a woman who self-mutilates. It was helpful for her to figuratively walk in the skin of one who self-mutilates. It is through the creation of personal art work and poetry that this author was able to continue to listen with compassion and write.

Like the very blades they hold against their skin, the experience of self-mutilation cuts deep into their psyche. It tears their soul apart in the same way it does their flesh. It pushes back memories and quiets the voices that need to be heard—the voices that need to be heard by us all.

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