

THE INNER PREDATOR:  
TRAUMA AND DISSOCIATION IN BODILY SELF-HARM

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People who live with self-mutilation (scratching, picking at, burning, or cutting the self), disordered eating (binging, purging, self-starvation), or compulsive body piercing, tattooing usually cling to it ferociously, and have little ability to reflect about how and why they live this way. To be really helpful to these patients, we must engage them in wondering about just what self-harm does for them, how it evolved in their lives, and what they will need in order to relinquish it (Farber, 1995, 1997, 2000, 2003; Farber, Jackson, Tabin and Bachar in press). These questions are the subject of this presentation.

These acts are generated out of dissociative experiences. In every act of self-harm there is more than one participant and more than one self-state. There is the dissociated part of the self being abused and another dissociated part doing the abusing. Dissociation makes possible the extraordinary feat of being the victim and the victimizer all at the same time.

There is a growing psychoanalytic interest in dissociation as basic to human mental functioning, and a view of the mind as a configuration of shifting, nonlinear states of consciousness, shaped not only by repression and intrapsychic conflict but also by trauma. Dissociation is a precious psychic survival tool that arises from the need to separate and compartmentalize aspects of traumatic experience while maintaining the attachment, to those who have neglected or abused them (Howell, 2005; Bromberg, 1998). Human responses to trauma involve physiological and behavioral hyperarousal, along with numbing, dissociative responses (Herman, 1992). When confronted with a life-threatening situation at a very young age, human beings, like the other animals, may react as if they were frozen, immobilized, paralyzed (Marks, 1994). Like the other animals, humans also exhibit radical changes in eating behavior and may become self-injurious (Epling and Pierce, 1996; Farber, 1995, 2000; Favazza, 1996).

Trauma not only separates cognition from affect (the customary psychological definition of dissociation), but also psyche from soma. Many patients have chronic physical symptoms that are actually dissociative in nature, because events that should have been processed mentally have been dissociated and experienced instead as somatic events (Nijenhuis and van der Hart; Nijenhuis, 2004; Sacksteder, 1989a, 1989b). Because trauma dissociates thought from affect and mind from body, the body may repeat and relive that which the mind wants to forget.

*When the body weeps tears of blood, we need to wonder what terrible sorrows cannot be spoken. When food that had tasted good suddenly feels like poison and has to be purged from the body, we should wonder what traumatic experiences exist that cannot be contained, metabolized, and integrated. ...The body speaks of that which cannot be said in words, of secrets, lies, and trust that has been broken (Farber 2000).*

The split between psyche and soma starts to form in infancy, when the mother's lack of relatedness to the infant's soma and developing psyche, reflected in how she cares for and holds the infant, leads to the development of the infant's own lack of relatedness to his soma and psyche. The capacity to develop mental representations of the body and its contents is thwarted, and thus the unity of the mind and the body does not develop.

This view of the split between psyche and soma was basic to nineteenth-century views on hysteria, particularly by Pierre Janet, (1907), the French neurologist and psychiatrist, and Charcot, but was not basic to Freud's view. Janet (1859-1947) was the most important clinical investigator of dissociative states who studied the "mysterious leap from the mind to the body" (Deutsch, 1959), known then as conversion hysteria, the process by which repudiated mental content is transformed into physical symptoms. Freud recognized that the dramatic somatic symptoms of hysteria were induced by psychological trauma (Freud, 1910) but subsequently dismissed the phenomenon of dissociation that Josef Breuer<sup>1</sup>, his associate, believed was at the root of hysteria (Breuer, 1895). The result in psychoanalysis is an emphasis on repression at the expense of dissociation. "Part of our work as analysts facilitates the restoration of links between dissociated aspects of self so that the conditions for intrapsychic conflict and its resolution can develop (Bromberg 1998. p. 13)."

Dissociation has been called "the escape when there is no escape" (Putnam, 1992, p.104)." Self-harm allows the individual to adapt to the most horrific of circumstances without becoming psychotic and without killing himself or someone else, and in that way serves an invaluable defensive function. But it is far more than a defense, and more than a symptom. It is the behavioral component of a part of the self with a set of needs, feelings, and perceptions that have been dissociated from the patient's total self-experience. It meets the needs of a part of the self that is at odds with the patient's ordinary experience of herself. It both expresses and defends against unrecognized archaic needs and feelings. It numbs painful affects and protects the patient from fears of annihilation and disintegration. Often the patient experiences this part of herself as foreign, alien, as "not me" (Bromberg 1998) because it is self-destructive and out-of-control. "It is like there is a monster or a demon in me urging me to stuff myself and make myself throw up." Or, there is an external seductively caring

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<sup>1</sup> Breuer believed that lying at the center of hysteria is a splitting off of a portion of psychic activity that is also a splitting of consciousness.

voice urging her, "Go on, sweetheart. Do it. Just a little cut will make you feel so much better. You know it will."

Despite her view of the self-harm as negative and crazy, this secret part of the self is precious, and so anyone who tries to take it away from her will be met with ferocious resistance, and sometimes even more violent and dangerous symptoms. We need to understand the nature of the attachment to self-harm if we want to keep these patients from developing careers as mental patients, going from therapist to therapist, hospital to hospital.

Attachment theory helps us understand how human beings can become so attached to pain and, suffering that they cannot imagine living without it. If we examine how self-harm evolves as a survival tool, this will tell us something about the treatment of patients who harm themselves. Darwin's theory of natural selection tells us that when survival is threatened, one can "kill or be killed", "eat or be eaten". One can be the predator or one can be the prey. To be the predator is to be powerful; to be the prey is to be annihilated.

Each species in the animal kingdom has its own biologically based attachment system that attaches its offspring to its caretaker and caretaker to its offspring in order to protect the newborn from predators in the environment (Bowlby, 1969). The caretaker must have a deep attachment to the child to insure his biological survival, and to provide the sense of security needed for the development of self-regulatory functioning, such as eating, sleeping, heart rate, breathing, body temperature, growth hormones (Hofer, 1995). A secure attachment helps the child to develop a basic sense of trust and to tolerate separations. The attachment ensures that the child survives and thrives in other future attachments as well.

When those who are meant to protect the child are neglectful or unattuned, the child comes to feel unprotected, in his real environment or in his imagination, from those who might harm him, and can experience an intolerable anxiety about being annihilated, as Marvin Hurvich (2003, 2006) has thoroughly described. This annihilation anxiety engraves a pathway in his brain, creating a template upon which all subsequent anxiety-provoking situations are patterned (Farber 2000). When those who are meant to protect the child come to harm him instead, this creates a deep and confusing attachment in which the child becomes powerfully attached to the parent he fears will annihilate him, and powerfully attached to pain and suffering.

The object becomes split into good and bad object representations that allow him to maintain his attachment to both the good aspects of the object and to the bad, as if they were two separate people. Despite the shift from passive prey to active predator, the predator-to-prey object relationship is repeated and the attachment to pain and suffering is repeated by means of presymbolic wordless physical traumatic reenactments in behavior, in relationships to others and to ones own body, as I will describe.

These individuals articulate through their bodies what may be biologically based primal and universal urges that remain relatively unarticulated in the rest of us. Robert Stoller (1991) asked "How common are the little sadomasochisms of everyday life, covert but observable: the skin pinching, cuticle tearing, gum picking, colonic treatments, deep massage, hairpulling, dreamy-self-and-other-stimulations (p.23)."

### Self-Regulation and Symptom Substitution

The primary function of self-harm is to regulate both the self and relatedness to others. The individual turns to self-harm in order to circumvent the need for human relatedness, and to release tension by terminating dysphoric moods, affect states, and states of consciousness.

Although the remarkably high comorbidity between disordered eating and self-injury had been documented in numerous studies, there was no explanation as to how and why they were linked together. This question became the subject of my dissertation study (Farber 1995), and became the adventure of a lifetime. I found that these behaviors actually serve as a form of self-medication (Khantzian, 1985). Both bulimic behavior and self-mutilation were found to be extremely potent forms of self-medication, of approximately equal potency (Farber 1995). When a patient gives up one behavior before the ego is ready to relinquish it, as often happens when a patient stops the behavior to please the therapist or gain discharge from the psychiatric hospital, another self-harm symptom of more or less equal potency will crop up in instead (Farber 1995).

Here is an example from my practice (Farber 2000). Dina, age 23, was one of numerous children from a large chaotic family. Two sisters remember being beaten by their father although Dina has no memory of this. For years Dina experienced depression, drinking binges, promiscuity, bulimia, compulsive shopping and shoplifting. Shortly after her first shop-lifting arrest, she recognized that her life was out of control and was hospitalized voluntarily. While in the hospital she Prozac was prescribed and she began attending daily Alcoholics Anonymous meetings. When she was discharged and resumed her treatment with me, she no longer drank or engaged in bulimic behavior. However, she began to feel the impulse to cut herself. And while driving over a bridge, to drive over the railing. When I asked what the cutting would do for her, she said she felt like a balloon, so full and tight; popping it open would release the tension. Further exploration revealed that when she was around ten, her sister teased her about a large brown mole on the back of her thigh, saying that it looked like a piece of shit stuck there. Dina then took a paring knife and cut the mole away. Years later, while looking in the mirror as she applied her makeup, she became transfixed by the crease in her eyelid. She picked up a razor blade and in a depersonalized state drew it slowly across the eyelid crease, watching in excited fascination as drops of blood appeared and dripped down her cheek.

Psychic Functions served by self-harm

These patients tend to be alexithymic, unable to identify emotions or use words expressively (Cochrane, Brewerton, Wilson, and Hodges 1993; Farber 1995, 1997, 2000, 2005; Farber, Jackson et al, in press; Nemiah, Freyberger and Sifneos, 1976; Taylor, Bagby, and Parker, 1991; Taylor and Bagby, 2005). Not surprisingly, alexithymia has been found to be associated with dissociative tendencies (Clayton, 2004 ; Grabe, Rainermann, Spitzer, Gänsicke, and Freyberger, 2000; { Sayar and Kose, 2003; Taylor, and Bagby 2005; Tutkun, Savas, Zoroglu, Esgi, Herken, and Tiriyaki, 2004; { Wise, Mann, and Sheridan, 2000). Phobic about experiencing emotion, they dissociate and harm themselves instead, which essentially is an attack on language itself and on the process of creating meaning. These acts of self-harm are very creative attempts to serve certain psychic functions, such as self soothing, defining and differentiating inner and outer body boundaries, bodily expression of emotions, and psychophysiological reenactments of past trauma. There is not time to discuss all of them so I'll limit myself to self soothing and psychophysiological reenactments of past trauma.

#### Self-Soothing

The individual turns to self-harm in much the same way a toddler may turn to his transitional object, usually a favorite stuffed animal or old blanket, when feeling lonely and anxious, thus comforting himself with the illusion that he is being held and comforted by his mother (Winnicott, 1953). This transitional object is a "not me" object, not part of his body. The binge-purger or self-mutilator seizes upon the symptomatic behavior, immersing herself in the comfort it provides. It does calm her for a brief time, releasing serotonin into her system, but it fails as a transitional phenomenon. It does not promote separation-individuation processes (Mahler, Pine and Bergmann, 1975). It fails to further the capacity for symbol formation. It functions instead as an addiction or a fetish, shoring up a defective sense of self for the brief time that the shoring up lasts, until it is time to do it again, and again, more severely and more frequently. It is like the alcoholic developing a tolerance for the effect of alcohol, progressing to drinking greater volume and with greater frequency. The self-harm episodes may become more severe and more frequent. When even the escalated form of the behavior fails to do what it is supposed to do, another self-medicating behavior that is even more severe may be added to the repertoire. Thus, after even the most severe bulimic behavior no longer is strong enough self-medication, self-mutilating behavior may well be needed to supplement it.

#### Bodily Reenactments of Past Trauma

The body becomes susceptible to a heightened somatic stimulation in general or in the part of the body that was abused or injured (Terr, 1990, 1994), what is often called body memory. For example, many sexual abuse survivors complain of chronic pelvic pain for which no organic basis can be found. The body memory can be a cue to the therapist of dissociated experience related to that part of the body.

The addiction to self-harm behaviors often represents a compulsion to repeatedly reenact severe childhood trauma on the body (Farber, 1995; van der Kolk, 1988, 1989). For example, in the self-harming behavior in a survivor of sexual abuse, we might see a dissociated reenactment of the trauma she experienced. In the reenactment, she is in control and is active, in a vain attempt to master the trauma. In a depersonalized frenzy in which she identifies with the hateful abuser, she shoves food into her mouth as others shoved a penis, fingers, or other objects into her body. Then as the identification quickly shifts to an identification with her abused self, she vomits the food out to rid her body of those things that were inserted by force. Or she may penetrate her flesh with a razor blade, lit cigarette, or fingernails, as her abuser penetrated her. As she watches liquid oozing from the wound, she feels pleased that the vile stuff that had been inside her, (semen, the hateful parts of herself) is being expelled, leaving her clean and pure. She also has the pleasure of discharging rage and violence onto the abuser. She is both the abuser and the one being abused. She is the sadist and the masochist. She is a cool observer of her own self-abuse, like the parent who was present but failed to protect her. In the self-harming act she is all these, oscillating crazily from self to bad object to good object and back again, traumatically attached to both the affects and her abuser.

Similarly, the individual who was traumatized by intrusive and painful medical or surgical procedures may repeat the trauma by sticking himself or others with needles, and/or getting others to stick him with needles. It was striking in my study that quite a few of the subjects who reported a history of childhood medical trauma and severe self-mutilation became intensive care or emergency room nurses. The women with this history also reported having acquired professional tattoos and piercings significantly more than those without this history. In fact, two of them earned their livelihood as professional tattoo artists and body piercers.

#### Transference Reenactments of Past Trauma

Enactments in the relationship with therapist tend to be around these same themes as in the bodily reenactments, reflecting the childhood relational patterns that have become internalized as dissociated parts of her self experience (Davies and Frawley, 1994 ; Farber 1997; Miller, 1994). These manifestations, most pronounced in survivors of sexual abuse, can alternate in a dizzying sequence in which the patient tries on various dramatic roles and assigns corresponding roles to the therapist. The patient may cast the therapist in the role of her abuser while clinging to her role as victim, may then cast the therapist in the role of the parent who failed to protect her while demonstrating her need for protection, then will cast the therapist in the role of the helpless victim while she traumatizes the therapist as she had been traumatized, and may cast the therapist in the role of seducer while clinging to her role as the seduced. As you would expect, intense counter-transference feelings tend to be evoked, and therapists should not expect

themselves to maintain neutrality. What is more important is that the relationship be vital and authentic.

When dissociation is a major component of the patient's defensive operations against annihilation anxiety, this can actually induce a parallel dissociative process in the therapist (Bromberg 1998), evoked by the therapist's own annihilation anxiety (Hurvich, 2003, 2006). By means of dissociation and the powerful process of projective identification, the patient projects these dissociated aspects of himself into the therapist, causing him to lose his ability to think, contain, and reflect upon the patient's experience, thus annihilating the therapist's mind. This is when the most destructive enactments in the treatment are likely to occur, created by both patient and therapist. The therapist is in danger of retaliating mindlessly against the patient, which can destroy the treatment. If this occurs, and if the therapist can genuinely acknowledge his role, and apologize for it, this allows the patient to begin to acknowledge his own role, and the treatment can be saved.

When the therapist can help the patient to decode the enactment, either through understanding what it communicates via his own countertransference responses or through understanding the enactment on the body, then what had been dissociated can become integrated into the self, to be thought about and reflected upon. Thus, these dissociative defenses are permeable enough to serve as a bridge to a more satisfying object relationship and to growth in the therapeutic relationship.

### The Remarkable Power of Self-Harm

The attack upon the self has what may seem like magical power. If a period of depersonalization becomes painfully lonely, as may well happen when accompanied by the feeling that the rest of the world is not real, inflicting pain upon the self can terminate the dissociation. When hyperarousal lasts too long and is painful, inflicting pain upon the self can terminate the hyperarousal. When the raging depression is too much to bear, inflicting pain upon the self can terminate that too. That is why people who inflict harm on themselves often say it makes them feel better.

Kim, a young woman who had been sexually abused in childhood by her father, was no longer his victim but nonetheless reenacted the attacks. Cutting herself was a way of pre-empting his attack as well as triumphing over it. She wrote the following in *The Cutting Edge*, a newsletter for women who live with self-inflicted violence:

Tonight I've done everything to distract myself from thoughts of cutting. . . I feel angry and I'm not very good at that feeling. They say that behind anger is always fear. So I ask myself: "What are you afraid of?" Well, what do you think?! I'm afraid my father will jump right through my skin and scare the silence right out of me. When I put down this pen, who'll get me first? My daddy or me? I'd rather get there first. This belongs to me! cut, cut, cut (Kim, 1993 470 ), pp.3-4.)

## A Multi-Phased Approach to Treatment

The Shakespearean injunction to "give sorrow words" is the key task of psychotherapy with all patients. With patients who cannot use words about their inner life, and whose behavior puts them at such great risk, much preparatory work must be done before they can become able to put words to their sorrow and trauma. Treatment must be a phase-oriented process, roughly divided into three phases with considerable overlap: 1) safety, stabilization and trust; 2) trauma work; and the third, mourning, resolution, reconsolidation, and reconnection (Farber 2000, 2004). Treatment is usually a long, hard road with many detours, regressions, plateaus, enactments, and negative therapeutic reactions, in which progress may be followed by a regressive move backward.

The cardinal rule in working with these patients is safety first, meaning both their physical safety as well emotional safety in the relationship with the therapist. The development of a safe and secure attachment to the therapist is what helps the patient relinquish the attachment to pain and suffering. It is the significant interactions between patient and therapist that ultimately lead to structural psychic change, and so it is these interactions that are emphasized from the beginning.

Before the patient can come to care for himself, he must feel cared for and know that his well-being is paramount in the therapist's mind. The therapist's real presence, reliability, punctuality, attentiveness, empathy – all the elements of support-- are in the forefront for the patient. In the early stages and at times of unusual vulnerability, the therapist must make himself unusually available, to be used as a transitional object, by phone or for emergency sessions. As the relationship develops, the patient becomes more receptive to learning ways to regulate anxiety states on his own.

All defenses must be treated respectfully and cautiously, even when those defenses are potentially life-threatening symptoms. Because the expression of emotions, especially anger, is so concrete, impulsive, and destructive, these patients cannot tolerate analysis of defense; in fact it can evoke more anxiety and more self-harm behavior. They can benefit greatly, however, from ego psychological techniques of ego building and strengthening (Blanck and Blanck 1974), as well as cognitive-behavioral tools for affect tolerance and regulation, such as distraction, postponing the self-harm behavior. When they cannot speak of their emotions, I have found that helping them to write down their thoughts and feelings in the therapist's presence during a session is a very powerful intervention. It can promote freer associations, help them identify and tolerate affect states, and provides containment for their impulses, and promotes more reflective thinking (Farber 2005).

The therapist needs to make himself unusually available, inviting the patient to call at critical times for soothing, even in off-hours or the therapist's vacation, thus functioning as a transitional object. These experiences are extremely potent,

and can become mutative, corrective emotional experiences that lead to structural change in the personality. They can also prepare patients to acquire tools for self-soothing and affect regulation from the therapist. Because these patients often turn to self-harm to make their dissociated selves come alive or to calm themselves, bodily techniques that stimulate circulation (exercise, cold showers, touching the skin with an ice cube), will make the body feel alive, or techniques that promote relaxation (exercise, yoga, deep breathing, warm baths) will be invaluable.

Premature exploration of trauma may cause symptoms to worsen, but focusing on eliminating symptoms can do the same. Symptom management, however, is an essential part of the treatment, and is determined according to an assessment of the self-harm behavior along several axes, which suggest points for immediate intervention. The therapist should evaluate: the potential lethality of the behavior, the frequency or repetitiveness, chronicity, the directness of the harm, the extent to which the behaviors are compulsive, impulsive or both, the extent to which the behavior is ego-alien or ego-syntonic, the level of consciousness that accompanies the act, the degree to which the intent is suicidal, sadistic, or masochistic, and the multiple psychic functions served by the behavior (Farber 2000).

*The first axis, the lethality of the self-harm behavior, is most critical.* The therapist should engage the patient in trying to make his self-harm behavior less dangerous, so that it is safe for him to be treated on an outpatient basis. The therapist will have to rely on his powers of observation, the information he gets from the patient and/or family, which may or may not be reliable, and quite possibly, medical monitoring. To assess the lethality of the behavior, the clinician will need to know how severe and out of control it is. The rapidity of weight loss, the severity of purging (number of purging strategies and frequency of purging), the severity of self-mutilation, and alcohol or drug-related medical damage are indicators of severity. For example, episodes of bingeing and purging twice a week is less dangerous than seven or eight episodes a day in which each binge is followed by several purges; superficial controlled cutting is less dangerous than deep jagged cuts.

When the patient becomes sufficiently stable, the work of deconditioning traumatic memories and responses can begin, which further stabilizes the patient. When the therapist can help the patient restore the links between dissociated aspects of the self, the patient begins to integrate the traumatic experiences and redirects the rage which had been directed at his body. As ego functioning becomes more able to sustain the demands made by a more intensive treatment, the work can shift, to psychoanalytic psychotherapy or psychoanalysis.

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