

to become established, so that over time the capacity for self-knowledge can be developed. The idea of the psychotherapeutic relationship acting as a second skin allows for the release of the pressure on the person's actual skin, and attacks on the therapy can be held and dealt with by the psychotherapist.

## Chapter 3

# Turning the anger inwards

## Masochism and mastery

This chapter is about the terribly destructive nature of cutting, and the way aggressive instinctual processes are affected and linked with both the early parental environment and later traumatic experiences. In the first chapter, Glasser's (1992) core complex was outlined: briefly summarised as the fantasy of fusion leading to annihilation anxiety; the concurrent defensive responses from that, and also from the fear of the mother's indifference; both these defensive responses leading to aggression turned inwards against the self, and enacted on the surface of the body. The encaptive conflict that I suggest as a central unconscious psychic formation among the young women seen for psychotherapy who were self-harming is a variant and possibly perverse side formation of this core complex. In this context, it is interesting to note that Glasser's (1979) original concept was seen in the context of perversion. However, instead of fusion with an idealised mother, the encaptive conflict involves the captivation by an avaricious object who overwhelms, and from whom there is ambivalence about separation. The fear of being possessed conflicts with the fear of rejection, and the psychic conflict leads to a defensive compromise. The solution to the conflict is hostility, which is turned inwards against the self and the body, rather than directed outwards on to an external object.

Writing about aggression and violence, Glasser (1998) refers to conscious, intentional action involving the actual assault on the body of one person by another. He separates out self-preservative violence and sado-masochistic violence. In the former type the aim is to negate danger, while in sadism the aim is to inflict pain and suffering. For the young women who were cutting, the attacks seemed to involve a combination of both these types of aggression. Instead of attacking another person, the young woman turned her violent action against her own body, but *as if* attacking another person, or a separate part of herself. It seemed that her

body was at that point both connected and dislocated from her sense of self. At an unconscious level her body, or part of her body, felt owned and possessed by an all-powerful 'other'. The patients hurt themselves to ward off the dangerous thoughts evoked by the partial emergence of the sensations linked to the encaptive conflict.

In both cases of aggression – towards other people and the self – the underlying motive is the same: 'a wish to attack *thoughts*, in oneself or in another' (Fonagy 1995: 582). So what are the terrible thoughts that need to be attacked and kept at bay at all costs? The thoughts are those resulting from uncomfortable sensations and frightening or anxious feelings. This discomfort originates from processes derived from early object relations. In addition, it may include how experiences of specific trauma, such as physical and sexual abuse, have been taken up, internalised and so managed. The encaptive conflict is a formation involving a tyrannical inner object configuration which both overwhelms, and from which there is ambivalence about separation. The fear of being possessed conflicts with the fear of rejection. In those who are harming themselves it involves the earliest experiences of object relations, and how these are remembered and structured. This structure can be compounded by direct trauma or cumulative traumatic events. Alternatively the encaptive conflict can be triggered and activated by specific trauma, which then provide the impetus for its emergence. The process is intrapsychic, it has become an inner object relationship, although it originated as an interpsychic relationship. The wounds from cutting can be seen as a metaphoric representation of the encaptive conflict, suggesting both the marks of enslavement and the desire to cut free. In that sense the symptom can be seen as evidence of the return of the repressed, and a statement about the self and what has happened.

Self-harm is a registering of the dynamics of an inner object formation, a form of mapping on the body, and an embodiment of the related mental phenomena. It is in part an enactment, founded on projective identification of unintegrated feelings from these earlier experiences and trauma. What is felt initially and internally as a sensation is externalised and fixed as memory on the skin. Paradoxically, cutting is both a defence against thinking about the past, and the evocation of sensations of an earlier violation in another form. As a noticeable proportion of the patients seen for psychotherapy had been abused during childhood, the specific link between this and cutting is explored in the next part of this chapter.

## The dynamics of abuse and the link with self-harm

Clinical recognition over the past twenty years of the long-term effects both of child sexual abuse and physical abuse has emerged from findings linking later mental illness in women with these earlier assaults. In general, those who report abuse are more likely than those who do not to experience symptoms of depression, emotional problems and suicidal ideas or attempts. They also report feelings of low self-esteem, alienation, distrust, sexual acting out or sexual difficulties, and self-harm. Other long-term effects may include eating disorders and induced obesity. Some children cope with abuse by dissociation, or attributing the sensations experienced to another child or to another part of themselves, while others repress the memory or try to block it out from their conscious memory. Even if the dissociation seems successful, the underlying distress will usually re-emerge in some form of symptomatology, or later as a recovered memory. The effects vary according to the age of the child, the life circumstances, the frequency of the abuse and the degree of aggression and physical damage involved (Gardner 1990).

An important study by Van der Kolk *et al.* (1991) demonstrated that early histories of physical and sexual abuse, as well as parental neglect and separation, were strongly linked with later acts of deliberate self-injury. De Young (1982) found that 58 per cent of the forty-five sexually abused women and girls whom she interviewed injured themselves by cutting, burning, attempts to break bones or self-poisoning. Most used several methods, and continued to hurt themselves over months and years. The motivations given were varied, but included the wish to make themselves sexually unattractive or ill so that further assaults would be avoided. Some were trying to seek help, while others were punishing themselves for the abuse which they felt responsible for, or had enjoyed. De Young suggests that for some the act of injuring themselves can be seen as a form of ego reintegration, and quotes the case of a patient who would cut her arms after each sexual assault, which seemed to cleanse her of guilt and responsibility. This may be an example of the self-preservative type of violence.

The word 'trauma' is used here to cover both physical and sexual abuse. In my view there is a correlation between the extent of the trauma and the degree of powerlessness experienced by the child during the abusive acts. The child is often left with a feeling of being different and distant from others, and wary of future relationships. In some cases, this psychic closing off can be seen as a defence against the feelings aroused

by the abuser. Passive resistance and dissociation of feeling seem to offer a type of defence against an overwhelming situation. One way to cope is to cut off from any feelings. Dissociation works because it gives a sense of personal control and power, in a situation where there is none. If left unresolved and not treated, it later carries over into relationships with others. It also carries over into the relationship within the self and becomes reinforced as a way of being.

The encaptive conflict can be compounded or triggered by later abuse because similar sorts of dynamics are involved. The 'relationship' or experience with the abuser can become internalised as an overwhelming, intrusive and dangerous figure in the psyche, yet one with whom there is deep involvement, and from whom it is hard to break free. The involvement can be especially complicated if the abuser is also someone who was previously non-abusive, trusted and loved. The abused consciously longs to have nothing more to do with the abuser, the whole experience, and to forget about it forever. Yet in sexual abuse the relationship is often explained to the child as a 'special' relationship. This creates an additional psychic dilemma when the child then simultaneously perceives and confuses the 'good' object with the 'bad' behaviour. The unbearable confusion leads to a splitting with the rage and horror internalised as part of the 'bad self', thus allowing the child to hold on to a fantasy of the originally loved and needed object as 'good'.

For example, a woman patient in her late thirties came into private psychotherapy with feelings of depression and hopelessness, feelings which quickly emerged in the therapy. In her twenties she had cut herself over a period of several years, and had long-term problems controlling the amount she ate. When I met her she was seriously overweight. About six months into the therapy she revealed that, while away at the weekend, she had realised that between the ages of 8 and 12 she had been regularly sexually abused by her uncle on frequent weekend visits. She had known about this, but understood and thought that it was part of her 'special' relationship with him that involved secrets. Once she realised she had been abused, the patient insisted she had no feelings on the subject, and for some time she did not speak again about her memories. Later she persuaded herself that if she had wanted to have stopped the abuse she could have done so, and that therefore she was responsible for it and wanted it to happen in the first place. She also felt guilty because she had betrayed the aunt who loved her. Both aunt and uncle had given her lots of presents and this contributed to the guilt she felt. If they were 'good', loving and generous then she became 'bad', hateful and ungrateful.

For people who have been sexually abused there is a desire to break free from this inner, abusive, malevolent figure – an internalised representation of the person who externally and physically threatened total possession and painful intrusion into the body. None the less, this desire to separate will stimulate an unconscious experience of rejection, abandonment and isolation. As explained at the beginning of this chapter this is linked to the earlier patterning, and the threat of loss leads in turn to low self-worth and feelings of despair. This conflict is unconscious, and one way of dealing with the uncomfortable sensations involved is to inflict pain on the body.

Furthermore, the body violation and actual penetration of the skin by cutting can also be seen as in part a repetition and unconscious re-enactment of the processes derived from the experience between abuser and abused. This time it takes place apparently under the young woman's own control and, at one level, because of her own wishes. By opening up the surface of the skin, aspects of the dynamics of the internalised experience are repetitiously evoked, though not necessarily consciously recollected. One function is seemingly to excise and expunge what was internalised, by getting it out of the body and externalising it by fixing it on the body surface. The angry violence is unconsciously directed both at the tyrannical, abusive object and the victim self. It is self-preservative and sado-masochistic – and ultimately self-destructive. In this sense what is appropriate anger at something which may have actually happened in childhood is both expressed and suppressed at the same time.

Anne, whom I discuss again in later chapters, had been sexually abused by an adult relative over a period of a few days when she was young. She had been terrified and physically hurt. In psychotherapy, Anne was able only occasionally to speak about the experience, and she felt very anxious about talking about it at all. She acknowledged no anger, and initially the very mention of the abuse provoked a period of cutting her arms and thighs. Four years after the abuse had happened, Anne began to try to control her body, initially by not eating, later by bingeing and vomiting, and laxative use, and then by cutting and attempting suicide. This seemed to provide a form of compensation for what she could not control, which were the thoughts and images that came into her mind about the abuse. What was difficult was expressing the images, sensations and feelings that haunted her in words, so that they too could begin to feel under control. The way in which the encaptive conflict emerged during the therapy is explored through detailed session material in Chapter 6.

Perhaps, for some of the young women, the attacks on the body were an attempt to recollect – to somehow bring to mind – earlier abusive



experiences. The dissociation and inability to remember the abuse can, paradoxically, reflect a disordered inner preoccupation with it. This preoccupation can block internal space, preventing thoughts and feelings from being assimilated. This in turn would relate to the fact that no child could adequately integrate such a mind/body assault. The child is unable to integrate the abuse adequately at the level of its whole psychosomato-affective existence. The trauma may be grasped and interpreted by the child some time later than his or her original observation of it by 'after-revision' or 'deferred action' at a time when she is able to put it into words.

However, in the inner world of the child the trauma often remains 'thing-like' with little room for the use of fantasy and metaphorisation. It is then that the 'real' ritual and procedure of cutting, burning or hitting the body, or laying out the razor and counting out pills for an overdose, comes to repeat the 'thing-like' quality that belonged to the earlier trauma. In my view the procedure becomes a reification of the internalised conflict. It is too difficult for the child to think or speak about what happened, and so it all remains in a 'concrete' and indigestible form. It is as raw and unprocessed as the action of wounding the skin and bleeding. In a similar way to the abuse which was 'something that happened', the cutting becomes 'something that I do'. The defence is an inhibition of thinking because the sensations and feelings involved in thought seem unbearable.

The physical, concrete nature of sexual abuse seems to leave little space or opportunity for any sense of sexual fantasy, but does leave the accompanying guilt often fuelled by a strict and punitive superego. If there was a body response of arousal or gratification, or a confused feeling of having been loved, the abused may be left with an idea about the 'betrayal of the body'. If the child knows, then or later, that something wrong took place, there is a sense of the body colluding with the aggressor, and of having been in conflict with the child's own mind. In this situation, the young woman uses harming herself as a way of punishing her body for any gratification she might have inadvertently experienced. The punishment can also be linked to a feeling that she, as a child, was somehow to blame. This belief often remains, despite other people's reassurances to the contrary. At a deep level, the child takes on the guilt and responsibility, and so feels the need to hurt herself and make reparation. The superego, formed from identification with, and processes linked to, feared authority figures, often seems to be especially cruel and critical among those who have been abused. There is also sometimes a perfectionist and strongly narcissistic element involved. In the following clinical extract, I want to

draw attention to the power of the critical superego, and the weight and implications of carrying guilt for one patient.

Laura, who is discussed further in Chapter 6, disclosed sexual abuse by a relative. The authorities were involved but, for various circumstantial reasons, all charges were dropped, and Laura was left dealing with the after-effects of not just the abuse, but also the shock of the news for the immediate and extended family. One result of the disclosure of the abuse was that various family members no longer spoke to others, while Laura's immediate family tried to pretend that nothing had happened, and none of them spoke to her about it. Laura felt very guilty about everything that had occurred. It seemed to her that she was left carrying the guilt of the abuser, and a feeling of responsibility for the abuse, the disclosure and the rifts in the extended family.

The abuse had happened in the past on an intermittent basis over several years. Laura had never forgotten that it had happened, though she said that for a while she thought it had happened to this other girl who lived inside her, and not to herself. She spoke of her disgust about men and boys, but this left her feeling excluded among her college friends, who were all talking about who they wanted to go out with and who they fancied. She also felt disgusted by herself. Laura wanted no part in being female so she chose to wear men's clothes when she could – usually in large sizes and baggy so that her body shape could not be seen, and had her hair cut very short. Again, this set her apart from her friends.

I wondered whether at one level there was an embodying of the confusing figure who had abused her. This was a relative whom she had loved and trusted, but whom she now hated. Laura said she felt that she must have encouraged the abuse, that she felt guilty about this and that the responsibility lay in her body. She thought how she had looked had led to the abuse taking place. She spoke about how important it was now to cover up her body, and leave no room for anyone's imagination about the shapes underneath. Shortly after the disclosure she had begun to lose weight, but at the time of the therapy she was eating a great deal, so that her body form became less defined and she was able to build some sort of protective body armour. It almost seemed as if her 'guilty body' was being wrapped up and kept out of sight so that no further damage was done. Intellectually, Laura understood that the abuser was responsible and should feel guilty, but emotionally she took the blame. Her physical appearance and the deliberate self-harm represented the solutions she had found for this. She was reluctant to let go of them and think about the feelings involved.

The inner dynamics derived from childhood experiences of sexual or physical abuse – both being forms of mind/body assaults – involve mind and body memories, and mind and body fantasies linked to revenge, punishment or removal. The inner configurations derived from early object relations tend also to involve mind and body associations. The tensions arising from these compounded processes are relieved by attacking the body. Both sexual and physical abuse involve penetration of the body barrier, and as mentioned above, it is this that is unconsciously recollected by cutting. All violence and inappropriate touching of the body have their counterparts in the mind, and leave the traumatised young person fearful of further intrusions. Some of the same sensations may emerge as a result of witnessing physical attacks against siblings or another parent. Children who are witnesses to domestic violence are frequently fearful, angry and anxious, and can feel guilt and responsibility. One way of dealing with these feelings is 'letting rip' on the skin – a substitute for the direct articulation of anger which is often so difficult for young women to openly express.

Nicky, who often seemed to find herself in risky situations, was a friendly, open and overly trusting person. She seemed to insist on being cheery, and tried, as she said, always to look on the bright side. Following disclosure of sexual abuse by her mother's boyfriend, she had ended up having to move away to live with another member of her family. As she saw it, her mother had chosen her boyfriend over her daughter. Again, despite the involvement of the authorities and the abuser's previous convictions, the abuse was not proven, and he remained free to stay with Nicky's mother. One of the strangest aspects of the abuse was that, aware of the boyfriend's previous history, a social worker had regularly visited the home, and had involved Nicky and her brother in exercises encouraging them to say 'no' to inappropriate touching, and explaining how to protect themselves. It was only later that Nicky linked this to protection against sexual abuse from her mother's boyfriend, which ironically was actually happening at the same time.

In the therapy it seemed very hard for Nicky to think about how angry she was both with her mother and her mother's partner. Instead she wanted to cut herself, take drugs and get very drunk. She longed for a 'proper relationship', she wanted someone to love and to love her back, but she only met men who wanted sex, usually a one-night stand and nothing more. It was too difficult for her to connect with the rage she felt towards all the adults who had let her down, and to minimise the rage she inflicted on herself. Each new man whom she slept with would be, she hoped, the one to love her, and each betrayal left her feeling a little

more desperate. In terms of the encaptive conflict, Nicky appeared enthralled by a non-protective, negligent abusive part of herself, revealed both in the sexual acting out and by the self-harm. Her cheeriness and positive wish to make everything better belied the deeply destructive aspects of her inner object relations. A constant preoccupation she voiced was about the part her mother had played, both while the abuse was taking place and after the disclosure. Did her mother care? Did her mother know? How could her mother have chosen him over Nicky? Nicky kept visiting her mother in an attempt to somehow find answers to her questions.

Key aspects that link abuse with self-harm are control and power. Both are owned by the perpetrator during the abuse, and retrieved and repeated by the abused when she harms herself. In this way there is an experienced traumatic interplay between the perpetrator and victim that is internalised and remembered through other relationships and behaviours. It builds on and consolidates the earlier patterns found in the encaptive conflict. It is this interplay between masochism and mastery that becomes 'intraplay', and it is this that is explored in the following section.

### Aspects of masochism – the links with trauma and self-harm

Freud (1924) distinguished three forms of masochistic states of mind which he called erotogenic, feminine and moral. The erotogenic form of masochism, which is a form of sexual pleasure found in pain, was, he felt, ultimately the basis for the other two categories of masochism. This state of mind underlay many types of sexual relationship, and linked back to infantile sexuality. In his description of feminine masochism, Freud saw it as a possibility for either sex placed 'in a characteristically female situation' of passivity, or being hurt or injured (1924: 162). There was a point reached where pain, or unpleasure, reached a state of such tension that some sort of internal excitation of the sexual instinct occurred. The experience would result in a form of body memory, which would act as some sort of base for future similar experiences.

The link between masochism and its counterpart, sadism, can be understood by seeing masochism as a derivative of the death and destructive instinct as described in Chapter 2. The libido diverts the instinct outwards into the external world, where it can be described as 'the destructive instinct, the instinct for mastery, or the will to power' (Freud 1924: 163). The part that is transposed outside on to others is sadism, while the portion that remains inside the person directed against the self is masochism. This interrelationship between sadism and masochism can



change at any point, so that what is projected outside can be re-introjected, and so on. It is also part of any normal infantile and childhood development. Moral masochism is not so clearly linked to sexual excitement, although the erotic component is still present. On one level it seems that it is the suffering itself which is important. Freud linked this to a sense of guilt which was mostly unconscious, and to the need for punishment which the actual experience of suffering fulfils. The person then experiences some pleasure at their own destruction and suffering.

When childhood sexual abuse takes place, the child has been prematurely sexualised, forced to grow sexually but unable to grow emotionally. As mentioned above, the memory of the body pain from both physical and sexual abuse leads to some sort of body/mind correlation around pain, and an inner tension contributing to excitation. This is either deeply repressed or dissociated, remaining in some split-off corner of the mind. However, mental representations are greatly affected and chaotically influence the internal world. There can be an unconscious compulsion to repeat the experience, and masochistic, destructive attacks on the body partly fulfil that function.

The sense of guilt linked to masochism can be conscious, partly conscious or repressed. Children usually feel that things are their fault, so it is not unexpected that there is a strong sense of guilt around the idea that something wrong has taken place. Furthermore, in the case of sexual abuse, the 'something wrong' that has happened is usually a secret, and most children who have been abused believe that, as they took part in it, it must be their fault. The child can end up carrying the guilt of the adult abuser, as in the example of Laura. Another aspect of guilt is a feeling that somehow as a child they could have prevented what happened. In sexual abuse, the abusive relationship is often hidden, seen as a 'special' secret and yet stigmatised, and this aspect is also recalled and re-enacted by the secrecy and feelings of stigma associated with cutting and scarring the body. By internalising the dynamic processes, the child may keep the abuser safe as an external 'good object', and this may explain the link between masochism and separation difficulties. This is strongest when the parents have been the source of the trauma. It is as if the young person keeps close to the abusing parent as part of their own masochistic actions. This point is picked up by Glenn (1984), who comments that the child (who has been hurt by the parents) seeks pain-producing objects in order to imagine his parents' presence.

### Aspects of mastery – the links with abuse and self-harm

The concept of mastery inevitably involves a relationship with another – initially externally, then as an internalised object. Mastery reflects a desire to ignore or neutralise the other person's wishes or needs. There is no space for difference or otherness – again, interestingly, no separation. The other person/victim is seen and treated as a part-object available to be used. This is why mastery is so destructive. Dorey writes: 'the aim is to reduce the other to the function and status of a totally assailable object' (1986: 323). This is achieved first through perversion, when mastery takes place through seduction of a sexual partner; second through an obsessional configuration demonstrated in the field of power and duty through force. When a child is abused, the abuser may use both configurations of mastery to get his way. The abuser often wants to believe that the abused is subject and dependent, and agrees to what is happening. In some situations the person seeking mastery makes an actual imprint on the body of the other to confirm their power and control. In adult sado-masochistic relationships this can be made through the use of a whip or bondage equipment.

When this relationship of mastery is internalised, and for some of the young women repeated by deliberate self-harm, there is then a corresponding need to mark and wound. The sado-masochistic elements are imprinted and reflected in the slashes on the arms and legs. These can be seen to replicate the marks of enslavement and imprisonment to the wishes of another, previously experienced at an emotional level when the actual abuse took place, but then internalised. At an even deeper level they represent the dynamics of the encaptive conflict based on the earlier inner object relations. The cuts may be seen as symbols of this and of what has subsequently happened to the self – scarred through emotional abuse, physical abuse or internally 'marked' by sexual abuse.

When mastery takes an obsessive form, the central issues become those of domination and appropriation. The obsessive is compelled by internal destructive drives which are perverse and narcissistic, and are then projected out into the external world. The body is treated in a perverse way. Perversion is used here in the analytic sense, in which 'the individual afflicted does not feel free to obtain sexual genital satisfaction, but instead feels subjected to a compulsive activity that takes over and involves unconscious hostility' (Welldon 1988: 155). The recipient of such an obsessive form of mastery submits and internalises the experience, and, later, compulsively repeats the experience – this time having power and

control over the destruction. Wellدون reminds us that victims of perverse actions or attitudes will not necessarily act in a perverse way themselves, but there is great strain and difficulty in achieving mental equilibrium if there has been an experience of perverse parental behaviour in early life (1988: 156).

At times, these aspects of mastery fuse into one another, and these unconscious formations contribute to the need of victims to cut themselves. For some patients, cutting takes an obsessive form. These abusive experiences probably exacerbate already over-stimulated internal destructive and aggressive drives.

There is a further aspect of mastery to consider, what Freud termed 'the instinct for mastery'. This can be a transformative activity, a way of changing the death instinct, and therefore controlling destructive urges (1924). Another description is of the instinct for mastery as the driving force behind children's play, as 'the impulse to make over in the mind some overpowering experience so as to make oneself master of it' (Freud 1920: 16).

### **The need to repeat an abusive experience through attacking the body**

Repeating an experience is often linked to the need to remember what happened. Repeating and remembering are closely interwoven. The repetition of hostility, in the form of the act of harming the body and the feelings associated with that act, is a kind of remembering, albeit an unconscious one. In turn, remembering as a conscious mental act involves some form of repetition. Uncovering the unconscious need to compulsively repeat earlier experiences is the cornerstone of analytic understanding and treatment. If we repress something and try not to think about it, it will seek to return even more powerfully through dreams, fantasies, symptoms and acting out. With increasing awareness, the repressed or denied comes into consciousness, and so can be understood. However, repeatedly attacking the body can be seen as a form of mastery by working through, or can be seen as related to the most instinctual part of our unconscious and a form of sado-masochism. In other words, the need for repetition can either be seen as a process that allows us slowly to gain control of a situation that was previously out of our control – a form of revenge and so triumph over childhood trauma; or it can be seen as a process through which we endlessly punish ourselves, and perversely and narcissistically gratify that urge for punishment. One is a process of mastery, the other of masochism. What I am suggesting here is that there

may be a fusion or interrelationship between the two inner processes in those who are cutting.

One effect of repeated cutting is that this re-creates, represents and may reinforce already embedded and burned-in body memories. Traumatic repetition is, like many physical over-reactions, an excessive response. When this happens the repetition, rather than leading to the process of transformation via mastery, becomes a more self-defeating and masochistic process. This is linked to the belief that 'this is what I am' (guilty, hateful, angry, trapped and so on) – 'so this is what I do' (cut, hurt, bleed, feel sore). Both the transformative and self-defeating aspects of mastery are blended in a given action. The danger, as previously discussed, is that the behaviour contains its own addictive aspects. The term 'traumataphilia' is used to describe this unconscious and compulsive need to repeat abusive experiences. One possibility for interrupting this compulsion is that through the therapeutic relationship some freedom from this need can be found.

### **Fusion and intraplay in the after-effects of trauma which lead to self-harm**

The intrapsychic dynamics become fused with one another quite quickly. In other words, any distinction between the self and the other object involved in the traumatic experience become blurred and indistinct. The person who is harming herself demonstrates aspects of omnipotent self-sufficiency, and becomes identified with the aggressor. In contrast, another form of fusion that can emerge is with the victim – corresponding to the opposite of identification with the aggressor. This is where the person is unable to project, or to maintain the projection of aggressive feelings, away from the self. In other words, the person cannot turn passive into active aggression.

The idealised object, still largely fused with the primary narcissistic self, is seen not as omnipotent, but as a victim; while the subject, instead of turning passivity into activity and externalising the aggression or imitating the aggressor, turns the aggression against himself, becoming one with the victim-object.

(Orgel 1974: 531)

The roots of this state of mind belong in infancy to a type of primitive identification with a parent who is unable to provide a safe focus for the projection of aggressive instinctual impulses, and the satisfaction of the



infant's needs. The developing infant requires someone who can respond to the discharge of aggression by an appropriate balance of loving counter-aggression, and direction-giving limit setting. When this happens there is a limit set on self-injury, such as biting and scratching, which can establish a prototype for later experiences. If this does not happen then aggressive impulses can become over-stimulated, and feel dangerously out of control.

Infants who are depressed because of failures in attachment can slowly become self-destructive, as there is no one on whom they can reliably vent their aggression in the outer world. The only available object is the young child's own body, as she is incapable of expressing any aggression in an object relationship. This is not the same as the sado-masochistic relationships discussed above; rather the experience is of an inability to defend against the aggression. Indeed the victim role is sought out, and there is an immediate identification as potential victim. For young women who have experienced emotional neglect, or some form of abuse, there is little sense of safety and appropriate limit setting. They experience alongside the trauma a form of regression to a place where no boundaries are maintained, and there is no safe place for angry and frightened feelings to be contained and managed.

In the following clinical material the patient demonstrated this fusion and intraplay of aggressor and victim. At times it seemed that her obsessive compulsion to repeat through self-harm was mainly fuelled by perverse and narcissistic drives, and there was little sense of her gaining control through her actions, or making any change to the way she coped. Martha was a woman in her early forties who was brought to private supervision by a colleague. She had received psychiatric treatment in the past, and had had previous counselling. She was referred by her doctor for counselling at the surgery, and then taken on for open-ended work. However, nothing seemed to curtail her cutting, which she had been doing since adolescence. She cut whenever she felt upset by others. This occurred frequently, since she seemed easily overwhelmed by circumstances and her own sense of hopelessness. She had also taken several overdoses in the past, and this threat remained. During her therapy she spoke of her inability to see herself as ever being different. She was married but lived with her husband as 'brother and sister', finding the idea of sexual contact repugnant. Martha was not able to work, but sometimes carried out clothes alterations for neighbours in return for a small fee.

During therapy it became apparent that this woman's fantasies were linked to a neglectful and indifferent mother, later compounded by inappropriate sexual touching by her grandfather. She felt unsafe away

from home, and found the short journey to the sessions highly stressful. She was emotionally very fragile, and so the cutting seemed to provide a boundary for her, and some form of identification. If she cut she knew who she was – 'hopeless Martha' she called herself. Her expectations were that she would be let down, or left, or forgotten about, and this inevitably put the therapist under enormous pressure. Martha's belief that cutting was the necessary and only possible solution revealed her omnipotence and narcissism. She could do it alone, it worked, and cost much less than the counselling. She was frightened at any display of her feelings, and seemed to be 'at home' with her victim status. Her envy and rage were muted, but very powerfully projected on to the counsellor who felt buffeted by different emotions. These ranged from an anxious, gnawing concern about Martha's welfare, to impotent frustration and fury – a state no doubt experienced by Martha's husband in their sexless marriage.

It seemed that Martha's inner world was primarily populated by two fused figures structuring the encaptive conflict: one a poor, deprived victim who needed to bribe, wheedle and manipulate to get anything for herself; the other a denying, all-powerful, cruel figure who could do anything and needed no one. The struggle in the counselling was to see if there was a part of Martha that could allow these aspects to be recognised. Over several years it became clearer that for Martha thinking about these sensations was too dangerous. She continued to cut, especially after sessions where her self-made equilibrium was threatened, and indeed she spoke again about death as the only real answer to her 'hopeless state'. The destructive part of Martha seemed to gain strength as it came under increased threat, and the splits were firmly maintained. It seemed as if it were not possible for Martha to have a sense of unity of her self, and to bear the pain of insight. The counsellor felt increasingly close to being submerged, and in the supervision we discussed possible ways that this could be held and managed. The ending was precipitated by the counsellor feeling that she needed to strengthen the liaison with Martha's doctor, a move with which Martha did not agree. She felt that the counsellor had betrayed and let her down by this idea, and said that she would not continue the treatment.

This case suggests that Martha's conflicts, derived from the maternal environment and later abuse, might well have been traceable back over at least three generations. One could speculate that Martha's mother was repeating her own experiences of parental handling, and that she too might have been abused by her father – the grandfather who abused Martha.



### **'Cutting off one's nose to spite one's face'**

The unconscious encaptive conflict is fuelled by, and interacts with, instinctual aggressive processes. Instinctual processes are also affected and linked experientially to the maternal environment and early parental handling. The internal and external aspects are mutually influential and adaptive. This dialectical process is graphically illustrated by Ritvo (1984), who outlines the developmental sequence observed in the behaviour of a 21-month-old boy. Initially as a baby boy he bites at his mother's breast as a way of gaining pleasure, yet by a year old this has evolved into an organised aggressive response, usually as a result of frustration. At this stage it is still directed outwards – as he is biting, hitting or throwing actual objects. After an incident when the infant throws a glass, another child is injured and the 1-year-old boy is told off. In the months following this event, whenever the small boy is discomfited, alarmed or spoken to sharply, he says he is being bitten – for example, he complains that the nappy rubbing him is biting. Ritvo's suggestion is that the mother's anger, worry and sharp words when the boy threw the glass may have been a dynamic factor in the timing of the boy's reversal of the drive, turning it against his own body.

The observation showed that by 21 months, the external object had become the little boy's own body. In other words the internal feelings were being dealt with through the use of his own body. This action was reinforced by the boy's fear of losing the love of the adult if his aggression were to be directed outwards. This example demonstrates the process involved in the developing use of the body to express psychic conflict – the child uses the image and perception of the body to externalise and master his aggression. The instinctual processes are affected and altered according to the experience of object relations. The resulting process turns back on the child in the form of fear. In adolescence there is a re-emergence of the strength and danger of instinctual processes such as aggression, and a re-emergence of ways of managing it – although these are obviously adapted to more age-appropriate modes of expression. The emerging aggression can become inhibited or uninhibited – either way it can feel uncontrollable.

### **Inhibited aggression**

The development of these internal processes is also affected by other external aspects including social and cultural factors. It is well known that the socialisation of girls, despite the widespread knowledge

of assertiveness training and the need to voice feelings, still carries a deeply embedded prohibition against aggressive behaviours and outward expressions of anger. The threat of such behaviours is the loss of sexual identity and attractiveness, alongside the loss of a favoured female characteristic of loving concern and service. The result is that young women's anger towards both men and other women can be redirected against the self or the body, or against the even more powerless such as their children. An accompanying aspect is the tendency for women to seek approval from other people, which leads to compliant behaviour.

Alongside these social aspects there are more subtle processes which lead to the inhibition of aggression. One is repression, which serves as an obstruction between the different layers of the conscious and the unconscious. While this can be seen as a horizontal obstruction, another process – dissociation – can be seen as a vertical barrier, separating and isolating the traumatic experience, so that the central self escapes from the pain and the reality of what has happened. It is not just an overloading of the circuits; there is a breakdown between the event and any sense of its meaning. With both forms of inhibition, all the complicated conflicts between opposing emotions, such as love and hate, are kept out of conscious awareness. There can also be an inhibition of anger because of fear of what the effect on another person might be. A further complication is that when angry feelings cannot be directed outwards, either verbally or physically, it can be because there is a sense of the inadequacy or fragility of the other person. For example, some of the patients seen for psychotherapy would talk about needing to protect their parents, especially their mothers who might not be able to cope or manage. The secret cutting thus helped the young women by relieving the tension of such inhibited feelings, and at the same time in their minds no one was being hurt by the action. The fear of damaging another person can be dealt with through psychotherapy.

### **Uncontrolled aggression**

Sometimes sensations of aggression can feel uncontrollable – this is especially true during adolescence. This could be compounded by an inability to mentally represent feelings of anger and fury – in other words, to put such affects into words. Fonagy's understanding of what he calls the capacity to 'mentalise' defines this as 'the capacity to conceive of conscious and unconscious mental states in oneself and others' (1991: 641). He points out that the ability to represent the idea of an affect or

sensation is crucial in the achievement of control over overwhelming affect. He goes on to argue that the development of this capacity is dependent on a degree of consistency and safety in early object relationships, and what he calls 'good enough' psychic functioning in the parents to 'empower the process of internalisation' (1991: 642).

The inability or inadequacy to mentally represent affects then compounds the sense that they are uncontrollable. The experience of this functional disturbance leads to action. This takes the form of turning the anger inwards against the self (predominantly found in young women; cutting is one example of this), or, paradoxically, a complete lack of control of aggression in the external world (predominantly found in young men), or an experience where both happen – extreme aggression inflicted both on self and other.

Pithers (1983) describes his work with a group of young people who violently acted out feelings either towards themselves or each other. Conventional psychotherapy was inappropriate, so Pithers used an activity-based approach. He writes: 'if I tried to remove "fuck" or "shit" from their vocabulary little else would remain and the unsafe little structure would collapse, their social behaviour is inelegant, their controls primitive' (1983: 2).

One of the young people whom Pithers describes is Kim, a tall and powerful skinhead noted for her quick temper and instant violent retaliation. His compelling account continues that on one evening she knocked out one of the boys in the group with little effort, because he referred to her as female. Kim tried to disguise her gender because she hated being female. The denial included trying to get rid of her breasts, which were large and prominent. Kim had tried to remove them a number of times, including by using a hacksaw. Her left breast was the most mutilated, and was subject to a recurring infection for which she was given a large dressing, which only served to accentuate what she wanted to get rid of. Pithers gives a moving account of containing her threatening violence towards him, by getting her to rock him in an activity which he used to great effect with deprived young people, though usually the other way round, in that he would rock them. In this instance:

eventually she began to hold me more firmly and, as sometimes happens the experiences overwhelmed me. I began to cry and as I did she held me more tightly. Until as she struggled to contain it she held my head to her breasts.

(Pithers 1983: 11)

Pithers believed that this was a key moment in Kim's experience, and one that they could both talk about in terms of Kim starting to accept that she was female. If aggressive processes and sexual activity are key elements in adolescence, they can become especially important in inarticulate young people with only rudimentary controls. Adolescents like this have few controls for dealing with overwhelming feelings; their response is based on impulsive action and accompanied by an impoverished inner world. When the perception of the world is crude and simple, the conditions for developing reflective and thoughtful behaviour do not exist. Then the response is based on impulse and acting out. To change this, and develop the ability to think about one's own feelings and other people's, there needs to be modelling or encouragement by a respected adult to help the child or adolescent to think imaginatively. Through such a process there develop possibilities for containing, transferring, redirecting and in other ways utilising aggression in personally satisfying and socially significant directions.

### Self-punishment

When the young women spoke about hating and punishing themselves, they demonstrated the relentless pressure from the demands of their superego. There often appeared to be no respite from this internal critical judge. In self-punishment the patient is treating her body as an object worthy of chastisement. The self-punishment is not just taking the place of disciplining someone else, nor just where the self has become merged with the external object, but it is also because of the strength of hateful feelings themselves. The aggressive element can be both active or passive. In the above example Kim was actively punishing herself for being born female, which she felt to be a passive condition.

The self-punishment can be linked to fantasies about the developing sexual body, masturbation or sexual fantasies, and, as discussed in the context of sexual abuse, can be linked to sexual feelings and feelings of guilt and shame. The aggressive and sexual aspects can be conflated. For example, a highly disturbed young man was seen in a team assessment at the clinic. He was aggressive towards others and himself. The disguised sexual element in his aggression was revealed as he was leaving. When thanked by the psychiatrist for 'coming' (to the appointment), the boy became agitated, commenting that he had never heard anything so disgusting in his life.

Self-punishment can reflect a sexualisation of aggression, and there is a clear sexual aspect to penetration and opening up of the skin, whether



by razor, knife, cigarette or through piercing. Bovensiepen (1995) puts this perspective plainly when he suggests that as girls attack themselves with sharp objects, such as a razor, there is a concomitant fantasy about the violent penis (bad object) penetrating into the containing object. This sort of fantasy can be seen to link back to the fears of patients who had been sexually abused, and were using the attacks on their bodies as a way of controlling the awful thoughts and feelings about their experiences. As mentioned above, the very action of cutting the skin paradoxically recalls the physical experience of the body violation during the abuse – this time self-perpetrated. The dilemma is how to manage and contain the violent aggression, so that it can be redirected in a constructive, though not necessarily conformist manner. The focus then is to help the patient believe in the possibility of benign relationships both intrapsychically and interpsychically.

The redirection of aggressive processes towards the self can also be seen as serving to restore some threatened relationship through repentant self-punishment. The act can be seen as representing retaliatory abandonment directed against objects whose loss is feared. In other words, an angry defiance – 'If you leave me then I'll leave you too'. The aggressive action against the self may be the conflict between needs, and the anticipation of the apparent frustration of these needs.

For example, a supervisee described her work with a woman in her twenties who had a history of cutting and overdosing. The therapy was primarily of a supportive nature which this woman found a great help. She had become increasingly dependent, and found the holiday breaks very difficult. These feelings of being let down and abandoned by the therapist became overwhelming before the summer break, when the woman spoke about her wish to finally end her life. She confided in the therapist that she had managed to get a prescription of powerful pain-killers from the doctor, which she might use while the therapist was away. Naturally the therapist was very concerned, and brought this anxiety to supervision. In the supervision we discussed the ways in which the therapist might both interpret the actions, and convey a sense to the client of 'being held' in the mind of the therapist over the break. We also examined the therapist's feelings of resentment about being manipulated into this anxious position, and how she might resolve that within herself. After the break I heard that the therapist had discussed her concern with her patient, commenting on the patient's warm feelings towards the sweet and concerned doctor in comparison to her perception of the therapist as uncaring. There had been talk over whether the pills should stay in the consulting room over the break, but the patient had said she would keep

but not use them – they remained a security – and the patient survived the holiday.

Several of the patients described in this chapter were women long past adolescence. In the next chapter the link between self-harm and an adolescent state of mind is explored.