

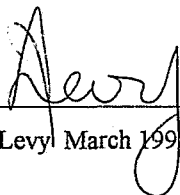
**A PHENOMENOLOGICAL INVESTIGATION OF
THE INHIBITION OF SELF-MUTILATORY
BEHAVIOUR IN BORDERLINE PERSONALITY
DISORDER**

A dissertation submitted to the department of
Psychology in partial fulfilment of the requirements for
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by
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I hereby declare that this dissertation is my own work and has not been submitted to any other University for the purposes of any other degree.



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ABSTRACT

The aim of this research was to describe the borderline individual's lived experience of inhibiting self-mutilation and thus capacity for healthy functioning. A question which would elicit a description of the experience of this phenomena was formulated. Three self-mutilators were interviewed and the two psychologically richest narratives were chosen for the research. Based on phenomenological methodology the two protocols were analysed in detail.

From the results it becomes clear that borderline individuals are ambivalent when attempting to inhibit self-mutilation. Although they have a need to be self-sufficient and through a process of trial and error find the method of inhibiting that best suits them, it appears difficult for such individuals to trust that they have this ability and their inner resources to find such a method.

Borderline personality structure may be viewed along a continuum. The technique chosen by the individual is likely to fit with where they are developmentally in relation to this continuum. Hence, while each individual may or may not make use of transitional objects within their techniques, they do have a need to draw on 'soothers'. Although the 'soothers' may vary with regard to shape and form, they do appear to share similar qualities and to become imbued with like meanings by the individuals. The 'soothers' create a safe and holding space which is empathic, attuning, non-judgmental and non-directive in its interaction with the borderline individual. 'Soothers' need to allow the individual a sense of mastery and control over their otherwise chaotic environment. Repeated use of 'soothers' allows the borderline individual to begin drawing on good introjects as opposed to negative introjects which serves to increase confidence, sense of self and the ability to trust in their own inner resources.

This pin points an area of healthy functioning in the individual with borderline structure which until presently has been overlooked in the literature on the functioning of those with borderline structure

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CHAPTER 1

INTRODUCTION

The individual with borderline personality organisation has been described in numerous ways and from differing perspectives. Searles (1986) describes the borderline personality as: "walking the tightrope between neurosis and psychosis" (p. 498). Kernberg (1986) suggests that in order to accurately diagnose an individual as 'borderline' a structural analysis of the derivatives of internalised object relationships is required. He lists these as including: (1) non-specific manifestations of ego weakness, such as displaying a lack of anxiety tolerance, impulse control as well as a possible lack of sublimatory channels; (2) a shift toward primary process thinking; (3) specific defence operations such as splitting, denial, projective identification, omnipotence and devaluation; and (4) pathology of internalised object relationships resulting in identity diffusion. Giovacchini (1987) goes on to suggest that borderline individuals are fixated in an 'in-between' transitional space - they have been unable to develop a continuum between their inner mental life, transitional space and their external world. Such a lack of continuity may be seen to reflect the structure of their psychic apparatus and hence may explain sudden fluctuations between behaviour which appears sophisticated and rational, and cognitions which seem bizarre and primitive. Goldstein (1989b) describes those with borderline personality structure as being distinguished by a particular pattern of relative ego strengths and underlying ego weaknesses. He makes the point that while the specific nature of the ego strengths and weaknesses may vary from individual to individual it is the particular pattern which differentiates these individuals from those with a healthier neurotic pattern and those with more pathological psychotic structural configurations. Viewed from this perspective, personality structure may be seen to form a continuum with varying degrees of healthy and pathological functioning as opposed to being viewed in an either/or manner. The present research will be adopting the former perspective.

Borderline individuals appear to fluctuate between healthy and pathological functioning in what appears, at times for the observer, a chaotic and erratic manner as explained by Giovacchini (1987). In contrast to the abundant literature on borderline pathology, very little has been written about the more healthy aspects of the borderline individual's functioning despite its acknowledgement within the literature, as indicated above. This research attempts to explore the inhibition of self-mutilatory urges in borderline individuals, which is seen as one facet of the more healthy aspects of the borderline patients' functioning. The literature lacks information on the borderline personality's subjective experience of inhibiting self-mutilation and consequently this aspect will not be addressed in the literature review. Instead it will explore concepts and theories around the borderline individual's psychic structure and development in greater detail, so as to create a solid foundation on which to build a deeper understanding of the borderline individual's propensity for healthy functioning.

CHAPTER TWO

LITERATURE REVIEW

2.1. THE ENIGMA OF THE BORDERLINE INDIVIDUAL

Gunderson and Singer (1986) state that despite the frequency of use of the term 'borderline', there is still some disagreement and contradiction over its actual definition. Although the term is well accepted, there is conflict over whether it refers to the borderline patient, state, personality organisation, character pattern, schizophrenia, condition or syndrome. Knight (1986) suggests that initially the term 'borderline' was something of a wastebasket diagnosis, applied to those patients who could not be classified as either neurotic or psychotic. According to Gunderson and Singer (1986), prior to popularisation of the term borderline, numerous other names were suggested for the condition. These included *preschizophrenia*, *schizophrenic character*, *abortive schizophrenia*, *pseudopsychopathic schizophrenia*, *psychotic character*, *sub-clinical schizophrenia*, *borderland* and *occult schizophrenia*. The term *pseudoneurotic schizophrenia* emerged as the most predominantly competitive diagnosis.

The enigma and confusion associated with the terminology and identification of borderline patients is clearly emerging. This appears to have led to a focus on the pathological non-functioning of the individual with borderline personality organisation. Inherent in this view, however, is the apparent dismissal of any potential for healthy functioning. According to Giovacchini (1987), healthy functioning can include an ability for reality testing and sensitivity (albeit on a superficial level), the capacity for good insights about themselves, friends and family and often a large degree of creativity. Knight (1986) suggests that at times, giving the label of 'borderline state' as a diagnosis, may convey more about the uncertainty of the clinician than the condition of the patient. Kernberg (1986) offers the ego-psychology view that in accurately describing these patients, one is referring to a personality organisation rather than a state, that is, these individuals

have a specific and stable personality organisation. Their personality organisation, in contrast to Giovacchini's (1987) view, is not a transitory state fluctuating between neurosis and psychosis although their presenting symptoms may resemble those of the neuroses and character disorders. Without a thorough examination and exploration, the particular characterological organisation of these patients may be missed. In order to better understand this specific and stable personality organisation as mentioned by Kernberg (1986), a more in-depth exploration of the relative ego strengths and underlying ego weaknesses is necessary.

2.2. BORDERLINE STRUCTURE VERSUS BORDERLINE PERSONALITY DISORDER

2.2.1. Defining the two:

DSM-IV (1994) offers the following definition of the borderline personality disorder: "A pervasive pattern of instability of interpersonal relationships, self image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts" (indicated in DSM-IV; p. 280).

On closer inspection it becomes clear that 'Borderline Personality Disorder' can be thought of as two distinct levels of functioning. The one referring to the behaviour and symptoms of the disorder as detailed by DSM-IV. The other referring to the psychic structure of the individual and their associated psychological traits as elaborated by object relations theorists such as Klein, Kernberg and Masterson.

The former may be seen to inform a diagnostic category which is symptom based. However, according to Fribble (1997) there is still a lack of agreement as to whether individuals with a 'borderline personality 'disorder' comprise one distinct diagnostic category, a statement which parallels the object relations perspective which focuses on the structure of the personality rather than symptomatology. For the purposes of this research the term 'borderline structure' involves a more in-depth analysis with its concept of a lack of object constancy and self representation than the term

'borderline disorder'. Furthermore, an investigation of 'structure' allows the researcher far more scope and flexibility with regard to interviewing respondents due to the focus being on their structural functioning as opposed to a specific psychiatric diagnosis. This research highlights that behaviours traditionally associated with borderline personality disorder can be investigated perhaps more profitably when criteria of structure become the focus

2.2.2. The Borderline Structure as a Developmental Continuum - Kernberg versus Adler:

Rather than a system of symptom categorisation, the borderline structure may best be understood in developmental terms, and described along a developmental continuum (Coonerty, 1986). This developmental view of the borderline individual offers the scope to examine and assess all areas of development. Areas of development include those which have been stunted, leading to more pathological functioning, as well as the areas which have been reached and mastered, leading to healthier functioning. Furthermore by adopting this perspective theorists as diverse as Kernberg and Adler can be viewed together, in a non-contradictory manner. The greater the variety of theories, the more enlightening and richer the understanding of the borderline individual's dynamics and propensity for functioning, be it healthy, pathological or a combination of the two. This is illustrated below.

For Kernberg (1975), the core problem in the borderline patient relates to their difficulty in integrating positive and negative introjects. This results in a failure to obtain object constancy. Adler (1985), however, believes the core problem in borderline individuals to be their inability to successfully form a particular kind of positive introject, that is, the holding introject. Kernberg's theory is known as the 'conflict' theory, while Adler's is known as the 'deficit' model (Goldstein, 1989a). A more detailed discussion of the two follows:

Kernberg (1975) states that borderline personalities have achieved one of two crucial developmental tasks. The task of differentiating self from object representations has been negotiated adequately, and hence such individuals have a somewhat stable sense of self and of others - that is, a more mature and organised level of psychological development than the psychotic. The ability to form realistic and mature relationships, however, is impeded by the lack of resolution of the second developmental task, that is, the ability to successfully integrate contradictory early life mental representations. The failure to obtain libidinal object constancy combined with the simultaneous difficulty in integrating good and bad self-images and introjects, results in a splitting defence or feelings of ambivalence towards the caregiver and themselves. It is this ambivalence which results in the theory being called a 'conflict' theory.

Adler (1985) posits an inability on the part of the borderline individual to use transitional objects for holding and soothing purposes. This is said to be due to the inability of the borderline to attain solid, evocative memory which is the ability to recall an object without being reminded by external cues - a precondition for introject formation. With the attainment of evocative memory, the holding and soothing provided previously by the mother or transitional object can be internalised as a holding introject. The potential introject must, however, have the characteristic of being continually available to the infant. Hence, borderline individuals due to their inability to internalise holding introjects, remain dependent on external self objects to supply the necessary and very needed holding and soothing. Adler believes such deficits to be the consequence of a lack of 'good enough' mothering (Winnicott's term, 1975) and hence, the unavailability of the essential holding and soothing. According to Favazza (1989) and Malcolm (1994), one of the functions of self-mutilation may be to self-soothe the borderline individual in times of distress. In relation to the present research, it is hypothesised that if self-harm as a self-soother is inhibited then the borderline individual may choose to rely on sources completely external to themselves namely an animate/inanimate object in order to soothe themselves in times of distress. These external 'objects' it is posited, could be another person such as a therapist or someone else who is

perceived of as offering safety and containment. Should the borderline individual choose to rely on internal resources it is hypothesised that a more recent memory would need to be drawn on, in a conscious manner, rather than simply being able to rely, possibly in a more unconscious manner, on early positive introjects due to the reasons as set out in Adler's (1985) theory.

According to Goldstein (1989a), Kernberg's 'conflict' theory (1975) on closer inspection can be said to point to a partial deficit, that is the deficit of integration. Similarly with Adler's 'deficit' model (1985), conflict is likely to emerge due to the dependence on external objects. The conflict may involve rage, regression, anxiety, defence as well as painful affect. Consequently, both theories may be seen as simultaneously involving elements of deficit, conflict and mastery, rather than being described in an either/or manner which would need to be the case if a system of symptom categorisation was to predominate in the present research. Furthermore, the use of a system of symptom categorisation would negate and make redundant an exploration of the borderline individual's *lived experience* of restraining his/her self-injurious behaviour - the essence of the present research.

2.3. STRENGTHS AND WEAKNESSES OF THE BORDERLINE INDIVIDUAL

In discussing areas of strength and weakness, both the impact of the environment on the borderline individual as well as his/her innate strengths and weaknesses needs to be taken into account. Bowlby's (1969) attachment theory (to be discussed further on) highlights the interaction of both nature and nurture on the infant without assuming biogenetic factors such as inborn abnormal personality traits or defects. This is a stance which he maintains in his discussion of borderline development and which other many theorists, such as the ones below, appear to subscribe to.

2.3.1. Innate Borderline Empathy:

Park, Imboden, Park, Hulse & Unger (1992) highlight the ability of many borderline patients to sense psychological characteristics of significant others. This ability is frequently present but not essential as an etiological factor to borderline personality organisation. Such patients appear to have an inborn talent and a need to discern the feelings and motivations of others. Because of its innateness and positiveness, these researchers choose to refer to it as a 'gift' and call it "personal intelligence" (p. 227). This giftedness may also be termed "borderline empathy" (p. 228). Empathy is generally viewed as a healthy, inborn trait rather than an inborn weakness or vulnerability leading to psychosis. However, this particular talent is frequently overlooked in borderline individuals because it is embedded in the service of control, rage and neediness, all of which form the function of self-protection. Park et al (1992) go on to suggest that borderline personality organisation is born out of two interacting factors: the biogenetic giftedness (as mentioned above) and the severely disturbed parental involvement (to be mentioned further on) which forces intuitive talents to become almost completely directed to pathological patterns of relating. For instance, Park et al (1992) refer to the experience of most clinicians who have had significant dealings with borderline patients whereby clinicians become very aware of the patient's exceptional capacity for sensing the psychological characteristics of significant others in their lives, the therapist included. This ability is sometimes coupled with the manipulative induction of feelings similar to those experienced by the patient, otherwise known as projective identification.

2.3.2. Internal Structure and External Behaviour:

In examining areas of strength and weakness with regard to day-to-day functioning, conventional ego functions such as superficial object relationship maintenance appear to be relatively intact and functional in those with borderline personality organisation. Certain functions such as memory, calculation and certain habitual performances, appear to be fully functional (Knight, 1986). Frosch (1964) stresses

that although borderline individuals have alterations in their relationship with reality and their feelings of reality, their ability and capacity to reality test is preserved. This is in contrast to patients with psychotic reactions and this highlights the borderline individual's ability to be more functional in the world than is generally suggested in the literature. Furthermore, Kernberg (1986) makes the point that borderline individuals often display specific, active defensive operations rather than solely a lack of integration of the ego. This is especially true with regard to the defence mechanism of splitting. Rather than regressively re-fusing self and object images as occurs in the psychoses, the borderline person instead actively separates out the positive and negative introjections (to be discussed later).

Other features, often classified as weaknesses, appearing to characterise the borderline state involve the presence of intense affect, a history of impulsive behaviour, social adaptiveness but often in the form of mimicry, brief psychotic experiences with a paranoid quality, poor psychological testing performance on unstructured tests such as the Rorschach and transient interpersonal relationships which oscillate between superficiality and intensity (Gunderson & Singer, 1986).

Knight (1986) states that the normal ego functions of integration, secondary-process thinking, realistic planning adaptation to the environment, in-depth maintenance of object relationships and defences against primitive, unconscious impulses appear to be compromised but not lacking in the borderline individual. Kernberg (1986) states that sublimatory capacities and the creative enjoyment and creative achievement found therein are often lacking in borderline personalities. There is also a lack of anxiety tolerance and impulse control.

Goldstein (1989b), in agreement with above theorists, extrapolates the borderline individual's areas of functioning and pathology. He views borderline individuals as having four relative ego strengths and four underlying ego weaknesses. Goldstein's (1989b) modification and expansion of the ego-psychological diagnostic approach describes the borderline person as: "someone with a specific structural configuration, characterised by a specific pattern of relative ego strengths and

underlying ego weaknesses" (p. 340). He stresses that this is "...to be differentiated from the normal-neurotic, the narcissistic, and the psychotic configurations" (Goldstein, 1989b, p. 321).

While Goldstein (1989b) reiterates much of what is said by the other theorists, he discusses the information in a far more cohesive manner. At the risk of repetition, parts of Goldstein's (1989b) discussion will be further included due to its bearing and relevance on the research topic.

According to Goldstein (1989b), the first relative ego strength is that of reality testing which in the borderline individual's day-to-day functioning is basically intact. This ego function may, however, regress sometimes into brief periods of psychosis in stressful and very close interpersonal situations. Psychotic episodes in the borderline individual (if they occur) as opposed to those in the schizophrenic or psychotic individual, are far briefer (involving minutes up to a day or two), they can be spontaneously reversed and are often related to clear cut precipitants. The second relative ego strength relates to thought processes which in day-to-day functioning and structured situations involves sophisticated secondary process thinking. Under stressful and less structured situations the more primitive primary process thinking may emerge. The third relative ego strength involves interpersonal relations whereby the borderline individual on the surface appears to 'relate' to others, have numerous acquaintances and maintain long-term relationships. The weakness here concerns the apparent lack of depth and the vacillation between superficial and intense relationships marred by primitive defences. The fourth relative ego strength involves an adaptation to reality which is often superficially intact. The borderline individual may display adequate achievement at work and school and may seem of normal appearance. Weaknesses involve the adaptation being less than optimal and this may make it difficult for the borderline individual to maintain his/her adaptation. Goldstein (1989b, p. 324) does speak of 'exceptional' borderline individuals who have the ability to maximise certain strengths and adapt adequately over time, especially in structured settings. Such individuals often achieve well professionally but display chaos in their social

lives and interpersonal relations. They, however, appear to seek out intensive psychotherapy more than the other 'less exceptional' borderline individuals. This suggests that those with borderline personality organisation cannot be viewed as an homogenous entity as there appear to be degrees of functionality and pathology which are sure to fluctuate from individual to individual. Consequently, a distinction needs to be drawn between the terms 'borderline personality organisation/ borderline structure' (the focus of this research) and 'borderline personality disorder'

2.4. A DISCUSSION OF SELF-MUTILATION

In order to adequately explore and understand the present research involving the borderline individual's experience of restraining his/her self-injurious behaviour, a discussion of the behaviour itself follows.

Self-mutilatory behaviour may be described as: "deliberate, non-life threatening, self effected bodily harm or disfigurement of a socially unacceptable nature" (Walsh & Rosen, 1988, p. 10). The most common examples of self-mutilatory behaviour in borderline individuals are self-inflicted wrist cuts, tattoos and cigarette burns (Walsh & Rosen, 1988). Head-hitting and banging, self-biting, and skin scratching are used by borderline individuals but are more frequently found among severely retarded patients (Malcolm, 1994). Other examples, although quite rare in clinical populations, are self-excoriation and inoculation of the skin, self-mutilation of the nose, tongue and self-inflicted conjunctivitis. Rarer yet are the more extreme forms of self-mutilation such as self-blinding, autocannibalism, female genital self-mutilation, self-castration and self-inflicted penis removal (Walsh & Rosen, 1988).

The borderline self-mutilator is reported to feel a compulsive, even addictive need to mutilate according to Novotny (1972), and the act of mutilating is frequently conducted secretly, in what could be termed a semi-masturbatory manner (Kafka, 1969; Podvoll, 1969). The action of self-mutilating is said to serve a cathartic, self-purifying function with a resultant modulation of anxiety states, sexual tension,

anger and/or dissociated emptiness. It may also cause a tremendous quasi-physical sense of relief (Burham & Giovacchini, 1969) suggesting something akin to self-soothing.

Several explanations for the above mentioned self-mutilatory behaviour exhibited by borderline persons have been postulated. Impulsivity as described in the borderline characterology may be an important factor (Gunderson & Singer, 1986). Kernberg (1986) describes lack of impulse control as being a possible defensive characterological formation which is highly specific. He suggests that the specificity of the 'lack of impulse control':

is manifested typically by the ego-syntonicity of the impulses being expressed during the time of impulsive behaviour, by the repetitive nature of the kind of lack of impulse control involved, by the lack of emotional contact between that part of the patient's personality and the rest of the self experience, and finally by the bland denial which secondarily defends this dissociated breakthrough (p. 297).

In addition, Kernberg (1993) suggests more dynamic explanations for such behaviour. For instance, self-mutilatory behaviour may also be viewed as a way of manipulating or imposing one's will on the environment. A further, somewhat related possibility describes aggressively invested internalised objects resulting from early world experiences with persecutory figures. Kernberg (1993) goes on to posit that self-mutilation may be a way of signalling intense hatred, as well as a sadistic enjoyment of ensuring that the object suffers, that is, mutilating may be a symbolic way of controlling, subjugating and dominating the object. As a result of this, self-mutilation may result in feelings of immediate relief from the aforementioned emotions. Fonagy et al (1996) emphasise that early distressful experiences may inhibit mental processes which allow for the capacity to reflect on one's feelings and mental functions. The inhibition of these mental processes may result in the expression of feelings in a destructive, acting out manner rather than through non-destructive methods such as verbalising. Furthermore, without internal representations of safe and consistent attachment figures, there may be a tendency to rely on external sources of comfort and activities, namely self-mutilation, substance abuse, violence and promiscuity (Sable, 1997). Kernberg

(1986) suggests that pre-oedipal conflicts may predominate in persons with rather primitive fusion and defusion of aggressive and sexual impulses. Aggression is discharged indiscriminately towards one's own body or towards the outside. Kernberg (1993) posits that such behaviour may also provide the borderline individual with secondary gain, related to the experience of impotence and horror on the part of significant others. He goes on to suggest that feelings of superiority over family and friends, perceived of as torturers by means of projection, may consequently result from such actions. In some instances, discrete self-mutilation may also involve undertones of sexual meaning, that is sexualised sadomasochistic fantasies (Kernberg, 1993).

From this point, the literature can be divided into two main groups: i) an exploration of the theory and concepts underlying early borderline development i.e. considerations and explorations of ego weaknesses and primitive cognitive structures related to primary process thinking; and ii) the specific defensive operations characteristic of borderline personality organisation. It is on the former that the literature now focuses.

2.5. THEORIES UNDERLYING THE DEVELOPMENT OF BORDERLINE PERSONALITY ORGANISATION

According to Kernberg (1986), in order to fully understand the borderline personality organisation with its areas of strengths and weakness, one needs to first understand the pathology of the borderline individual's internalised object relationships. An exploration of this concept from various theoretical perspectives within the field of object relations and symbolic thought, as described in the literature, follows:

2.5.1. Symbol Formation:

Humans are symbolic animals (Cassirer, 1994). In order to cope adequately with inner and outer stimulation, symbols are required to serve a mediating function. Symbol formation may therefore be viewed as the basic common element for all mental activity, whether healthy or pathological (Deri, P., 1990). Deri, S. (1990) suggests that the specificity of a symbol is that it represents that which is absent: "The storehouse of symbolic structures of imagery and language serves as a halfway house through which the unbound passions of the id have to pass in order to come out on the other side as tamed and practical usable intentions" (p. 529).

Deri, S. (1990) suggests that symbols may be seen as tools for aiding in the synthesising function of the ego. The function of the symbol is always a dual one: the act of bridging the different areas results in symbolisation connecting that which is disparate. Simultaneously, the establishment of delineated structures results in a distanced order from existing unbounded chaos. According to Deri, S. (1990) symbolisation may also be seen to involve both boundary-crossing and energy-transformation in that the transformation of energy in the symbolic function originates from an area of relatively unbound energy and then into a state where mental energy becomes more bound and structured. (The energy transforming function of symbols involves the change from primary to secondary process functioning). Hence, in situations where the process of symbolisation is seriously impaired, boundary formations associated with containment and limits may be ill-defined and ambiguous - as illustrated in the borderline structure where thinking may resort back to primary process thinking. The binding of disturbing energy does not ensue in this instance.

Deri, S. (1990) stresses the importance of good object relations which serve to tame the disruptive forces of instinctual demands. The paucity of good object relations in the individual with borderline structure could be a partial explanation for the chaotic and sometimes destructive, acting out behaviour such as self-mutilation. Hence, with regard to the present research, it is postulated that the inhibition of self-

mutilating behaviour will depend on the nature of the individual's object relations which in turn may depend on the individual's ability and capacity for symbolic thought. Symbol formation involves a gestalt-like process and can produce structures which may be highly creative in value as well as psychologically distorted. In this respect, Leichsenring (1991) suggests that essential diagnostic criteria of the borderline personality disorder are disturbances of both thinking and of object relationships.

2.5.2. Phantasy and the Development of Symbol Formation:

The Kleinian view of object relations postulates two positions, namely the depressive position and the paranoid-schizoid position (Segal, 1988). Klein (1986) has defined the depressive position as that area of development where the infant recognises a whole object and relates him/herself to this object. The infant has the ability to simultaneously hold both good and bad aspects of the object in his/her mind. The main anxiety in this position constitutes the infant's fears that his/her own destructive impulses have destroyed, or will destroy the loved object on which the infant is so dependent. This carries the ambivalence inherent in loving and hating the same object which further fuels the anxiety. In the paranoid-schizoid position which precedes the depressive position, there is a split between the good and the bad objects and the loving and hating ego. The leading anxiety in the paranoid-schizoid position is that the persecutory object/s will enter into the ego and overwhelm and annihilate both the ideal objects as well as the self. According to Klein (1958) the process of symbol formation occurs when the ego becomes better organised - projections are thus weakened, and repression takes over from splitting. Psychotic mechanisms are replaced by those which are neurotic, and mechanisms of inhibition, repression and displacement also become obvious. Capacities for linking and abstraction develop. Hence, the infant partially inhibits and displaces instincts onto substitutes, thus manifesting a primitive form of symbol formation which unfolds through the development of phantasy. According to Segal (1988) phantasy serves the function of being the mental correlate of the instinct. It also enables the ego to sustain tension without immediate motor discharge

occurring. Klein (1958) states that the symbol, having developed through the process of phantasy, is differentiated from the self in that it is perceived as being created by the self and therefore can be readily used by the self. It must be noted that good external objects in adult life perpetually symbolise and contain facets of the primary good object, such as a mother or a caregiver. In the paranoid-schizoid position the functional ability to use symbols is primitive.

According to Segal (1988) the infant capable of sustaining phantasy can sustain his or her desire until satisfaction is available without it turning into overwhelming frustration. However, in the infant unable to maintain phantasy, frustration becomes severe and results in motor discharge and possible disintegration of the immature ego as a result of excessive projection. In relation to the present research, acting out behaviour in the form of mutilation may be seen to be the result of poor symbol formation born out of poor 'phantasying', the activity of splitting off a species of thought activity and keeping it free from reality testing (Segal, 1988, p. 22). It is hypothesised by the researcher that the mechanism of primitive 'phantasying', initially, and at a later stage symbol formation, may play a large part in aiding the borderline individual's inhibition of cutting behaviour. Mature symbol formation, developed through the process of primitive 'phantasying' assists in impulse control and frustration tolerance which form one of the underlying weaknesses of the borderline individual according to Goldstein (1989b).

In relation to the present research, the individual who manifests healthy functioning may be perceived as having moved closer to the developmental depressive position, while the individual fixated in the paranoid-schizoid position could be viewed with greater propensity towards regression and possible psychosis. It could be hypothesised that an intermediate process occurring between the two positions is involved. This process could be said to involve transitional phenomena (Winnicott, 1975) which is explored in the next section.

2.5.3. Transitional Phenomena:

The transitional space and transitional object may be collectively termed transitional phenomena (Winnicott, 1975).

Winnicott (1975) goes on to suggest that there is a definite connection between transitional object use and personality development. He states that the transitional object '*stands for*' the breast or the object of the infant's first relationship, and that it also precedes established reality testing (p. 236). Arkema (1981) further expounds on Winnicott's notion of the transitional object by indicating that it is animate or inanimate, but the essential quality is its non-demanding nature. The use of transitional objects may be found in all stages of life, and the undifferentiated soother of childhood may be superseded by the elusive, often intricate soothers of adult life which suggests the possibility of self-mutilation constituting a form of self-soothing.

Winnicott (1975) states that transitional phenomena do not necessarily have to be part of the infant's body, e.g. a thumb, nor do they necessarily belong to external reality, e.g. a teddy bear. Examples of transitional phenomena inherent in the transitional space or associated with the object could be a repertoire of songs and tunes sung over and over by an older child before falling asleep. He locates the transitional space and object in the symbiotic phase. As infants emerge from the symbiotic phase on the path to individuation, an intermediary space is constructed between the inner and outer world which ultimately helps in consolidating ego boundaries. This is termed the transitional area between the 'me' and the 'not-me' and it may house the transitional object. This space is also an extension of ego boundaries which should allow the child to sustain the belief that they can exercise omnipotent control. Hence, although it is both part of the infant and part of the external world it resides in a space which is completely under the developing ego's control. In a facilitating environment the mother supports the illusion of omnipotence.

Comparisons are made by Winnicott (1975) with Klein's notion of the 'internal object'. However, Winnicott (1975) states that for the infant, the transitional object is neither an internal nor an external object, but rather a possession. The transitional object, however, can only be used when the internal object is alive and good, that is, not too persecutory. If not good, the internal object becomes persecutory and dead, whereupon the transitional object fails to have meaning for the infant. With no living object relation, there is no potential, no space and no development of a meaningful transitional object.

Giovacchini (1987) suggests that the child who has had optimal mothering gains the conviction that the source of nurturing resides within rather than without, leading to a healthy sense of omnipotence. In situations which are not optimal, the mother has difficulty in allowing her child to individuate or have some control over his/her own environment, transitional object and nurturing experience. Giovacchini (1987) stresses however that this difficulty in separating is not the same as Masterson's (1976) formulation around the borderline fixation at separation-individuation stage. The difference resides in the fact that the impact of the traumatic environment is felt and experienced from the very start of life, and the distortions in ego development occur in both the pre-symbiotic and symbiotic phases. Hence, Giovacchini (1987) views the impact of the traumatic environment as all pervading while Masterson (1976) perceives the impact as affecting specific developmental stages.

In psychopathology, Winnicott (1975) suggests that the transitional object and transitional object usage in adulthood can be transformed into an addiction, involving regression to an early stage where the transitional phenomena are re-instated but assume a more adult guise. Persistence with a specific phenomena dating from early childhood experience may manifest - such as in overeating, where food may become symbolic and may then stand in for the early nurturance at the mother's breast. Another possibility of pathological transitional object usage involves pseudologia fantastica and thieving where the individual has an unconscious urge to bridge a gap in order to create a continuity of experience with regard to a particular transitional object. This may manifest in therapy in the

projection of the individual's own superego deficits onto the therapist who may then be viewed as dishonest (Snyder, 1986). In relation to the present research, although borderline adults may engage in transitional object usage, it may be at times in an addictive and pathological way as opposed to a healthy way. It could be hypothesised that self-mutilation involves a regression to an earlier stage of transitional object usage due to its potential for self-soothing in the borderline individual. Self-mutilation could therefore be conceptualised as a transitional phenomenon in its own right in that it is postulated that the transformation of emotion to symbol formation is stuck at an intermediary level of somatic expression - a me/not me experience.

Transitional object usage can be viewed as having the potential to be both healthy and pathological (Morris, Gunderson, & Zanarini, 1986). This has implications for the present research whereby the borderline individual's use of transitional phenomena, be it in a healthy or pathological manner, suggests that the individual has the ability to enter into the transitional space. This in turn suggests that the borderline person has the capacity for a more sophisticated way of being in the world than, for instance, does the psychotic patient. Hence, it is hypothesised that the borderline individual with the potential for symbol formation (due to the capacity for transitional object usage) has the capacity to re-articulate distress in new and meaningful ways other than through self-mutilation. However, the borderline individual's tendency to over-use or destructively use transitional objects needs to be considered as well. Based on this, the work of therapy could be in assisting the borderline patient to channel their existing potential in a careful and less destructive manner. In other words, the borderline individual has more of a capacity for transitional object usage than the psychotic, but it is hypothesised that a 'superego type figure', which could be the therapist, is needed to channel the individual towards healthier as opposed to more destructive transitional object usage.

2.5.4. The Role of the Mother/Caregiver and Transitional Object Development:

Giovacchini (1987), suggests that Winnicott's (1975) notion of a transitional object may be viewed as that: "which enables a tentative entrance into the external world" (p. 187).

In the development of borderline characterology Giovacchini (1987) suggests that the child is viewed by the mother as a transitional object, that is, treated as though the child was inanimate. The infant also receives very little sensory input as a result of physical needs being met mechanically with little other meaningful interaction taking place between mother and child. By treating the infant as a self-object, the infant is kept in the mother's omnipotent control, and by so doing, the mother feels protected in that her infant is rendered helpless and 'safe' from directing murderous manipulations onto the mother. All the mother's behaviours are therefore based on her phantasies surrounding her child, which arise out of her own emotionally deprived childhood. Mothers may also relate to their infants as transitional objects in an attempt to move themselves into the external world. The child is used as an intermediary step, in other words, the mother tries to recapitulate the infantile emotional development that she failed to achieve during her own childhood.

According to Giovacchini (1987) the mother may be able to function relatively well in the external world in that she achieves a sufficient degree of psychic equilibrium by relating to her child as a transitional object whether this be as a protective defence or as an intermediary step. This occurs, however, at the expense of her child in that the child's id needs are met, but not its ego needs, the consequence being a lack of ego relatedness. The child is treated as a self-object whereby the mother projects the devalued parts of herself onto the child, namely her bad introjects. Children having experienced such a symbiotic phase frequently develop a hateful image of themselves. They tend to revile themselves because of their perceived badness and are, in general, self destructive and often they feel as though they do not exist. In relation to the present research, the feeling of not existing

could partially explain the borderline individual's need to self-mutilate in that according to Kafka (1969) and Malcolm (1994) the experience of mild pain resulting from self-mutilation is associated with the return of feeling alive and real. Giovacchini (1987) suggests that as infants, the borderline individual's parents could not relate to their emerging sense of aliveness in that any interest expressed towards the external environment was not responded to or shown any reciprocity. A further consequence of this is lack of intimate object relations as adults, others may be related to as 'objects' in the literal sense. Despite having numerous friends, borderline individuals are likely to have no close ties or emotional attachments, an absence of feeling in relationships may be all-pervading. Giovacchini (1987) also suggests that these individuals lack 'bridges' between lower and higher psychic constellations - there is no smooth dipping of ego into id but rather abrupt differences between the primitive and sophisticated. As a result of the fixation in an in-between transitional space, no continuum has been developed between their inner mental life, the transitional space and the external world. Such a lack of continuity serves to reflect the inner structure of the psychic apparatus. This in turn serves to explain fluctuations between sophisticated rational behaviour and bizarre, primitive reactions which can be explosive. The modulation of reactions becomes difficult for these individuals which could explain why, for the purposes of the present research, there are *times* when the borderline person is able to inhibit self-mutilation but that the ability to inhibit fluctuates and is frequently inconsistent. In relation to the present research it is hypothesised that the borderline individual has difficulty internalising and at a later stage drawing on the more sophisticated ways of inhibiting self-mutilation. The modulation of impulsivity is at times too difficult for the individual. It is hoped that the present research will illuminate what the borderline individual is able to draw on and how it is used to modulate and contain the impulsive and primitive reactions which would otherwise lead to self-mutilation.

2.5.5. Transitional Object Usage and the Borderline Individual:

Winnicott's (1975) concept of the transitional object has stimulated numerous applications and extensions of his theory. Some theorists have posited that pathology is related to an absence of transitional objects in early childhood (Horton, Low, & Copplillo 1974; Lobel, 1981; Provence & Ritvo, 1961 and Sansone, Fine & Mulderig, 1991). Others have suggested that prolonged and/or maladaptive use of transitional objects can be linked with borderline pathology in adolescents and adults (Arkema, 1981; Fintzy, 1971; Giovacchini, 1985; Modell, 1968 and Sansone et al, 1991). Morris et al (1986) state that to restrict the development of the transitional object to normal development would be to blur the point made by Winnicott.

Morris et al (1986) suggest from the findings of their research that borderline patients show a relatively high degree of transitional object usage. The use of transitional objects is, however, not closely related to severity of psychopathology and yet characteristics correlating positively with high transitional relatedness scores included countertransference difficulties, interpersonal dependency, self-mutilation and manipulative gestures. The relationship between borderline individuals and transitional phenomena is a complicated one, however, which is not only specific to borderline patients.

Morris et al (1986) state that transitional object use, which is associated in childhood development with the awareness of the separateness of significant others can be expressed both normally and pathologically. In opposition to this view Arkema (1981) describes transitional object usage in the borderline individual to be solely maladaptive, rigid and involving repetitive usage of transitional objects, where: "They...wrung from it everything they could get" (p. 175). Arkema (1981) suggests that evolution to mature expression is lacking in that when the borderline individual perceives the object to have failed him or her, tantrum-like behaviour often ensues, combined with self-destructive acting out. Fintzy (1971) hypothesises, however, that it is the covert existence of a transitional object which

assists the borderline individual in perpetuating a facade of functionality outside of therapy. He suggests that borderline individuals often have a history of a prolonged relationship with a transitional object of sorts. According to Winnicott (1975) in the development of the healthy child the transitional object is gradually decathected. Fintzy (1971) suggests that in the borderline individual the transitional object does not disappear but rather becomes disguised in the form of an altered or modified transitional object. He points out that the selection of the persisting transitional object is random, the specific object chosen is less important than the properties with which it is imbued by the patient's imagination.

There is still much debate with Gunderson, Morris and Zanarini (1985) maintaining that whether borderline individuals' attachments with transitional objects and phenomena in adulthood can be termed rigid or regressive or whether such objects or phenomena are used in a covert manner to maintain an outward appearance of 'normal'/healthy functioning are questions needing further investigation.

Sansone et al (1991) state that the reported use of transitional objects in both childhood and adulthood appear to be high in those diagnosed with borderline personality disorder, but could also be found in those with non-borderline diagnoses which dovetails with Morris et al's (1986) abovementioned research. Such a finding is interesting in that it implies a developmental breakdown not necessarily associated with the development of the borderline condition, but rather something which runs parallel to the condition. This suggests that an investigation of the use of transitional objects, irrespective of diagnostic considerations, might provide some useful insight into the function of self-mutilation.

2.5.6. Object Constancy: Attachment and Separation/Individuation

2.5.6.1. Object Constancy and Evocative Memory:

Cardasis, Hochman and Silk (1997) indicate that within the psychodynamic perspective, object relations theory addresses the relationship between what is described as psychologically 'internal' and 'external', in addition to exploring how early formative relationships become internalised and how this subsequently affects the individual's experiences of self and others. Object representation is a key element of object relations theory and relates to conscious and unconscious mental schemata of significant early interpersonal interactions. Emotional object constancy or the ability to retain consistent images or representations of important persons allows the individual to achieve an increasingly stable sense of self and others, especially in times of threat or anxiety. One theory describing borderline development (Cardasis et al, 1997) suggests that the borderline individual as a child was unable to traverse the rapprochement sub-phase of the separation-individuation process (discussed below) due to deficits on the part of the caretaking parents. As a result, the child internalised poor object representations and thus exhibits impaired object relationships and poor evocative memory. Sable (1997) states that inconsistent and neglectful caretaking of the infant also results in heightened feelings of anger and anxiety on the part of the infant. Furthermore, the caretaker is unable to reduce these feelings of distress as a result of self deficits, resulting in a chronic fear and anxiety superimposed with anger and resentment once again on the part of the infant. Defensive numbing on the part of the infant may develop in order that the caregivers be kept safe from the infant's rage and resentment. This defensive numbing can often last beyond reunion with the caregiver, and into adulthood, possibly explaining, in part, the borderline adult's difficulty in identifying and verbalising their emotions.

According to Cardasis et al (1997), the ability to retain images or representations of important persons or caretakers during childhood is an essential step in developing 'emotional object constancy'. Mahler (1971) suggests that this anchors the child,

which allows for the achievement of an increasingly consistent and stable sense of significant others and of self. The infant's evocative memory or the ability to evoke these images in times of anxiety or threat is essential in the process of developing object constancy and hence a self that can withstand fluctuations of consistency in the environment. The borderline individual appears to have a lack of object constancy and inability to maintain consistent, inner representations. Cardasis et al (1997) goes on to suggest that borderline persons use transitional objects, due to the object's evocative memory potential, to help reduce desperate feelings of loneliness and vulnerability. The transitional object may help to provide the individual with a way to soothe themselves in an environment where consistent representations of caregivers are difficult to maintain.

It is hypothesised, in relation to the present research, that borderline individuals may attempt to use transitional objects and their capacity for evocative memory to inhibit self-mutilatory behaviour. It is noted that the use of the term 'transitional object' in Cardasis et al's (1997) article may differ slightly from the classical function of a transitional object - a substitute/symbol for a meaningful and important relationship originally thought to be with the individual's mother or caregiver. Cardasis et al (1997) refer rather to possessing an object of special and significant meaning in adulthood (which may well have unconscious significance). Transitional objects and their usage appearing in the interview material of the present research may well relate to Cardasis et al's (1997) definition as opposed to the classical definition due to the adult status of the respondents interviewed in the present research.

Sable (1997) goes on to posit that the individual cannot defend against separation anxiety, for example, by spontaneously holding a sustaining image or representation when separated, or by merely soothing themselves, hence the need for transitional object usage. Johansen (1983) supports the idea that transitional experiences may be a major aspect of the borderline individual's effort to gain object constancy, albeit in a very subtle manner.

2.5.6.2. Attachment:

Bowlby's attachment theory (1969) also recognises the significance of the mother-child bond for mental health. Bowlby (1969) explains pathology from the point of view of disruptions and/or adverse experiences with key figures of attachment. In borderline pathology there appears to be intense oscillations between a desire for both attachment and emotional detachment from others suggesting an internal world compromised of coherence with regard to thinking and affect regulation. According to Giovacchini (1987), this fragile cohesiveness of self-representation can be said to be the outcome of a specific type of defective mothering. Disturbed personality structures can be conceptualised as an organisation of attachment behaviour along a continuum of secure versus insecure. Borderline personality structure could be placed at the extreme end of insecure.

Bowlby (1969) believes attachment to be complementary to exploration. He suggests that with a springboard of secure attachment, children can spend more time away from caregivers, tolerating separation and experiencing less distress. However, the lack of a secure base results in curiosity and willingness to explore being inhibited. As a result of early childhood traumas and/or discontinuities, the individual grows up with a heightened sensitivity to separation and loss but with a lack of awareness as to why they react the way they do. Melges and Swartz (1989) compare the oscillating behaviour of the borderline individual to that of prickly porcupines, there is need for another, but if anyone comes too close they are driven away by the borderline individual's fear. Hence, according to Bowlby (1969) borderline individuals are desperate for a secure base but are afraid to allow themselves to become attached to anyone for fear of rejection and the resultant feelings of abandonment, anger and anxiety. Borderline individuals could be said to be preoccupied with regulating space, in an ongoing attempt to deal with the conflict between attachment and exploration.

It is hypothesised by the researcher that in being preoccupied with regulating space, the way the borderline individual inhibits self-mutilation may not be constant.

There may be a need to vary inhibition through inanimate and animate/human means depending on each particular situation for the individual. In other words, depending on whether the borderline individual in that particular moment is needing contact with another (attachment) or solace from impingement (separation) may impact directly on the manner in which inhibiting of self-mutilatory behaviour is carried out. This in turn suggests that there may be a link between the choice of inhibiting behaviour and the precipitating factor which leaves the borderline individual with a need to self-mutilate in the first place. Clearly the same hypothesis could relate to mutilating behaviour as well.

2.5.6.3. Separation/Individuation:

Mahler (1971) states that borderline disorders of the self arise as a result of failure to negotiate the rapprochement sub-phase of development. The rapprochement sub-phase may be defined as the transition from symbiotic attachment to separation-individuation. Mahler (1986) suggests that failure to adequately negotiate this sub-phase may be due to three possibilities namely (1) the fear of re-engulfment; (2) precocious differentiation of a false-self; and (3) the narcissistic hypercathexis resulting from overstimulation as opposed to tender emotion. Berzircanian, Cohen and Brook (1993) suggest that both the freedom from interference and a stable secure structure need to be lacking in order for the separation-individuation phase to be so hindered as to result in identity disturbance and the poor sense of self worth characteristic of the individual with borderline personality structure.

According to Mahler's (1986) schema of normal development, during the first year of life the child passes through a pre-separation period of development. Included in this phase is the autistic or internally preoccupied phase and symbiotic phase where the child displays early signs of attachment. Following attachment to the caregiver being successfully achieved, a gradual process of separation-individuation follows. The early signs of this process are differentiation of self from others. Following this is the practicing period where the child experiences an omnipotence and developing sense of narcissism in relation to self and the caregiver. The final step

involves the rapprochement phase in which the child's emotional attachments and ever developing cognitive capacities intrude into the sense of omnipotence and grandiosity. During this phase the child develops an acute and painful awareness of separateness and vulnerability in continuing to strive for mastery and independence. A parallel could be drawn here with Klein's (1986) depressive position. According to Price (1990) failure to negotiate the rapprochement phase successfully results in the incapacity to view objects ambivalently, which according to Kernberg (1975) forms the core pathology of the borderline individual. Mahler (1986) suggests that if there was a failure during the first three sub-phases of separation-individuation, the child may have failed to take autonomous, clearly separated possession of his or her own bodily self, which in part may be as a result of not experiencing the caregiver's gradual relinquishing of possession of the child's body. According to Stein (1956 cited in Mahler, 1986) borderline individuals in later life: "may act out the unconscious role of a cherished or rejected part of the parent's hypothetical body-self ideal" (p. 445).

In relation to the present research the borderline individual's perception of his/her body as a cherished or rejected part may impact on how severely they choose to cut themselves. This in turn would reveal much about the nature of the individual's internal world, and its tendency to be punitive or benevolent. According to Westen, Ludolph, Lerner, Ruffins and Wiss (1990) borderline individuals produce richer, complex and more cognitively-developmentally advanced object representations than neurotic or 'normal' individuals, however, theirs is a more hostile and malevolent object world. The activation of these more malevolent representations depend on certain conditions such as strong affective arousal, and hence are not always present. The inhibition of self-mutilation may depend in part on the borderline individual's propensity to identify their bodies with the cherished part and draw on the positive, more benevolent introjects associated therein. If one compares the borderline individual with the psychotic patient, while the borderline person may have the phantasy of hurting the rejected part of the parent's hypothetical body-self ideal through self-mutilation, there is awareness that in reality it is their own body which is being inflicted with wounds, unlike the psychotic

individual. The borderline individual's relative ego strength for reality testing may well play a part in inhibiting self-mutilatory behaviour in certain instances such as that mentioned above.

2.5.6.4. Abandonment:

A lack of object constancy prohibits separation, which can result in a borderline structure as discussed above. However, themes of abandonment have also been linked to the development of this structure (Price, 1990). It is believed that the prohibition on separation with the resultant threat of abandonment, should the infant choose to separate, can result in an inner emptiness resulting in struggles with aloneness so often apparent in borderline individuals (Masterson, 1976). Elements of overprotection and neglect frequently apparent in the history of borderline individuals could explain their oscillations of attachment which could be said to involve both the feelings of engulfment and feelings of abandonment by others (Zwieg-Frank & Paris, 1991). It is also possible that the borderline individual may strive to generate an external focus by maintaining contact with a primary other in order to avoid painful internal realities such as an awareness of abandonment issues (Kroll, 1988). In relation to the present research it is hypothesised that the primary other could be viewed as a form of transitional object. Furthermore, it is hypothesised that this tendency towards an external focus which allows for contact with a primary other may be another way of inhibiting self-mutilatory behaviour. This could point to another area of relatively healthy functioning within the borderline person whereby compensatory mechanisms could be said to be operating in an attempt to cope with the underlying developmental deficit. However, in order to better understand this, the area of abandonment and deficit therein needs to be explored in more detail. One of central theorists focusing on functioning of the borderline individual from the perspective of abandonment is Masterson (1976) who postulates borderline object relations to result from the mother's failure to maintain emotional investment and availability in response to her infant's behaviour regardless of whether it is separating, clinging or regressing.

Masterson's (1987) model of borderline development focuses on the individual's failure to self-activate and take responsibility for their own life in an environment of abandonment versus enmeshment set up by the caregiver. Masterson (1987) posits that the mother rewards regressive, dependent behaviour and punishes attempts on the child's part to individuate by withdrawing libidinal supplies. He suggests that the child needs these supplies to grow, but when the child attempts to individuate these supplies are withdrawn creating a no-win predicament for the child. Such a situation initiates an abandonment depression. The need to defend against the depression produces the developmental arrest. This arrest in turn produces a persistence of the splitting defence in addition to the child's failure to internalise the ego functioning that the mother previously performed. The result of this is ego functioning defects with regard to reality perception, impulse control, ego boundaries, frustration tolerance and failure to achieve object constancy which has bearing on how others are related to. Bezirgianian et al (1993) suggest that these mothers have disturbances as to their own sense of identity, affects, and interpersonal relationships.

According to Masterson (1987) the rewarding/punishing behaviour, which the mother utilises, results in a 'rewarding object relations unit' - a RORU, and a 'withdrawing object relations unit' - a WORU, both of which are split off from one another. The child attempts to deny the reality of the WORU and instead to evoke the RORU by means of clinging and regressive behaviours. According to Masterson (1987), the WORU is cathected with aggressive energy and the RORU with libidinal energy - the mechanism of splitting is used to separate the two. The affective component of the WORU is abandonment depression, used here as a blanket term covering six affects - suicidal depression, homicidal rage, panic, guilt, hopelessness, emptiness and void. The mix and balance of these affects depends upon the individual's constitution and early developmental experiences. The mother's withdrawal is experienced by the infant as a loss of self. The RORU on the other hand is experienced as ego syntonic in that it relieves the abandonment feelings associated with the WORU. The RORU does result in a regressive denial of reality and a lack of confidence in the self although the affective states associated

with the RORU on the part of the infant is a feeling of gratification at being 'loved'. Both the WORU and RORU are pathological because it is as if the borderline individual has but two alternatives - to feel bad and abandoned (WORU) or to feel good and loved (RORU) creating an 'all or nothing' situation. The WORU is externalised through projection and acting out behaviours while the RORU remains internalised but is expressed through hidden fantasies and compliant behaviour. Both involve the denial of the reality of the maladaptive behaviour. Masterson's (1987) theory elucidates the role and implications of splitting.

Hence, to sum up thus far, while the borderline individual's core difficulty appears to be in integrating splitting defences, there appears to be potential for transitional object usage and 'phanstaying'. The difficulty for these individuals appears to be around taking refuge from their malevolent inner world comprised of punitive introjects. It is hypothesised that ways of seeking such refuge from these introjects may form an important part of self-mutilation.

This research is concerned with investigating the resources which are called upon when self-mutilating behaviour is inhibited.

2.6. DEFENCE OPERATIONS CHARACTERISTIC OF BORDERLINE PERSONALITY ORGANISATION

In order to explore healthy functioning in the borderline individual, one must be aware of the defences which operate and which may be so well developed that they serve to obscure the aspects of relative ego strengths.

Gunderson and Singer (1986) suggest that anger seems to constitute the main if not only affect that the borderline individual experiences. The expression of this anger and use of defences around it can be a major discriminating feature in identifying the borderline individual. Depression of the lonely type (rather than the guilt laden, self-accusatory type) is the other main affect sometimes experienced by borderline persons, often the result of the realisation that they have difficulty in committing

themselves in a world of transacting individuals. This suggests the ability for insight in these particular individuals, a relative ego strength.

2.6.1. Splitting:

In exploring the work of many of the psychodynamic theorists, one is struck by the importance many attach to the defence mechanism of splitting in the aetiology of the borderline personality structure. Kernberg (1986) defines splitting as the active process of keeping apart introjections and identifications of the opposite quality. The integration or synthesis occurring under optimal conditions allows for the neutralisation of aggression. Splitting, however, blocks this process which leads to ego weakness which then falls back on the splitting defence and a vicious circle is set up.

Brown (1987) suggests that Masterson and Kernberg both consider the borderline individual to have successfully negotiated the differentiation between self and object representations and has therefore developed beyond the symbiotic phase of development and onto the stage of having internalised object relations. Hence, up to this point the borderline person is able to display quite healthy functioning in terms of being able to use transitional experiences and objects due to the objects' potential for evocative memory. Both theorists are in agreement that the area of difficulty for the borderline individual involves the integration of good and bad self representations. According to Kernberg (1986) initially the lack of integrative capacity occurs because of the early, undeveloped ego. However, further on, the lack of integration becomes used defensively by the emerging ego to protect against anxiety and to protect the ego core which is built around positive introjections. Hence, Kernberg (1986) suggests that: "this defensive division of the ego (in which what was at first a simple defect in integration is then used actively for other purposes) is in essence the mechanism of splitting" (p. 299).

Kernberg (1986) points out that in optimal situations, the mechanism of splitting is rapidly replaced by higher level defensive operations of the ego during the first year

of life. These mechanisms involve repression, reaction formation, isolation and undoing all of which serve to protect the ego from intrapsychic conflicts. In the borderline individual, however, contradictory ego states are alternately activated but in order to prevent anxiety they are kept separate from one another. This is, however, detrimental to the integrative process which normally consolidates into a stable and consistent ego identity. The need to preserve both the good self, good object images and good external objects in the presence of 'all bad' self and object images leads to a number of subsidiary defensive operations which are present in borderline personality organisation.

2.6.2. Idealisation:

Kernberg (1986) states that primitive idealisation is another defence which involves viewing external objects as totally good in order to serve as a protection for the individual against 'bad' objects. All good objects also cannot be contaminated then by the individual's own aggression. Unrealistic, 'all good' and powerful images are created, often borne out of a guilt over the individual's own aggression towards the object. This defence serves the function of protecting the individual against a surrounding world of dangerous objects.

2.6.3. Projection and Projective Identification:

Kernberg (1986) goes on to state that projection and projective identification are also defences characteristic of borderline personality organisation - such individuals exhibit very strong projective trends. The purpose of this mechanism is to externalise primarily the 'all bad', aggressive self and object images. Good object images, however, may also be projected. The main consequence of this defence mechanism is the development of dangerous, retaliatory objects against which the individual needs to defend. The individual may feel as though the object has to be attacked and controlled before it has an opportunity to attack and destroy the individual. Kernberg (1986) summarises projective identification as being characterised by: "a lack of differentiation between the self and object in that

particular area by continuing to experience the impulse as well as the fear of that impulse while the projection is active, and by the need to control the external object" (p. 304).

2.6.4. Denial:

Kernberg (1986) discusses denial, a further defence mechanism frequently used by those with borderline personality organisation. Primitive manifestations of this defence are frequently used. Denial can be seen to reinforce splitting in that the individual is aware that perceptions, feelings and thoughts about self and other people are completely opposite to those held at other times but this memory has no emotional relevance for the individual. As a result, one could speak of 'mutual denial' (Kernberg, 1986, p. 305) where there appears to be no capacity for the emotional linkage of the two separate ego states, the reinforcement of splitting. If pushed, the individual may have an intellectual awareness but cannot integrate it with the rest of their emotional experience.

2.6. 5. Omnipotence and Devaluation:

Omnipotence and devaluation form another area of defence mechanism for borderline individuals according to Kernberg (1986). Individuals using these two forms of defence may oscillate between the need to establish a demanding, clinging relationship to an idealised 'magical' object at times, coupled with fantasies and behaviour indicating a deep feeling of magical omnipotence over the object at other times. On a deeper, unconscious level the idealised person may be treated ruthlessly and as though they were an extension of the patient. Hence, even when there appears to be apparent submission to the idealised external object, the less overt, omnipotent fantasies of the patient can be detected. Both stages indicate an identification with an 'all good' and powerful object as a protection against 'all bad' persecutory objects. The need to control the idealised objects in order that they be used in an attempt to manipulate the environment and 'destroy potential enemies' is connected with an overwhelming sense of pride at 'owning' these perfect objects

which are completely dedicated to the individual. If an external object is seen to provide no further gratification or protection it may well be dropped, dismissed or devalued. This occurs because there was no real love nor concern for the object to start with. Devaluation may also occur when the individual has a vengeful need to destroy the object which is felt to have frustrated their needs, or to protect against the object becoming the feared and hated 'persecutors'.

From the above discussion, it becomes clear that the defences employed by the individual with a borderline personality structure impact greatly on their object relationships. Gunderson and Singer (1986) state that a frequently cited characteristic of the borderline individual's interpersonal relationships is a predictable superficiality and transiency. Conventional adaptation to the environment, apparent maintenance of object relationships on a superficial level and apparent social functioning can appear intact. Borderline individuals have also been said to form intense, clinging relationships at times as opposed to the schizoid and schizophrenic individuals, suggesting a consistent albeit primitive ability for object relations. Thus, it can be said that in their everyday relationships, despite the early developmental deficits and active need to engage in pathological defence mechanisms, borderline persons are able to relate in a fairly normal, but superficial and transient manner, while in their close relationships they may become intense, dependent and manipulative. Such individuals can therefore be said to be actively involved with other individuals as opposed to being particularly socially withdrawn. Furthermore, although the aforementioned defences impact on areas of ego development, Gunderson and Singer (1986) make the point that the borderline individual can test out their experiences as opposed to the psychotic who cannot.

2.7. CONCLUDING COMMENT

He who ventures to accompany the borderline or psychotic child into the terrain of his inner world will find his journeys beset with many special hazards and bewildering phenomena. We refer not to the fluid landscape or to the archaic figures which emerge, coalesce and disappear, only to rise again in more monstrous display. For, despite the dimness of the landscape, some maps have already been charted and reports of previous travellers are available for aid. *However, even the most seasonal travellers will be puzzled by the phenomena of arrival and departure in this world of fantasy. Once having communicated his readiness to embark upon these journeys in whatever guise the child requires, the traveller cannot but wonder at the exact moment and at the startling abruptness with which the voyages commence and terminate.* Nor can he help but speculate that a knowledgeable grasp of the timetable might provide him with more adequate preparation of the journey, but with the means of effecting the course and destination of his young guide as well (*italics added*) (Ekstein and Wallerstein, 1954, p. 344).

From the literature it becomes clear that borderline individuals are seen to possess the capacity for healthy functioning. However, they appear to move into and out of these 'islands' of healthy functioning in an abrupt and sometimes confusing manner as is suggested by the quotation above. As a result of this, and possibly due to the defence mechanisms which are often highly developed, an exploration of healthy aspects of functioning in the borderline individual is made difficult. The paucity of literature on healthy functioning, or for the purposes of the present research, the inhibition of self-mutilatory behaviour, is notable. According to Gunderson, Morris and Zanarini (1985) the direction of future research in the area of borderline personality organisation should not, in their opinion, be that borderline psychopathology will come to be associated with a clearly demarcated point of developmental arrest. Rather, in order to be more fruitful, it should focus on an empirical definition to a clinically described aspect of borderline psychodynamics. The present research aims to elucidate and illuminate the aspect of borderline psychodynamics which enables them to inhibit self-mutilation and in so doing will attempt to fill the aforementioned gap in the literature and Gunderson et al's (1985) suggestion.

CHAPTER THREE

METHODOLOGY

3.1. INTRODUCTION:

This research is comprised of the phenomenological method developed by Giorgi (1978) and Kruger (1979).

The aim of this research is to explore and describe the borderline individual's lived experience of being able to inhibit the impulse to self-mutilate, in this instance to cut, and the associated feelings, thoughts and fantasies therein by means of the phenomenological method. According to Malcolm (1994) self-mutilation is a behaviourally-enacted symptom rather than a predominantly cognitively-mediated experience. As a result of the silent nature of the symptom the richness of the underlying dynamics cannot be tapped into through empirical and quantitative research alone. As the aim of this research is to elucidate the human lived experience with all its emotions, thoughts, beliefs, ideas and cultural biases the phenomenological methodology appears to be the most appropriate to use. According to Kruger (1979) and Giorgi (1976), phenomenology aims to include and focus on specifically those characteristics which are uniquely human. The content and focus of the research therefore involves looking as 'man-as man' rather than 'man as thing' (Kruger, 1979, p. 114). Phenomenology avoids the approach of pressing reality into a system of ideas where the human element is ignored. Hence, phenomenological research strives to lift the essential core universality of the human experience to a particular phenomena. As a consequence of the phenomenological methodology informing this research, the direction was: "to listen to what the incidents, the phenomena tell (the researcher)" (Van den Berg, 1972, p. 77), and in doing so, to remain true to the concrete magnitude of "the phenomenon as it appears" (Giorgi, 1976, p. 331).

3.2. RESPONDENTS:

Three women in their twenties who agreed to participate in this study were interviewed. Two of the referrals came from the out-patients department at Tara Hospital and the third from wards 4 & 5, Tara Hospital. One of the respondents taken from the out-patients department was eventually dropped from the study after reviewing her interview tape. She appeared to fall more within the psychotic end of the continuum, had difficulty disclosing her experience of not cutting and was difficult to facilitate within the phenomenological framework. This led the interviewer into being overly directive in the interview. The criteria for selection involved:

- 1) Borderline personality structure as evidenced by cutting behaviour
- 2) An ability to talk moderately freely and comfortably about their experience of inhibiting self-mutilation

3.3. COLLECTION OF DATA:

3.3.1. Research Question:

The primary question used in the study was as follows:

Tell me about the times that you wanted to cut but chose not to. You could think back to a specific incident to help you in answering the question. In your description comment on as many aspects of the experience as you can. The purpose is to obtain as full a description as possible.

In the facilitation of open-ended interviews, the interviewer is required at times to prompt and assist the respondent in elaborating on that which he/she has said which facilitates a deeper and more sustained exploration of the discussed areas. Examples of prompts used in the research were:

Could you describe your experience leading up to the actual act of not cutting?

What was your immediate experience after not cutting?

What effect did the experience of not cutting have upon you?

Is the experience of not cutting comparable with any other experience you have had in your life?

The interview process was structured with the main research question read to the respondent at the start of the interview. The respondent was then allowed to speak in as uninterrupted a manner as possible and prompts were offered when appropriate.

3.3.2. Interviews

The researcher contacted each respondent personally through out-patients and wards 4&5 at Tara, The H. Moross Centre. Respondents were informed that the research topic involved self-mutilation and that they would be interviewed specifically around their attempts to inhibit such behaviour. Respondents signed a consent form concerning their participation and an attempt was made on the part of the researcher to ensure anonymity. Following a discussion of the purpose of the study and agreement on their part to act as respondents, an interview was set up in an office at Tara, The H. Moross centre.

In the initial stages of the interview, the researcher attempted to place the respondent at ease by creating a safe space in which to explore their experience of not cutting by offering a non-judgmental and accepting attitude.

3.3.3. Ethics

One follow-up session was set-up with each individual. The sessions were set up with the intention of offering a space for debriefing if needed. The respondents, however, chose to use the session instead to discuss additional thoughts that they had had following the interview. With the exception of one respondent, the other

two left the interview feeling contained and without a need to cut, and this was reiterated by them in their follow-up sessions. The feelings of containment may have been due to the fact that the respondents were asked to focus on healthy as opposed to unhealthy functioning which required that they draw on their positive inner resources. The respondent whose protocol was dropped from the research due to her falling within the more psychotic end of the continuum left the interview feeling contained but admitted to cutting herself at a later stage. She did comment, however, that her need to self-mutilate was more as a result of personal issues occurring in her life at that time than because of the interview itself.

3.4. ANALYSIS OF THE DATA

The interviews were interpreted by means of the following stages as detailed by Georgi (1978):

3.4.1. Stage 1: Initial Reading of the Protocol

Each transcript was read and re-read several times in order to familiarise oneself with the material as a whole. The tapes were transcribed by the researcher herself in order that she be aware of and familiar with the emotional and tonal inflections of the spoken word which is often not captured by the one-dimensionality of the transcribed material.

3.4.2. Stage 2: Delineation of Meaning Units ¹

Each protocol was read through with the intention of dissecting the text into manageable segments or natural meaning units (NMU's). Each unit may be defined as: "a statement made by [the subject] which is self-definable and self-delimiting in the expression of a single, recognisable aspect of [the subject's] experience" (Cloonan, 1971, p. 117).

¹ The NMU's and re-articulated NMU's for both protocols appear in the appendix.

3.4.3. Stage 3: Re-Articulation of Meaning Units From a Psychological Perspective

Each NMU was then re-articulated in the neutral third person. The reason for this is to reinforce for the researcher the aim of the phenomenological methodology which is to understand the text from the point of view of the author of that particular text and not the perspective of the interpreting researcher (Parker, 1985).

Following the process according to Giorgi (1976), the NMU's are then further re-articulated into psychological language. The aim therein is for each transformed meaning unit to reflect the essential psychological meaning inherent in that unit with respect to the phenomenon being researched.

3.4.4. Stage 4: Regrouping of the Transformed NMU's into Themes

The re-articulated NMU's are regrouped according to their varied and sometimes overlapping meanings. The meanings and themes are carefully structured in order to remain true to the individual subject, her experience and specific situation. Irrelevant data which does not add to the existing meaning, fillers such as 'and' and 'but', and repetitive data is excluded from the regroupings.

3.4.5. Stage 5: Central Themes

The regrouped themes are expressed more directly in terms of the given research topic. A phenomenological description of each theme as it is experienced by the participant ensues so as to facilitate a clearer understanding of the essence of that which makes up each respondent's experience. Themes occurring only once are also included if considered relevant to illuminating the experience of not cutting. At the cessation of this stage the protocols have their essential core organised under various themes.

3.4.6. Stage 6: Extended Description

Stage 6 comprises the core area of the research where analysis of the varied themes ensues, the commonalties between the respondents' experiences is discussed and areas of significance are highlighted. This stage also involves a description of what the aforementioned themes tell the researcher about the overall question being investigated.

CHAPTER FOUR

ANALYSIS OF RESULTS

4.1. Central themes expressed more directly in terms of inhibition of self-mutilatory cutting - Respondent R

The relationship with others

- 1a) R's awareness of the impact of her cutting on other people, made obvious to her by their responses of intense distress, anger or intolerance, plays a big part in inhibiting her self-mutilatory behaviour.
- b) Professionals are given the power to control and remove her unpleasant inner feelings. R anticipates that they will be able to isolate and solve her problems.
- c) Other people's positive and encouraging responses when she does attempt to inhibit her behaviour leaves her with a sense of achievement and an awareness of the positive areas of her life.
- d) The experience of being listened to by others provides some shift around what other people could mean to R. Previously she would doubt that people would understand or be emotionally available to her.

Circumstances

- 2a) External circumstances such as blade availability and her fear around being transferred out of the ward play a big part in inhibiting the *act* of self-mutilation but not the *urge*. Should the circumstances be more conducive to self-mutilation R would be forced into making a choice around the consequences of her actions. She is still extremely ambivalent about her internal resources and her ability to inhibit self-mutilation. however.
- b) Sleep, rest and medication appear to be important to R. She attributes her calmer more contained behaviour to their influence.

Propensity for self-awareness

3) R is aware of the destructiveness of her behaviour. She is also aware of the impact of external factors and other people on her thoughts and feelings. Despite this there appears to be no continuous sense of self-awareness but instead flashes of introspection such as her realisation that inhibiting self-mutilation forces R to focus on her inner pain rather than allowing herself to be distracted by the external pain of cutting.

Somatic focus

4) R chooses to protect her body against bad food and external influences but this focus does not appear to extend to her psyche. She is aware that thoughts and feelings are put into her mind. This appears to follow upon her body's reaction to the situation at hand.

Body

5a) R appears to know herself through her body rather than through her emotional life. She rationalises that the mind controls the body but her body is what appears to be affected when she verbalises intense and overwhelming feelings of panic. Her body relaxes, her breathing calms down and she begins to feel more contained and affirmed.

b) R also draws on external factors which impact on her body, such as sleep and medication to explain her calmer feelings. Feeling better is attributed to somatic changes rather than psychic or emotional shifts.

Verbalising

6a) R's previous mode of relating involved a language of the body and hence there appears to be a newness in discovering the use and impact of words. This leaves R with a new experience which although comforting has also opened up old wounds.

b) The act of verbalising appears to reverse the process of self-mutilation and calm her inner chaos. It reaffirms her internal locus of control.

c) R does appears to have some ambivalence around the act of verbalising, however, and does express doubts around its ability to assist her in inhibiting self-mutilation.

Self-sufficiency

7a) R describes herself as an independent person who is not prescribed to easily.

b) Presently she displays ambivalence around her ability to be successfully self-sufficient and so chooses to draw strength from those external to her. She becomes angry, however, when those around her try and physically inhibit her attempts at self-mutilation.

c) In a crisis situation, such as needing to self-mutilate, R needs to be able to anticipate her own actions and make contact with another. The knowledge that she can anticipate her plan of action in advance leaves her feeling secure.

d) R's ability to successfully inhibit self-mutilation restores her faith in herself and empowers her.

Metaphors

8a) R makes use of numerous metaphors in trying to explain herself to others. She also has a need to explain her actions and behaviour to herself which she does through metaphor usage.

b) R compares her self-mutilatory behaviour to being a naughty child, while her attempts at inhibiting self-mutilation are compared with a more adult state involving perseverance and mastery.

c) R's metaphors also suggest that planning and preparation play an important part in inhibiting self-mutilation.

Soothers

9) The inherent qualities of attunement, a non-judgmental, non-directive listening stance, an accepting attitude and emotional availability all serve to soothe R. Soothing interactions with other people such as the nurse assist R in inhibiting self-mutilatory

behaviour by offering her containment. This containment allows R to feel understood and empowered to some degree.

Objects and introjects

10a) R confesses her actions to others in the hope that they will mediate her inner sense of badness. She has a need to negate and belittle all her past and present actions and this leaves her feeling out of control.

b) The sister, however, offered her a new and good experience by aiding R in grappling with her inner monsters. R tries to internalise this experience of affirmation and attunement to her needs and emotional state. The experience is something she carries with her and draws on.

4.2. General description of the inhibition of self-mutilatory cutting -

Respondent R

R fluctuates between an internal and external locus of control. Circumstances and people external to herself are given immense power and are accredited with the capacity and ability to cause her to inhibit of self-mutilation. This is contrasted with her awareness that she is able to successfully inhibit self-mutilatory behaviour by means of her own actions.

R's relationship with others appears to initially have taken on an egalitarian/authoritarian quality where the professionals are perceived of as all knowing and she as helpless and lacking any useful knowledge about herself. More recently, however interactions with others appear to have taken on a more three dimensional, interactive and interpersonal quality where they serve the function of non-judgementally reflecting back to R the impact of her behaviour on the external and the reality around her. R appears to have shifted the meanings given to people and now views them as having the potential for interaction and warmth where previously people were viewed as distant and there to be obeyed and feared.

R has great ambivalence around her own inner resources. She views the external as controlling her fate where the administration of the correct medication and the availability of a blade or lack thereof comprise the deciding factors as to whether she self-mutilates or not. However, there are also moments of realisation for R where the consequences linked to her actions are understood by her to be very much under her control. She becomes aware that whether she is transferred out of the ward or not depends on the choice that she herself chooses to make.

R appears to move in and out of these islands of self-awareness, showing insightful sparks of introspection coupled with areas devoid of any emotional understanding. There does, however, appear to be a consistent awareness of somatic sensations and the impact of the external on her body. R seems to read and make sense of situations through her body's physical response rather than via emotional insights. Consequently, the act of verbalising inner feelings, which R attempts in order to inhibit self-mutilation, is experienced as new, unfamiliar and something which invokes fear and doubts for her. It focuses on the inner feelings as opposed to the outer sensations. Despite this R is aware, following the act of verbalising, of the value and comfort inherent in such an interaction, it assists her in accessing her emotions and having them affirmed. This in turn leaves her feeling understood, contained and soothed all of which serve to reduce the initial inner chaos and terror.

The act of verbalising allows R to express inner turmoil emotionally and through her psyche as opposed to somatically which is what the act of mutilating would have involved. In order to make sense of the emotions for herself as well as having others understand her R makes use of numerous metaphors when verbalising her emotions. The use of metaphors appears to concretise and make more accessible her inner world and associated feelings therein.

The value inherent in the act of verbalising for R lies in the fact that it is conducive to her need for self-sufficiency. R is able to control the flow and direction of the interaction between herself and the other and is not left feeling impinged upon by the interaction, instead, she is left with a sense of achievement and some omnipotence over her environment.

4.3. Central themes expressed more directly in terms of the inhibition of self-mutilatory cutting - Respondent H

Self-awareness

- 1) Much introspection around the act of self-mutilation has ensued on H's part. Consequently H believes that cutting possesses greater psychological than physiological significance for her.
- 2) H ponders the impact of the external world upon her inner life in great detail but displays a fear and need to disengage from emotionally charged situations which appear to terrify her. This particular area of her life appears to be devoid of introspection.

External factors impacting on H's decision

- 2a) The dog's perceived resonance with H's distress when she cuts plays a part in inhibiting self-mutilation for H. H has a need to shield and protect the dog from her unpleasant emotions and does not want to let the dog down in this endeavour.
- b) People's responses of bewilderment, confusion, scorn and disgust towards her behaviour have also contributed to her decision. H needs to avoid contact with such negative emotions.
- c) The damage that H has inflicted upon her body leaves her feeling ashamed. She is humiliated by the curiosity that it engenders in other people.
- d) H wants to avoid the invasion and inconvenience of lengthy medical procedures carried out on her body following the act of self-mutilation.

e) Medication has also played a role in that it contains her anxieties and dilutes overwhelming feelings.

Self-sufficiency

3a) H has a need to be self-sufficient when choosing how to inhibit self-mutilatory behaviour. She has difficulty making herself vulnerable to people external to her and anticipates that she may become more destructive if she followed options other than her own.

b) The anticipation of the calm and controlled feelings which follow the utilisation of her technique has a containing effect on H.

c) H distracts herself from the urge to cut by focusing on calm, good thoughts and visualising medical interventions which sedate the areas of emotional pain.

d) H experiences doubts about her ability to draw on her inner resources to inhibit self-mutilation when there is a growing abundance of unpleasant and conflictual emotions internally and externally.

e) At present H feels that she has the inner resources to mediate the urge and intensity of self-mutilating. H anticipates that she may be building up to a point of being cured of cutting in the future but is ambivalent about using the term presently.

Bodily sensations

4a) The detailed imagining of somatic, tactile sensations plays a very important role in the process of inhibiting actual self-mutilation for H. In order to infuse the imagined experience with a sense of reality, H draws on past memories and images which incorporate as many of her five senses as possible such as the smell of the hospital, the faces and voices of the caring people around her and the sensations of pain and grogginess associated with a surgical wound.

b) H prefers the tiredness and exhaustion which follows the visualisation process than the build-up of energy associated with unpleasant and conflictual emotions which

trigger the whole cycle. H associates the lack of energy in her body with calmness and relaxation.

Symbolic usage of somatic sensations

5a) H tries to re-create past somatic sensations for herself but tries to re-create and re-experience them on a more psychic level in her mind instead of as the somatic sensation experienced previously.

b) Conflict can be intolerable for H. As part of her technique a symbolic form of cutting ensues whereby emotional pain resulting from the conflict is visualised as being cut out and removed by a surgeon instead of by H.

c) The symbolic experience of cutting is infused with contrasting sensations of relaxation and calm, the throbbing ache of a surgical wound and the sensation of stitches felt in the aftermath.

Soothers

6) Soothers such as H's dog, the kind faces of previous doctors, nurses and therapists all are imbued with the attributes of being supportive, sympathetic, empathic, trustworthy and likeable. Soothers create a feeling of safety for H. H experiences them as emotionally available and attuned to her. This is especially so with her dog who makes her feel valued and important.

Introjects

7) H used to adopt a critical, blaming and punitive stance towards herself resulting in her need to cut herself to ribbons. Presently, however, she has taken on a more nurturing and affirming stance which is played out in her visualisation process and the people whom she chooses to incorporate, their words of reassurance and affirmation and their soothing manner.

Metaphors

8) Metaphors are used by H in order to explain and understand herself. Psychic and emotional experiences of pain are concretised into surgical, medical and dental metaphors. Metaphorical usage aids H in expressing her inner world.

Role of the family

9) The meanings and roles which H previously attributed to family members have shifted. Her family are presently blamed for problems which H previously burdened herself with. She now views the family as flawed and emotionally stunted individuals and has imbued herself with elements of health.

4.4. General description of the inhibition of self-mutilatory cutting -

Respondent H

Respondent H displays a curiosity and need for introspection in relation to the world around her and her behaviour therein. She struggles, however, with the intense emotions which arise from the external world's direct impact upon her. She has a need to remove these feelings from herself completely rather than grapple with them. This has been previously enacted through the act of self-mutilation.

H's understanding of that which influences the inhibition of her self-mutilation partially involves an external focus whereby the impact of those around her is considered as a major contributing factor. She is also aware of the emotional issues of shame and humiliation which arise from the responses of others towards her behaviour. In this situation inhibiting self-mutilation becomes a way of avoiding the difficult and shameful interactions which occur with other people as a result of her self-mutilatory behaviour and their inability to understand her.

H's inhibition of self-mutilation involves a need to avoid real interactions with other people. The people who are involved in her inhibitory method need to be a part of H

and her inner world which she achieves by visualising selected people. This allows her to have complete control over their actions. They are carefully selected by H for their empathic, trustworthy and soothing qualities. H is able to ensure that none of them will harm her in any way which she could not ensure if she were interacting with real people.

The propensity for self-sufficiency and independence are important factors for H when choosing ways to inhibit self-mutilation. Despite this she displays an ambivalence around her inner resources and her ability to successfully inhibit self-mutilation, especially when she is forced to grapple with intense emotional conflict. This generates enormous doubt in her abilities and inner strength. However, despite these times of doubt, H is able to maintain a stance of nurturance, reassurance and respect towards herself by perceiving those around her to be overly critical, flawed and emotionally stunted. This indicates a shift of sorts in H's inner world from her previous stance whereby she perceived herself as problematic and those around her as capable and healthy. The extremes inherent in her thinking are still very obvious, however.

When inhibiting self-mutilation H focuses on past somatic as opposed to emotional experiences. Focusing on the somatic allows her a very real yet controlled experience as well as the ability to predict the outcome of her actions, all of which serve to soothe and contain her. Focusing on intense somatic sensations appears to offer a safe way of accessing and removing overwhelming emotional feelings in that it serves to concretise and thus make more manageable the inner feelings of distress. The numerous medical metaphors which H makes use of in describing her experience of inhibiting self-mutilation seem to serve this purpose as well. H is able to re-enact symbolically the experience of self-mutilating and is so doing inhibit the actual, physical act of self-injurious behaviour.

4.5. Extended description of the experience of inhibiting self-mutilatory cutting

The respondents display areas of insightful self-awareness around their need to self-mutilate and their ability to inhibit self mutilation. However, there are also great areas devoid of introspection specifically around intense inner emotion. R realises with difficulty that she must explore and submerge herself in this as yet uncharted territory while H is insistent upon separating off these terrifying emotions from the rest of herself. R attempts for the first time to use the vehicle of verbalising to embrace, ponder and release some of the feelings which would otherwise lead to self-mutilation. H symbolically self-mutilates in an attempt to exorcise these overwhelming feelings from within her.

The world is read and understood through bodily sensations for both respondents. This use of somatic sensation allows both to concretise and control the otherwise overwhelming emotions that they feel inside. The frequent use of metaphor appears to serve a similar function by allowing the respondents to concretely express that which is internal to them. While R experiences the world through her body, and gauges her psychic experiences by means of her body's reaction, H appears to use her body to store memories of past somatic experiences. Although the memories involve contrasting comforting and painful memories, the memories and sensations are imbued with the power to soothe her inner distress and turmoil. R, however, was able to partially transcend the familiar somatic experience by replacing it with a more intrapsychic experience instead.

In order to tame inner, tumultuous feelings which could lead to self-mutilation, both respondents have a need to feel an attunement and emotional connectedness with another individual/other individuals/animate objects. These other individuals/objects make the respondents feel understood, whole and with a strengthened internal core

which then assists them in drawing on their own inner resources. The individuals/objects encourage this sense of security by striking a balance of displaying sufficient interest without being overwhelming, over-impinging or overdirective towards the respondents. R is able to risk seeking this attunement from people external to her, she can trust that there is inherent good in others who are separate to her. H, however, needs control over the figures in order to ensure that she is not harmed by them in anyway and so she keeps them internal and under her own locus of control, even her dog whom is viewed as consistent in his unconditional acceptance of her.

Both respondents need to be able to feel self-sufficient in their attempt to inhibit self-mutilatory behaviour. They need to select and create their own technique of inhibition which is then imbued and infused with meanings and choices of their own. The respondents need to be able to create their own parameters within their inhibitory behaviour. However, both are ambivalent about their abilities to successfully draw on inner resources and stay within these parameters. It is difficult for them to unequivocally trust in their own sense of inherent worth and goodness. This frequently leads to a reliance on the external, be it animate or inanimate, to make decisions, offer solutions and curb their urge to self-mutilate but simultaneously creates a resentment at feeling controlled.

Both respondent appear to have experienced a shift in the perception and meanings that they attribute to people around them. Both initially viewed others as critical, punitive and rejecting. R appears to experience people differently following her attempt at verbalising her inner emotions. People now could be viewed as having the potential to be good and available. H has also altered her perception of others but in a more extreme manner, whereby those external to her are untrustworthy and flawed while those internal to her, living within her inner world and under her control are good and caring. Both appear to have developed a better sense of self through the experienced

shift. The respondents incorporate this shift in perspective into their respective attempts at inhibiting self-mutilation by adopting a less punitive stance towards themselves than previously held.

CHAPTER FIVE

DISCUSSION

The aim of the present research is to attempt to describe in specific detail the borderline individual's lived experience of inhibiting self-mutilatory cutting behaviour and in so doing reduce the paucity in the literature around this topic. The findings are presented in the previous chapter entitled 'Analysis of Results' in accordance with the phenomenological method. The present chapter is divided into two areas, a general discussion of the results and a more specific discussion of the results in relation to the literature review.

5.1. GENERAL DISCUSSION OF RESULTS:

From the analysis of the data it becomes clear that both respondents are able to successfully inhibit self-mutilation. It would appear that the area of healthy functioning for both respondents R and H relates not only to the physical act of inhibiting the self-mutilatory behaviour but also, on a deeper level, to their ability to know almost instinctively what it is they are needing and their ability to actively seek out, in reality or be it through imagery, the attunement, understanding, unconditional acceptance and affirmation which they both require.

The resources that both respondents R and H draw upon to inhibit self-mutilation appear to have a calming and relaxing effect on them and thus could be said to possess soothing qualities. Hence, from now on the terminology of 'soothers' will be adopted when referring to these resources, be they external or internal.

5.1.1. Inherent Qualities and Meanings of 'Soothers':

The respondents appear to draw on different 'soothers'. Respondent R, for instance, draws soothing from an interaction with another person which served to provide her with a sense of being understood, held and empathised with.

Respondent H draws on past experiences with nurses and doctors who offered her kindness and reassurance. Her dog is also experienced as a 'soother' as a result of the unconditional love and acceptance and the sense of being valued that he seems to offer her.

Both respondent R and H's 'soothers' appear to house similar qualities, however. This suggests that it is not the specific 'soother' which is chosen but rather the qualities and meanings with which it is imbued which make it important. The first quality and area of meaning appears to be that both 'soothers' allow the respondents to feel in control of their situations. Considering that both respondents indicate a need to self-mutilate when they feel out of control of their surrounding environment, this quality appears to be justified. Hence, for respondent R it was important that she was not prescribed to by the sister with whom she chose to talk and that she was able to lead the direction of the conversation and be active in her 'use' of the sister, so to speak. This can be contrasted with her experience of talking to a lay person who prescribes 'a good cry', thus leaving her feeling disempowered which fuels her sense of lack of control and leaves her feeling rejected and misunderstood. In the case of respondent H, by carefully and selectively choosing the figures that she incorporates into her technique and by focusing purely on the positive aspects of being in a medical setting, she places herself in a world which is solely under her control. Respondent H also resents being prescribed to by others and indicates that to follow another's suggestions around inhibiting self-mutilation could be the worst possible action she could take as this could have the potential for further destructive behaviour on her part. Hence, it would appear that in order to successfully inhibit the urge to self-mutilate, the individual needs to be able to choose the method that best suits her individuality and the psychological space that she is occupying at that point in time. The act of choosing or formulating her own method allows her to feel empowered and in control and appears to leave them with a sense of mastery and achievement thus allowing them to draw on their more positive introjects rather than being at the mercy of their more negative and punitive introjects.

A further quality and area of meaning involves the ability of the 'soother' to make both respondents feel empathised with and understood, particularly around their need to self-mutilate. Both respondents refer to their frequent experiences of feeling misunderstood by the people around them in relation to their need to self-harm. For respondent R being misunderstood invokes anger. She perceives others as rejecting and inaccurately judging her while for respondent H, shame appears to be the predominating feeling. People's curiosity and bewilderment around her behaviour and bodily scars result in her feeling ashamed and humiliated. This suggests each respondent's need to be acknowledged in a non-judgmental and uncritical way where their individuality is respected - an experience which may also have been lacking in early childhood. However, despite the possible deficit of this experience in early childhood, both respondents R and H seem to know instinctively that the qualities of empathy, safety and understanding are what they are needing to assist them in feeling more contained. This insightful awareness could be viewed as a further area of healthy functioning.

Following on from this, another meaning attributed to the 'soother' and inherent quality is the 'soother's' capacity to offer positive reinforcement which then begins to be internalised by the borderline individual. Whether it be the unconditional acceptance as offered by respondent H's dog, the reassurance of medical personnel, respondent H's own messages of positive outcome towards herself or the sister's repeated reinforcement of respondent R's decision to approach her, the essence of the 'soother' appears to be in its ability to contain the individual while offering them a feeling of mastery and of being in control.

The 'soothers' also serve to offer some form of structure for both respondents and offer them a 'plan of action' which they can follow each time they feel the urge to self-mutilate. In R's case the structure offered is more external, her ABC, which incorporates seeking out another person while in H's instance the structure is more internal involving her relaxation and visualisation technique. Both the respondents' plans of action could be viewed as a way of trying to impose a structure on their respective internal chaos. This indicates further that the 'soothers' ability to assist

in the inhibition of self-mutilation relies more on universal qualities than on specific items or methods.

The 'soothers' are also imbued with associated meanings of safety and security which appear to be linked to the characteristic predictability which they exude. Respondent R uses her recent good experience of verbalising to inform the outcome of future verbalising experiences while Respondent H tries to control the good experience she wishes to have by visualising it in her mind. Although not functioning to impinge on the respondents, 'soothers' are also infused with attributions of power and an ability to tame and digest the otherwise overwhelming emotions of helplessness and rage as experienced by the respondents.

The ability to inhibit self-mutilation results in feelings of achievement and empowerment in both respondents. While this is to be expected, the real achievement appears to be the ability of each individual to be able to seek out and adopt her own method which can then be relied upon repeatedly to assist in inhibiting self-mutilation. Although each respondent chose very different techniques to assist herself in inhibiting self-mutilation, it becomes clear that it is the cumulative essence of that particular option rather than the particular form that it takes which allows the individual to timeously inhibit self-mutilatory behaviour and thus tap into her capacity for more healthy functioning. It also becomes obvious that the more an individual uses and embellishes on her 'soother' as in the case of respondent H, the more able she becomes to master her mutilatory urges which creates a cycle of health, as opposed to a cycle of destruction. The individual's confidence and feeling of self-worth increase each time she is able to inhibit the said behaviour. This in turn may result in a dilution and lessening of the influence of punitive introjects and an increase in the development of positive introjects, the consequence of which may be an improved sense of self and greater ability to draw on inner resources in the future.

5.1.2. Malevolent/Benevolent Introjects:

The inner worlds of both respondents appear to be filled with punitive, critical and malevolent introjects. This is evidenced by their expectations of and perceptions around others (a projection of their internal world onto the external). R expects others, such as the nurse, to be intolerant, unavailable rejecting and impatient with her as other people have reacted towards her in the past. H perceives the members of her family as flawed. She expects that they don't and won't understand her and anticipates that they will belittle her repeatedly.

Both respondents appear to become overwhelmed by their negative introjects, predominantly during an argument or when they feel out of control, the result of which is an urge to self-mutilate. The ability to inhibit self-mutilation for both respondents appears to be dependent on their ability to draw on experiences or interactions with good objects. The good experiences could be external, as in the case of respondent R, where the nurse, rather than acting malevolently was non-judgmental and empathic, or internal as with respondent H who visualises and embellishes on past good experiences with good objects such as doctors and other medical personnel and her dog. The good objects, be they psychiatric nurses, medical nurses, doctors or a pet appear to serve a containing and calming function and assist the respondents in dealing with the more difficult emotions. The good objects could be seen to serve as role models, as it were, for dealing with difficult emotions, be it through sitting with the emotions - respondent R and the psychiatric sister; or banishing them completely - respondent H and the doctor cutting the emotions out (suggesting a symbolic form of self-mutilation). Over time, the good objects may be internalised and develop into good introjects which can then be called upon to soothe the individual in times of distress through the previous experience of attunement, understanding and empathy. This is apparent in the case of respondent H. Although her 'soothers' are drawn on from within (doctor and nurse introjects), they appear to be constituted from past, external good experiences with good objects, suggesting that the borderline individual may initially draw on

external resources (offered by later rather than early life experiences) which may at a future stage become internalised as intra-psychic phenomena or introjects.

5.1.3. Ambivalence:

Both respondents have been able to inhibit self-mutilation, and are aware of the 'soothers' that aided them in inhibiting the self-injurious behaviour. They both state that they would consider drawing on these aids or 'soothers' again should they feel the urge to self-mutilate. However, both respondents also display doubts and ambivalence around believing that they have in fact conquered the desire while simultaneously feeling powerless in the face of it. This ambivalence may well be evidence of the individual's inner chaos and ambiguity and may also suggest that it is difficult for the respondents to view themselves as possessing a constant, predictable inner health, possibly hinting at the inner sense of badness that they appear to carry (due to their predominantly negative introjects).

5.1.4. Use of Comparative Metaphors:

Both respondent R and respondent H made use of comparative metaphors to explain their feelings and experiences around inhibiting self-mutilation. Respondent R compares her experience of cutting to that of being a naughty child, while her ability to inhibit self-mutilation through attempting a new technique is compared to and explained via more controlled and adult related metaphors. Medical, dental and surgical metaphors are incorporated into respondent H's speech suggesting that the use of metaphor may also be a way of trying to make sense of an otherwise frightening and confusing situation. The incorporation and use of metaphor in the inhibition of self-mutilation may also point to an acting out at a concrete level of thinking where the expression of intense and abstract emotion may be too overwhelming for each respondent to deal with as it stands.

Both respondents appear to be more in touch with bodily sensations such as physical pain or awareness of temperature than emotionality and feelings. This may

partially explain their tendency to view self-mutilating as an easier option (respondent R) or a 'quick fix' (respondent H) than dwelling on the associated emotions and thoughts. However, this may also explain their tendency for metaphoric usage. It is hypothesised that metaphors may serve to bridge the divide between bodily sensations and emotionality, especially in the case of the medical and surgical metaphors as used by H. Common bodily sensations such as a toothache (respondent H) and well known medical rescue interventions such as the ABC of CPR (respondent R) 'stand in' for and concretise the more difficult and less easily accessible emotions and verbal explanations.

5.1.5. Experience of Emotions:

Both respondents appear to experience emotions intensely, to the point of extremes. More painful emotions, such as hurt and anger, are difficult for both respondents to tolerate. Respondent H appears to become so immobilised by her feelings of distress that she adopts a passive, almost manipulative stance in the face of these feelings, where she begins to wonder why her family are so intent on 'doing this' to her, that is, distressing her through their arguing with and belittling of her. H then places all the blame on her family for her existing problems and difficulties and in this way is able to focus externally rather than internally. Respondent R adopts a more dependent, regressed stance when overwhelmed by negative feelings where she begins to feel engulfed by her inner black monsters and becomes very helpless. She has a need to hurt herself but simultaneously wishes that she would be rescued from this place of deep despair by another person, who would then take control of her inner monsters for her.

The respondents' respective 'soothers' seem to offer each an exit from these emotionally charged and overwhelming spaces. R depends on and attempts to 'use' the other person to contain, digest and master the emotions for her, while simultaneously offering her a safe, calm and non-judgmental space in which to be. Respondent H's 'soother' offers removal of unpleasant and unmanageable emotions. She becomes completely cut-off, both in a literal and metaphorical

sense, from her inner word of turmoil as she visualises the surgeon operating on the area of recent conflict and cutting out the resultant pain.

5.2 DISCUSSION OF THE RESULTS IN RELATION TO THE LITERATURE:

This section explores some of the theoretical and therapeutic implications which arise from the findings of the present research. It also serves to expand on and elucidate some of the concepts and ideas already mentioned in 5.1. as well as to situate and re-conceptualise them from a more theoretical framework.

Both respondents were relatively disclosive and forthcoming in their approach to the interview process. Interestingly, there was a need in for both respondents to introduce and discuss their experiences of cutting in some detail suggesting a difficulty in focusing purely on a healthier or more functional side of themselves. As a result, the discussion focuses both on their inhibition of self-mutilation as well as partially on their acts of self-mutilation.

5.2.1. The Capacity for Self Awareness and Self-Help:

According to Favazza (1989) self-mutilation can be conceptualised as a purposeful, if morbid, act of self-help. Both respondents in the present research spoke of this tendency towards self-help with regard to their own acts of self-mutilation. Respondent R commented that she needed help but did not know how else to request it other than by self-mutilating. Both were aware of how much calmer and contained the act of self-mutilating left them feeling, albeit very temporarily. With regard to respondent R, her shift from cutting as a way of killing herself to a way of inflicting pain suggests that, although still in a fragmented and regressed state, she is now attempting ways of self-help with regard to dealing with and tolerating emotional pain rather than completely annihilating the pain (and herself in the process) when she cut to die. From this it becomes clear that the terms 'health' and 'healthy functioning' are relative to the situation at hand and need to be flexible

rather than static in their meanings. However, if one does view self-mutilation as an act of self-help, then the question needs to be raised as to whether inhibition of this act is useful or even necessary. A consideration of the consequences of self-mutilation, namely the damage, often irreparable, that it inflicts upon the body; the cycle of destruction which it can trigger such as the tendency to regression; and the function it serves of 'cutting out' and removing emotionality leads one to have to reconsider Favazza's (1989) statement in relation to the long term, detrimental consequences of self-mutilation.

Both respondents had the capacity to be aware of the destructive quality inherent in their self-mutilatory behaviour. They were aware that although it did serve a containing function it also left them with feelings of guilt and disappointment which were often as painful to bear as that which had led up to their need to self-mutilate. This ties in with a theme which occurred repeatedly throughout both protocols, the theme of partial self-awareness. H has tried to understand how self-mutilating makes her feel, suggesting an attempt to become introspective and more attuned to herself. With regard to self-awareness, Frosch (1964), Kernberg (1986) and Goldstein (1989b) point out the borderline individual's relative ego strength of reality testing in day-to-day functioning. The capacity for self-help, ability to be aware of themselves, and propensity for reality testing, all suggest the borderline individual's ability to choose realistically that which could be beneficial to their inhibition of self-mutilatory behaviour. For instance, R struggles with discussing painful things but has the ability to realise that her difficulty was coming from within herself rather than from her external environment suggesting her capacity to own some of her emotions and difficulties rather than merely projecting them onto others. She knew that, despite her difficulty, she needed affirmation and attunement and attempted to seek it out by speaking to the sister.

However, due to the intensity of the emotions experienced by the individuals and the critical stance adopted by friends, family and health-care professionals towards their behaviour, the borderline individual may feel powerless and helpless. As a result of this they may feel too innately 'bad' to even consider contemplating their

propensity for self-awareness and capacity for reality testing. Hence, they feel unable to think through and enact possible ways of inhibiting their urge to self-mutilate on their own. For instance respondent R began attributing her sense of containment to her medication, (respondent H also made this attribution) her ability to sleep and the fact that the professionals were in the process of isolating her problem. While these factors may well have been playing a part in her containment, her thinking also indicates the tendency to attribute improvements to external factors rather than internal shifts, highlighting R's difficulty in believing and trusting that she has anything good to offer. Respondent H's doubts about her technique and herself suggests something similar.

On a deeper level, the inability for the respondents to trust in their own inner resources and inner goodness may well be linked to early RORU/WORU experiences (Masterson, 1987) where the infant was not allowed to individuate and develop a sense of self. It may also relate to the inability to traverse the rapprochement sub-phase of separation-individuation (Mahler, 1971) due to deficits on the part of the caretaking parent. As a result, it is hypothesised by the researcher that the borderline individual relies on others to inhibit their urge to self-mutilate due to a lack of feeling separate and a difficulty in feeling truly omnipotent in their world (a result of the early WORU experience). Simultaneously the individual resents being 'prescribed to' by others because it evokes in them a sense of being engulfed and consumed (a re-enactment of the early RORU experience). This places the individual in a catch twenty-two.

The importance of being able to choose a way of inhibiting self-mutilation which is specific to the borderline individual, and their lived experience of mutilating, becomes apparent. The role of the therapist could be to affirm the individual's choice, thus allowing them to become aware of, and slowly learn to trust their own inner worth, goodness and existing inner resources. The role of the therapist in assisting with inhibition of self-mutilation may also be to allow the borderline individual to 'use' (but not abuse) them and the therapeutic space in a soothing manner in much the same way as the sister allowed respondent R to use their time

together in a way that fitted with that which respondent R was needing. This once again allows the individual to get in touch with and seek out that which they are needing rather than being directly or indirectly told what their needs are/should be and thus having early experiences re-enacted. It must be stressed, however, that the role of limits and limit setting in therapy is still very important in creating a safe and containing space for the borderline individual.

5.2.2. Awareness of the Other:

Park, Imboden, Park, Hulse & Unger (1992) speak of the borderline individual's giftedness for 'borderline empathy' which could link with the awareness of the borderline individual to the response, needs and motivations of others in relation to their self-mutilatory behaviour. This could explain why the response of others has made such a big impact on both respondents, whether it be in the present as with respondent R, or in the past as in the case of respondent H.

A factor which contributed to R's inhibition of self-mutilatory behaviour was her mother's reaction of intense distress. R's awareness of the impact of her behaviour on her mother points to the development of a possible 'empathy awareness' towards others. This could be viewed as the beginning of a bridge between internal and external factors and between R's internal and external world which until this point appeared to be completely split off from one another. With regard to R's internal world, her awareness of the other and how the other could be hurt through her own destructive impulses suggests that R may potentially be moving towards Klein's concept (1986) of the depressive position. Hence, R may have the capacity to move towards the depressive position despite repeated and frequent fluctuations between the paranoid/schizoid and depressive positions. The implication for healthy functioning for the individual with borderline structure, as opposed to the psychotic, may involve this ability to move towards the healthier depressive position. The difficulty appears to be in sustaining this position once it is neared, possibly due to a poorly developed, if not complete lack of, evocative memory (Adler, 1985).

5.2.3. Internal versus External Factors:

Both respondents had a tendency to separate their world and resources into internal and external factors, as mentioned earlier. While respondent R appeared to be more reliant on external factors in general to aid her in inhibiting self-mutilation, respondent H had a tendency to choose specific external factors to assist her. This may relate to H's ability to own her self-mutilatory behaviour and thus be more in touch with herself and that which works for her when attempting to inhibit such behaviour, possibly because she has been mutilating for longer than R. Respondent H and especially respondent R displayed a need to idealise the external and denigrate the internal world. This tendency to idealise the external/ parts of the external and denigrate the internal forms part of the splitting defence (Kernberg, 1986) and can be linked to Kleinian theory (1986) whereby the external is kept good and separate from the individual's internal world which is experienced as punitive and malevolent. This could be indicative of the respondents' fixation at Klein's (1986) paranoid-schizoid position due to early life experiences and a lack of 'good enough' mothering (Winnicott's term, 1975) and may further explain their difficulty in sustained and consistent movement towards the depressive position.

Respondent R's need to split to such extremes could be due to her anxiety that her inner badness might overwhelm and annihilate her good external objects such as her mother and the psychiatric sister. At this point R's level of vulnerability is so huge that it is hypothesised that it feels safer for her to engage in splitting, than to consider that the good objects surrounding her may be both good and bad. The implications of this might then be that she could not trust in them completely. Considering her difficulty in trusting herself (due to her punitive internal world) this would leave her in a terrifying and lonely space.

Other people's negative responses to R's self-mutilatory urges and behaviour, such as the other patients, other nurses at the other hospital and the ambulance driver may well be based on some reality but may also be partially a projection of her punitive and critical inner world onto the external. Her inner sense of badness

becomes too difficult to sit with. It appears that respondent R's experience with the sister enabled her to partially integrate her immediate experience of despair and terror thus drawing her away to some degree from her regressed state into the paranoid-schizoid position (Klein, 1986). R's experience of verbalising with the nurse also appeared to reverse the inner process of chaos which was occurring in her at that time. This may be due to the emotional connection and contact that speaking allowed R to have with another. It is hypothesised that this could then result in a sense of 'going on being' (Winnicott, 1975) where respondent R is able to resort back to an 'I AM' state where the threat of disintegration has been removed due to the environment offering her that which she needed (Balint, 1989) once again indicating an underlying propensity on her part for healthy functioning.

When the ego becomes better organised as in the depressive position (Klein, 1986) the process of symbol formation is more likely to occur. Respondent H's tendency to be closer to the depressive than the paranoid-schizoid position is suggested by her ability to own her self-mutilatory urges, unlike respondent R who explains them as 'another person doing the cutting'. A further indication of H's movement towards the depressive position is her ability to realise that she may well have setbacks but that they will be less intense than on previous occasions, in contrast to respondent R who expects to lose the urge to self-mutilate completely. Respondent H's ability to hold both good and bad in her head simultaneously, the crux of the depressive position, is still compromised, however, indicating that although she is moving towards the depressive position she has not reached it as yet.

Despite respondent R's tendency to split off the mutilating side from herself, she is able to recognise that there is a problem and that her present behaviour cannot be understood as normal functioning which points to a further area of health where the defence of denial (Kernberg, 1986) is not being so strongly implemented. However, until she can own that dissociated, new, unhealthy side of herself it is hypothesised that inhibiting her self-mutilatory urges will be even more difficult. Respondent H on the other hand appears to have integrated the self-injurious behaviour into her

sense of self and so is more able to own her actions and the consequences therein. It could be hypothesised that the more an individual is able to own their self-mutilatory behaviour, the more control they are likely to have over their actions and thus the more successfully able to inhibit this behaviour they will be. This suggests that the ability to inhibit self-mutilatory behaviour may also depend to some degree on the reduction of defences and the use of reality testing and insight, all of which can be linked with a movement towards the afore-mentioned depressive position. The work of therapy may well be in assisting the borderline individual to explore and work through these particular areas.

Another possible explanation for the need to separate the external from the internal links to Adlerian theory (1985). The separation may be as a result of the borderline individual's difficulty in attaining solid evocative memory, hence the reliance on external self-objects to supply the necessary and very needed holding and soothing of overwhelming emotions.

According to Giovacchini (1987) borderline individuals lack 'bridges' between lower and higher psychic constellations, hence no sense of continuity is created between the inner mental life, transitional space and external world. The modulation of impulsivity and repeated drawing on of consistent and predictable good inner 'soothers' in an attempt to inhibit self-mutilation becomes difficult due to this inner chaos. However, as the individual begins to move towards the depressive position, so the inner chaos and resultant lack of continuity begins to subside allowing for a more healthy and sustained use of external 'soothers'.

Having said this, respondent H appeared able to consistently draw on internal resources made up of previous external good experiences. This may possibly be because of her ability to have moved closer to the depressive position where capacities for abstraction and linking have developed, hence, her ability to self-mutilate symbolically in her mind as opposed to actually cutting her body in the real. Interestingly, respondent H seemed to draw on later rather than earlier experiences suggesting further that early capacity for symbol formation and evocative memory

was lacking, in accordance with Adlerian theory (1985). Of note, is the fact that in order to draw on these internal resources and images respondent H seemed to rely heavily on recalling bodily sensations as part of her inhibitory technique, such as the bodily sensation brought on by a tranquilliser or anaesthetic and her need to imagine the sensations of the operation in detail - surgery being an inherently somatic experience in itself. Further reliance on bodily sensations could be linked to her use of as many senses as possible during her visualisation process, such as the smell of the operating theatre, the faces of the doctors and therapists and the sensation of the stitches. It is hypothesised that bodily sensations, in this instance, may possess similar evocative memory potential as do transitional objects, as mentioned in the literature review (Cardasis et al, 1997) in that they 'stand in' for and serve as a linking bridge in assisting the individual in recalling 'soothers' and soothing experiences.

In exploring the protocols of the two respondents both appeared to be more in touch with bodily sensations than emotional experiences. Giovannini (1987) suggests that the infant receives very little 'sensory' input due to the child's physical needs being met mechanically with little other meaningful interaction taking place between mother and child. The infant is rendered helpless by the mother's intervention of this sort. In relation to the present research, being more in touch somatically than emotionally means that "it is easier to get into a bath and cut than to sit down with someone and verbalise". Respondent R begins to feel helpless in the face of her emotions and finds it difficult to believe that she is likely to have a meaningful interaction with another individual whom she can trust to be able to contain her feelings. It could also be that emotions are scary for both respondents who fear being overwhelmed by them. This suggests that it may also feel safer to be more in touch with somatic than emotional sensations. Respondent H seems fearful of the emotions taking on a life of their own, hence her need to cut out the painful parts completely and remain in control. Her need to cut out the painful emotions is so strong that her technique still involves self-mutilation albeit at a symbolic level. The capacity for healthy functioning, however, lies in her ability to

practice self-mutilation symbolically suggesting her ability for 'phantasying' (Segal, 1988) and thus the potential for developing evocative memory.

Despite the deficit and downfall inherent in being more somatically than emotionally attuned, as mentioned above, respondent H's reliance on bodily sensations in relation to her technique could be viewed as compensatory behaviour which allows her to access inner 'soothers'. The ability to seek out and implement a compensatory technique points once again to the capacity for lateral and creative thinking and thus healthy functioning. H appears to make use of a type of symbol formation, namely the operation, to assist herself with impulse control and frustration tolerance and thus inhibit self-mutilatory cutting.

The aspect of healthy functioning with regard to the inhibition of self-mutilation could be said, therefore, to lie in the inhibition of the physical act rather than the complete inhibition of the desire altogether which at this stage, and possibly even in the distant future, would be unrealistic.

5.2.4. 'Soothers':

Although the form and nature of the 'soother' differs between the respondents the various 'soothers' seem to possess similar characteristics, namely the individual's need to choose the object or phenomena, in much the same way that a child chooses their own transitional object or phenomena. The respondents' 'soothers' also allow them a sense of mastery and omnipotence over their world which leaves them with a sense of achievement. The 'soothers' may also be viewed as offering the respondents a different way of reacting to a familiar situation which in turn allows them to become an individual with options as opposed to an extension of someone else. (Once again early WORU/RORU experiences could be said to be involved in the latter). For instance, the sister offered respondent R a new 'way of being' and an alternative way of coping with 'the big black monsters' inside - she served to contain R's 'monsters'. She could be conceptualised of in this instance as a mother figure offering attunement of sorts to the little child whose world is filled with

uncontrollable and malevolent objects. R is unable to trust that she herself can contain these objects and so becomes overwhelmed with a need for instant, somatic gratification, this being her previous way of reacting.

Both respondents gain a new experience which in turn allows them to be good, reassuring and nurturing to themselves. This is likely to be a very different and unfamiliar experience in contrast with the early, punitive introjects that each carries. From the protocols it becomes clear that both respondents persecute themselves and in so doing engage in the aforementioned splitting behaviour. R believes that nothing she ever does is right and respondent H has taken on her family's projections and blamed herself solely for problems that exist in the family. Both internalise all the negative aspects of their lives and externalise all the good. This leaves them devoid of any inner resources upon which to draw. Fighting or conflict appears to mobilise both the respondents' punitive and critical introjects, which then appears to further sap them of their inner resources which could have the potential to lead to healthy functioning. While respondent H is aware that this is an old pattern of functioning and is trying to break free from it, respondent R is still very much stuck in this 'pattern of being' which may partially explain her difficulty and respondent H's greater sense of ease in attempting to inhibit self-mutilatory behaviour. Despite this, respondent R appears to have an awareness of what she is needing and/or desiring in order to be soothed. She also has the insight to realise that while she can't get it from within she can seek it from outside.

5.2.5. Use of Transitional Phenomena:

Winnicott (1975) states that a transitional object can only be used when the internal object is alive and good and not too persecutory. If the internal object is not good, the transitional object becomes persecutory and dead whereby it fails to have meaning for the infant. In relation to the present research it becomes clear that not all individuals with borderline structure will make use of transitional objects when attempting to inhibit self-mutilatory behaviour. Rather, their tendency for transitional object usage will depend on their own degree of attunement to and

awareness of themselves and as mentioned above, the state of their internal world at that particular point in time. In the case of respondent R, her world appears to be extremely persecutory and critical at present, as evidenced by her need to split between internal and external. In this regressed stage transitional objects would fail to have meaning for her and could not even serve as an aid to enhancing evocative memory. Hence, her ability to inhibit self-mutilatory behaviour at this stage appears to lie completely external to her. Her area of health lies in her ability to go and seek that which is external to her and draw on its containing and soothing properties.

Respondent H, however, while previously possessing persecutory and therefore dead internal objects, appears to have moved on from this point. It is hypothesised that her lengthy engagement in therapy may well have played a role in this in combination with her own inner resourcefulness. It must be stressed, however, that respondent H's objects are still subjectively rather than objectively perceived by her. They can therefore be referred to as 'ME' objects which are still very much under her control rather than the more sophisticated 'NOT ME' objects which can be acknowledged as separate entities (Winnicott, 1989). This becomes clear in relation to her visualisation of the surgery in that she is being operated on while also doing the operating to herself. According to Winnicott (1989) the 'NOT ME' experience can only occur through the mother's adaptive behaviour of good enough mothering. Her behaviour allows the child to find that which is needed and expected outside the self. Respondent R, despite her ambivalence and reliance on splitting defences in the present, appears able to seek outside of herself the empathic and caring nurse indicating her underlying propensity for healthy functioning and her ability to view objects objectively even in a regressed state. This points to her ability to function closer to the depressive position when in a more cohesive emotional space.

Respondent H's dog could be conceptualised of as a transitional object. The dog plays an important role in H's life in general, and serves as a transitional object in that the presence of the dog takes on a specific meaning for H and has a soothing

impact on her. This in turn allows her to enter into a world of 'phantasying' and symbol formation. Her ability to make use of a transitional object underlies her use of symbolism as illustrated by her ability to symbolically self-mutilate. The transitional object could also be said to be symbolic of her good internal objects. Hence, the dog could form both a 'ME' and 'NOT ME' object due to H's use of him in her phantasy and her relation to and acknowledgement of him as a separate entity in reality. This suggests an ability on H's part to begin viewing objects as separate from her, further evidence of her movement towards the depressive position.

It is proposed that the somatic experiences which H draws on fall within the realm of transitional phenomena as well, due to H's tendency to imbue the recalled somatic experiences with meaning. They may also be viewed as transitional phenomena because of their inherent soothing, and evocative memory potential on which H seems to draw, as discussed above.

From this it becomes clear that the term 'borderline structure' encompasses a wide and varied range of individuals displaying borderline functioning. Respondent R and H appeared to be occupying very different intra-psychic spaces in relation to this. However, regardless of where the individual is situated intra-psychically it becomes apparent, from the present research, that they are able to draw on inner resources of healthy functioning, the specifics of which will be suited to where they are situated developmentally and intra-psychically. It is for this reason that it is essential that the individual be able to choose their own soother in relation to the developmentally situated position that they are occupying at that moment in time. Whether or not transitional phenomena are involved will depend on each individual's own level of intra-psychic functioning and occupied space.

The concept of the borderline individual being able to inhibit self-mutilation either through seeking external help or by mobilising their own abilities, and thus possessing the capacity for healthy functioning, may have important implications for an improved therapeutic environment. According to Park et al (1992) this may

impact greatly on prognosis, suicide rate, and length of treatment for those patients who are generally viewed through a rather negative and pathology orientated conceptual framework.

CHAPTER SIX

CONCLUSION

The present research aims to explore the borderline individual's lived experience of inhibiting self-mutilation and thus capacity for healthy functioning. From the results it becomes clear that borderline individuals are ambivalent when attempting to inhibit self-mutilation. Although they have a need to be self-sufficient and through a process of trial and error find the method of inhibiting that best suits them, it appears difficult for such individuals to trust that they have this ability and the inner resources to find such a method.

Borderline personality structure may be viewed along a continuum. The technique chosen by the individual is likely to fit with where they are developmentally in relation to this continuum. This in turn is likely to impact on how they engage and manoeuvre their technique and interact with the world around them. Hence, while each individual may or may not make use of transitional objects within their techniques, they do have a need to draw on 'soothers'. Although the 'soothers' may vary with regard to shape and form, they do appear to share similar qualities and to become imbued with similar meanings by the individuals. The 'soothers' create a safe and holding space which is empathic, attuning, non-judgmental and non-directive in its interaction with the borderline individual. 'Soothers' can comprise both 'ME' and 'NOT ME' objects but need to be consistent and predictable in their interaction with the borderline individual thus allowing the individual to feel safe enough to return to them in times of crisis. 'Soothers' need to allow the individual a sense of mastery and control over their otherwise chaotic environment. Repeated use of 'soothers' allows the borderline individual to begin drawing on good introjects as opposed to negative introjects which serves to increase confidence, sense of self and the ability to trust in their own inner resources.

The impact of the 'soother' on the borderline individual is experienced and understood by the individual somatically as opposed to emotionally or intrapsychically.

6.1. LIMITATIONS OF THE PRESENT STUDY

The phenomenological approach of the present research required that the respondents answer a single question in as much detail as possible. The obvious limitations here involve not only the respondents' verbal skills but the researcher's interviewing skills as well. Should either have difficulty in the said area the result could be an interview lacking in richness or possibly even compromised with regard to the phenomenological technique itself.

The focus of the research on healthy functioning may have served to make the interview question a little easier to discuss than a question which focused predominantly on pathological functioning. There was still the risk, however, that the interview could have tapped into unconscious anxieties for the respondents due to the personal and sensitive nature of the issue being discussed. As a result of this there was some possibility of the interview being evocative for the individuals with regard to commencing self-mutilation following the interview. Furthermore, due to the focus of the question being on inner health, the possibility of the respondents trying to please the researcher by telling her what they thought she wanted to hear should not be ruled out completely. Linked to this is the fact that by using a hospital population the overarching attitude towards self-mutilation in such a setting is likely to influence the respondents' answer to the question. Other factors associated with a hospital setting such as medication, intensive therapy and groups (with regard to the in-patient respondent) may all have shaped the respondents' responses to the question. It could be argued, in response to this, however, that such factors make up part of the individual's lived experience at that particular moment in time.

6.2. SUGGESTIONS FOR FUTURE RESEARCH

A future area of research could involve looking at borderline individuals outside of a hospital population, their ways of inhibiting self-mutilatory behaviour and whether in fact there is a significant difference between the responses of the two populations. Favazza (1989) notes that self-mutilation occurs in both men and women. The present study focused on the inhibition of self-mutilation in female respondents only. The male individual's ability to inhibit self-mutilatory behaviour may reveal distinctly different phenomena to that of the female's experience. From research conducted by Westen et al (1990) it appears that object relations as studied in a small sample of borderline boys appear considerably different on the Rorschach to that of borderline girls with regard to complexity of representations of people, affect-tone of relationship paradigms, capacity for emotional investment and understanding of social causality. A future area of research could explore the male borderline individual's ability to inhibit self-mutilatory urges and the phenomena therein.

6.3. ETHICS REVISITED

One of the ethical dilemmas of the present research comprises the area of 'informed' consent and the implications therein. The degree to which patients in a hospital setting can participate in an interview of this nature and feel some degree of 'informed' and 'autonomous' consent is questionable. Rather than being viewed as a consenting population it becomes clear that they are instead a 'captive' population due to their hospitalisation which suggests that participation occurs under some degree of duress rather than involving total free will. Furthermore, the act of being hospitalised or seeking out-patient hospital treatment suggests some degree of vulnerability which in turn could make it more difficult for the patient to decide, of their own accord, to decline or accept participation.

Although respondents were asked to sign a consent form stating that they could withdraw from the interview at any time without fear of recriminations, the

unconscious fantasies surrounding the interview, their patient status as well as their possible need to please their therapist or consulting psychiatrist should to be considered and could impact to a large degree upon respondents' participation in the interview.

Another ethical concern is around the impact of the interview on the respondents' therapy - is it likely to stagnate or invigorate, be beneficial or damaging to the process and what types of transference and counter transference issues are introduced into the therapy itself following such an interview. Furthermore, although the focus of the research was on healthy functioning, the sensitive and personal nature of the material involved, the potential for discussing the act of mutilation itself and associated emotions in some detail, coupled with the evocative and powerful process inherent in the phenomenological approach, could facilitate the breakdown of ego resources. The interviewing of patients from a hospital population, which in itself points to an existing degree of fragility and vulnerability in the patients, makes this concern even greater. Although follow-up sessions were scheduled for the respondents, pressing ethical issues around the act of interviewing and who is selected for the purposes of being interviewed are very clearly raised.

APPENDIX

The appendix consists of protocols one and two which appear as the original transcribed interviews. Both protocols are presented with a full qualitative analysis, namely a delineation of the natural meaning units (NMU's) followed by the re-articulated NMU's.

PROTOCOL ONE

INTERVIEW WITH RESPONDENT R

Tell me about the times that you wanted to cut but chose not to. You could think back to a specific incident to help you in answering the question. In your description comment on as many aspects of the experience as you can. The purpose is to obtain as full a description as possible

R: Well its quite ironic that you asked that question because that's what happened yesterday, um, I cut myself on 4 occasions, and on each of those occasions I've had no desire to go and ask somebody for help and I am under threat that if I do it again I'm being transferred so that obviously motivates me to go for help, but yesterday for the first time I started feeling, its always precipitated by feeling panic and I got really panicked and I started thinking about hurting myself and I thought I'm going to go and speak to somebody so I went to the office and I spoke to the sister on duty and I was very honest with her, I said I feel like cutting my wrists, um and I need to talk to you and we sat and chatted for about a half an hour, spoke about, I couldn't specify why I wanted to do it there was nothing that had set me off, there was no particular reason why I wanted to do it just an overwhelming feeling, she kept asking me if I could clarify what particularly had made me want to do it and I couldn't, I just felt hopeless, I felt scared, I felt alone, just felt desperate. Then we started discussing the problems in my life and what were, do you want to know?

J: Its up to you if you want to share them.

R: For example, losing everything, my car being repossessed today, having to move back and stay with my parents, having to move from Durban to Joburg, leave my boyfriend and my friends behind and my two of my kids who I'm missing dreadfully, and just in discussing those problems I generally felt, gradually felt panic subside and once the panic had subsided then the desire to cut my wrists subsided.

J: Can we just stay with that and its probably difficult to put into words but what about that experience of talking to her reduced the panic for you?

R: I stopped feeling so alone because there was somebody who was genuinely interested in what I was saying, hearing myself express myself and all the reasons that I had not to do it, like my children and my boyfriend and the desire to build myself up again, cos when you are alone and you just go and do it, you don't think of any positives, you just think of all the negatives which really when you are with somebody you suddenly start seeing a few positives because the reasons that you want to do it the reasons that provoke you to do it are actually, could actually be positives like the reason that I'm missing my children is actually a reason not to do it because if I do it and I get it right I won't see them again you know and the reason that my car has been repossessed, if I cut my wrists and die I'll never have the car again so suddenly in verbalising it you start to realise all those negative reasons are actually positives and reasons not to do it rather than to do it. But its also, I think for me there's been two definite desires. There's been a desire to die and there's been a desire to hurt myself.

J: And have there been any other times when you've had both those desires and been able to do something to stop yourself?

R: This is the first time that I've ever spoken to somebody and stopped myself, on all four other occasions I've just gone and done it.

J: So this is really a first for you?

R: Ja,

J: Going back a bit you mentioned the aloneness, feeling alone and how talking helped take it away. Can you tell me a bit more about the aloneness and having it taken away?

R: At this point in my life I just feel extremely alone eventhough I have people around, I feel lonely and I suppose its hard to describe its just an emptiness inside, I feel like I'm in this really black hole and I can't get rid of it and I start off sort of at the top of the hole where I can still see the light and there's no desire to hurt myself and slowly I sink until I reach the bottom of this hole and then when I get to the bottom of that hole through a process of thinking and thinking and thinking and thoughts becoming worse and worse in my mind and probably becoming bigger and bigger and bigger, and somehow just speaking to her yesterday sort of pulled me back up to the top of the hole a bit because she made the problems seem a little bit smaller and she didn't say anything, she just said that must be hard, that must be difficult, you know she didn't offer advice, just the fact that someone was interested lifted me out of the hole and another part of me seemed a little bit more realistic instead of these big black monsters that I can never cope with. And it worked for a while. Then last night I had a run in with somebody here and I had the desire to kill myself again, but I didn't go and talk to anybody, I sat outside and did nothing.

J: And what there were you able to draw on that actually stopped you from doing that?

R: The fact that if I do it again they are going to go and transfer me to Sterkfontein, so its more like at the moment I'm living under threat. And I'm a bit worried, concerned, that's one of the major reasons that I'm not hurting myself, not the fact that I'm losing the desire to but the fact that I'm so scared that if I do hurt myself, they are going to transfer me out of here, this is my only hope.

J: Okay, so there is quite a lot of fear associated with it. Okay, lets go back to the first incident that you mentioned, you mentioned something about the listening, not saying anything but just listening to you. Can you tell me a bit more about that?

R: Ja, its important, I'm an independent, usually a very independent, competent person, so I'm not prescribed to very easily and generally I work my own problems out in my mind and so what I was looking for yesterday was just a bit of sympathy, I wasn't really looking for some advice because I know the answer, I know what I have to do, I know I have to get round here, then I have to get a job, I have to save a bit of money for a deposit on a flat and a deposit for a car, I have to get a car and then I can have my kids with me again, I don't know what to do about the boyfriend situation but I'm also realistic enough to know that if it has to end it has to end, so I actually do know what to do, its just that they become dragons in my mind and because I can't do it all now, I'm very sort of I want things to be right and I want them to be right, now, so because they can't all be right now, I'm frustrated, so I really don't need somebody to say to me x, y, z, this is what you need to do, I just need somebody to understand that I feel out of control.

J: Can you tell me more about the actual episode?

R: Ja, maybe it made me feel like I'm not crazy, because you start to think you're crazy, I feel totally out of control, there's not one aspect of my life that I actually hold in control at the moment and just to have someone who knows that that is real and to acknowledge that its right to miss your boyfriend and its right to miss your children, that its acceptable rather, lets say its acceptable and that its acceptable to feel lonely and scared and crazy, but you're not, makes you feel that you are not crazy that you are actually just a mixed up person at the moment who has a lot of stress on their plate and all your reactions are justified, so it gives you a kind of affirmation.

J: Can you go forward with the affirmation?

R: Ja, I think you become very negative in this kind of situation, you feel like nothing you do is right and nothing you have done is right because otherwise you wouldn't be in such a situation and even a small mistake, it makes it like you're okay to feel that way, it makes you feel like a better person and I think that's what we all look for in life is affirmation and getting it in our job and getting it in our role as parents and I'm not getting it in any of those sources at the moment, I'm not getting any positive strokes from my job, from a relationship with a man, um from even a relationship with my children because they are not with me so I have to get it from here and the way that I'm getting it is she really made me feel like I'd achieved something by not going and cutting myself, by coming and talking to her, by calming myself down and I did it, she didn't do it and she made that very clear to me she was just the bouncing board, I did it all by myself, I spoke my way through it, I got to the point where I could say I'm okay, I can walk away now. I had actually done it, she wasn't this magical person who waved her wand and took away all my bad feelings, she was just a person sitting there, agreeing with me and at the end of it she said to me, "that's all we want you to do, we just want you to come and talk to us and talk your way through it and I'm very proud of you" and that made me feel good.

J: And what do you think it was about the experience yesterday that made you choose to take that route rather than cutting?

R: Well, a lot of it revolves around the fact that they said to me if I did it again I'm going to be transferred. And I'm scared of that so a lot of it is based on fear of being transferred, but not all of it, some of it is also based on the desire to stop doing this to myself cos I mean it doesn't look nice and it doesn't feel nice and I know logically that it is not (unclear) but unfortunately logic doesn't prevail at the time.

J: Can you tell me a bit more about your desire not to do this to yourself.

R: Well until such time as I cannot have the desire to hurt myself, I won't be well, I won't have worked through my problems, I won't have worked through my guilt and my hurt and what ever is going on inside of me and I will only start feeling good about myself when I reach that point when I don't want to hurt myself anymore because then I'll know I've dealt with big issues and I don't want to hurt myself because in the back of my mind, although sometimes, I mean even today I don't enjoy life, I mean I really want to die, but in the back of my mind my sort of real self says, you don't want to die, what you really want is to stop hurting yourself, to stop scarring yourself, to be a whole person again, to lead a normal life, to get out of this place as a whole person and as a happy person and to be able to cope with life again because I've always coped with life, when my parents got divorced when I was nine

and since then things have not been easy for me, I've always coped but this is the first time that I've had the desire to hurt myself and I know I won't get back to my normal self until I can say I don't want to hurt myself anymore, so that's the desire, the desire to, I know that once I've reached the point I can say, gee, I really don't want to hurt myself anymore, I know I've made progress.

J: Tell me a bit more about the whole self that you mentioned.

R: Well at the moment as I said to you I feel out of control, I'm not in touch with my normal feelings, the feelings that I'm feeling now I'm not used to feeling, I'm feeling panic where I'm used to feeling calmness, I'm used to feeling control and I feel out of control now, I'm used to feeling confident and I'm feeling scared and anxious at the moment and so for me to be my whole self again I need to regain my confidence and to regain my passion for life cos I'm a very passionate person and I've lost that in all ways, um I've lost the desire to get up and look pretty, I only get up and do it because I know I must, I've lost the desire to eat and I've always enjoyed food, even though it's been healthy food, I've lost the desire to eat, I've lost the desire to brush my teeth, stupid things and I don't know, I have to regain all those needs again to be a whole person and I'm just not me, you know it's like this foreign person is living in my body and it tells me to do things that I would never do.

J: One of the things being cutting?

R: Ja, and other things like at one stage I was taking like ten to fifteen Syndol a day just to get through the day, it's also not me but in your case the cutting being the biggest thing, I mean I don't even feel it when I do it, it's like I go into a trace and this other person cuts and I've got to lose that person and let my old self back.

J: What were you feeling yesterday after you spoke to her in terms of a whole person?

R: I felt like I'd temporarily taken back a little bit of control, I felt very sad but I felt calm, I went and cried a lot but maybe out of a sense of relief, I'm not sure, but I wouldn't say that I suddenly started feeling good and doing cartwheels around the passage and said yay, I've achieved something but I did feel like I had achieved something and I'd broken a cycle which has been a self destructive cycle and I felt that I'd kept to the bargain cos we'd made a bargain, I made a bargain with them that I won't do this again and that if I do I'm going out and I'd stuck to the bargain and it was very difficult, it was very difficult. It would have been easier to cut myself, that's what is so ironic.

J: What was so difficult about that for you, maybe if you can try and put that into words?

R: I'm not sure, just approaching somebody that I don't know with a feeling that is very personal, on subjects that are very personal and also for me the biggest thing was facing the risk of rejection, I mean because going and saying I'm really feeling down, I'm feeling like hurting myself, I really need to talk to you, on one occasion I've had someone saying to me go and have a good cry and you'll feel better and that was a form of rejection and the relief of having this person really interested and concerned and available I didn't know whether she would be I didn't know whether she'd say oh here we go again because I sensed a level of intolerance in people and so I was scared, I was also scared of revealing more of myself because I feel so vulnerable at the moment and I feel so open and like people are probing into parts

of me that I don't really want them to but I know they have to so its just very hard to go in there and bare your soul its easier to go off in the corner and hurt yourself.

J: So a lot of not cutting for you is about baring your soul?

R: Ja, about being honest about things that you really don't want to be honest about, its about saying things that you know are going to not make you look so good and its about discussing painful things um because everytime I have to go, like even with you, everytime I have to sit down and discuss myself it opens up wounds, it brings back pain and I almost see cutting myself as an escape to facing my own pain, if I hurt myself outside it will distract me from the inner pain so now I'm happy to do the reverse and then to expose the inner pain to avoid the outer pain. It would sound weird to someone who doesn't have the desire but its easier to get into a bath and cut than to sit down with someone and discuss why you want to, its just easier when you're in this state of mind, I think when you are in a normal state of mind the thought of cutting is horrific and you'd much rather talk over a cup of coffee and a cigarette. The way I feel right now is not normal and I also think I have a lot of guilt over a lot of things that I've done and its almost like punishing myself and you can't really punish yourself by talking things out and having the person make you feel better.

J: That's true. In terms of that is the whole experience of not cutting and what you were discussing about yesterday comparable to any other experience you've had in your life?

R: Writing my exams. No its not really, its not, I've never felt like this before, I've never wanted to do myself harm and I've never had to face such emotions before so I can't really compare it but no I can't. So it feels like its a totally unique experience for me but I can almost relate it to being a child and having done something wrong and knowing that your parents are coming home and you re going to have to tell them, you know, it would be easier to try and hide what you've done but you know you've got to face a broken window, you know you've got to face your parents and you know in that case that they will be angry and I'm scared sometimes that when I go and tell people what I'm feeling they will be angry and its funny cos they never are yet I always feel scared, I always expect them to be and then I go in and say I'm feeling suicidal and I need to talk to you I always expect them to say to me don't be ridiculous because that's the reaction I've got from lay people so have a cup of tea and have a cigarette and don't be ridiculous so I'm trying to uncondition myself from that kind of thinking which is scary but I'm actually going to stay with it but sometimes the desire to hurt myself is just too great.

J: It overwhelms you?

R: Ja, I think also the need to, I can't remember whether I've said this or not, but to explain that there have been two different sensations for me, two different ways of thinking, the first time I cut my wrists it was a definite desire to die, and the second and third time were to hurt myself so my approach and my feelings have changed I mean I really really wanted to kill myself and I still feel the desire to die but I don't want to kill myself anymore, now I'm just wanting to get better already.

J: Would either of those two experiences have impacted differently on the not cutting experiences?

R: Ja, because when I cut my wrist to die the last thing I would have done was to go to someone cos they would have stopped me so it was almost like a ritual for

me, you know run the bath, relaxed about it, this is what I want to do, thank goodness it will all be over, the last thing I wanted to do was to attract attention to myself and I was actually angry when I was found and angry when I was stitched and angry when it was stopped and really frustrated that I didn't get it right. Now on the other hand I almost want somebody to walk in before I start and say what are you doing? So it would be so much easier if they came to me and also I don't cut as deep, and I don't get the same satisfaction and its funny when I try and cut my wrists to die I never felt anything, it didn't hurt at all and the blood didn't worry me at all and the cuts were bad, I mean one cut was so bad that I could move my finger and see the tendon moving, I could have fitted two fingers into it quite easily, it was very very deep and yet the blood rushing out of it actually made me feel good but now this, the latest one, they are small cuts and yet they hurt like hell when I did them and I suddenly got all panicked, maybe I am going to cut too deep so the way of thinking has changed and its more shifted from this desire to die to a desire to just hurt myself to try and rid myself from some of this inner pain.

J: What do you think has caused that shift for you?

R: I think maybe I just know that if I do kill myself I'm going to let everybody down, I'm letting myself down, I'm letting God down, I'm taking away the precious gift of life which other people fight for and go through hideous chemical things to stay alive another 6 months and I want to just throw it out the window and that's presumptuous of me.

J: And what do you think brought you to that point?

R: I don't really know, I just think maybe talking to my mom and maybe seeing the absolute distress on her face when she saw what I'd done and realised that she could have lost me and then I mean she was distraught and then her saying to me if this is how distraught I feel can you imagine how distraught your children would feel and that sort of took away that desire and also I really want to get better and I know I can't do that if I die so its just a shift in thinking, just a, maybe also a lot of what I'm experiencing is biochemical and I know that now so maybe the medicine just started to make me feel a bit better but not better enough to not want to hurt myself but better to not to want to die.

J: I'd like to come back to the medication but if we could also just go back to your mother's distress.

R: Well, my mom arrived at the hospital, not during visiting hours, she just arrived, and she, my mom is not a timid person but she's not usually all that pushy but there was no ways she was not letting them not let her see me and she just came and held me, she wasn't cross with me or anything and cried her eyes out and said to me you are so important to me you are probably the most important thing in my life at this point in time and I can't imagine what I would do if you died, I would never see you grow up to fulfil your dreams and you would cause me absolute heartache and I was shocked at her reaction.

J: You hadn't expected that?

R: No, I 'd imagined she'd be a bit unhappy but I didn't think she would feel such intense grief when I hadn't even got it right, you know, it really was a shock for me. I mean I felt so guilty when I saw her because in that sort of distorted way of thinking I imagined that she would be at my graveside and say well, ja, she did have a hard life so I can actually understand why she did it, I'll miss her but she's probably happier now and to see her totally devastated just over an attempt made

me realise if I had really got it right she would have been finished and I was amazed at the reaction, there was no anger, there was no judgement there was just this absolute sadness and such intense feeling from her that she had almost lost her baby and then I started relating it to how I might feel if I had lost one of my children and I could relate I mean I would be devastated, I would be devastated if I lost my child in an accident, but if my child took their own life I don't think I'd ever recover and then I think that made me realise how selfish suicide actually is.

J: And about the medication, how did your feelings about cutting change since the medication?

R: I think in general I'm a lot calmer, I used to suffer from panic attacks and often my anxiety would go up and I'd cut myself and this would be precipitated by a panic attack. After the panic attack I would just say I can't go through this again but now that the panic attacks are under control and also now that they have isolated what they think I have I'm sleeping a lot better and so I'm feeling more rested and sleep deprivation I think is one of the worst things for depression and um, so I'm sleeping better so I'm feeling better and I'm hardly having panic attacks so I'm feeling a whole lot better in that way so although I feel depressed I don't have that anxiety and that anxiousness and that I don't know what to do and the only option is to hurt myself, I've lost that and I think that's what made me able to go to this lady and speak to her, I mean, I'd had my medication at about 13:00 and it had included one of the medications that does calm me down so maybe that's what helped, it just the medication is balancing, me a little bit and I'm thinking a little bit more rationally and emotionally and I realise I've got to break the cycle cos it is like a cycle. You hurt yourself, then you feel guilty about hurting yourself then the guilt grows and makes you more depressed, you become more depressed so you hurt yourself again and you feel guilty about it and so you go. Your depression leads you to this point where you feel absolutely desperate so you hurt yourself and then you get guilty which brings you right back to the depression. And I just know yesterday that I actually had to break that cycle. I had to do it, if not for me, for my mom and for my kids, they always say you've got to do it for yourself but I actually don't think that that is true. If you are not feeling so good about yourself then its more than fair to shift the, your goal onto somebody else, right at the moment I don't want to live for myself so I'm living for my mom, she needs me.

J: Where do you think your panic went when you had the experience of not cutting?

R: I don't think it was an immediate disappearance of the panic I think it was a gradual relaxation because obviously when you get this panicky feeling and you get panic attacks you get very tense and when I got into the nurse's office I was shaking and breathing fast and I didn't have a panic attack but it was there, it was starting and I just felt my body generally relaxing and my breathing calming down and then my hands stopped shaking and my neck stopped twitching and my heart stopped racing, so it didn't happen and then gradually as I sort of spoke, the more I spoke the calmer my body became. For me a lot of it is how my body is feeling although I know your mind is controlling your body, when my body is agitated, when my legs won't sit still and my hands are shaking and I can't breathe properly that starts to put thoughts in my mind, what can I do where can I run, what must I do, there's no out for me, the only thing I can do is hurt myself, so the gradual relaxation and it took a long time, I mean I was in there for about an hour, sort of

with every vent it got better that thought went away and with every less shaking that I had the thought went away until eventually I was relaxed and I felt okay, I didn't feel happy but I felt I could walk away and not hurt myself.

J: Did you feel that you had taken anything away, was there something that you could hold onto?

R: Yes, as I said a bit earlier there was her definite affirmation of her saying to me "you've done a good job, you did the right thing" and I hold onto that and also I know next time, as I said to you I haven't had very good experience with approaching people and saying to them listen, I'm feeling suicidal. The average man in the street is petrified when you say something like that yet now that I've seen her response, how calm they are and how good they are I know I could do it a lot easier, its like the first time you dive into a swimming pool you are terrified of the water being cold, the second time its not quite as cold and the third time its not cold at all or the first time you drive a car on a public road by yourself, everytime it gets easier until it becomes second nature to you and I think it is the same on this side, the first step, the first time I had to go to somebody and tell them how I was feeling I was very anxious but I know that if I got another feeling I could go quite easily even if it wasn't the same person, so I'm hoping that with that ability to speak becoming easier and ability to approach them becoming more relaxed, I'm hoping that the desire to hurt myself will go, I don't know if it will work that way, I hope so cos I don't want to go home with that desire and unfortunately I still know, if I'm honest that probably 60 % of the reason that I haven't cut myself is that there was no blade available to me. The last time I did there were two razors lying in the bathroom and I now know an easy way to break the razor and get the blades out, I don't try and cut myself with the double blade in the plastic razor because it doesn't work but I've worked out such an easy way to snap it and get the two blades out and yesterday there was no blade available to me and I know no one will give me so I didn't have much choice but to talk about it.

J: But had there been a razor you would have used it?

R: Ja, and that scares me because if there had been a razor available it would have been a three way choice of either cut myself and be transferred or go talk to someone, and I feel that I would have had to choose between how strongly do you feel about staying in this ward, how much do you want to cut yourself and I probably would have cut my legs where no one could have seen it because that has crossed my mind and I know this is so obvious (*indicating wrists*) and if I bleed heavily and I have to have stitches then I have to tell them but now I've got to the way of thinking, I'll cut my legs just little cuts just enough so that it bleeds, but that it is not deep enough for stitches, and when I put my pants on then no one will know. But I mean I can't get my hands on a blade so it's not really an option.

J: Is there anything else that you want to add?

R: I just think that its very important to me that people understand, especially people close to me, that this is a disease and not an attention seeking thing because my boyfriend has got quite intolerant with me quite a few times and said to me, "if you do this again I'm not going to give you any attention", and I think society in general, I mean medical aids recognise depression but society doesn't and its been very important to me that people around me that are close to me understand that I don't have ultimate control of this at the moment, I will eventually but at this moment in time I'm like a puppet in a way and its a horrible feeling, and everyone

wants me to get better but there is nobody that wants me to get better more than me, there's nobody that, people hate seeing me this way, but I think that there's nobody that hates it more than me and I can wait to just feel normal again to just use a razor to shave my legs. So I just think that people need to be compassionate because it's a horrible feeling it's not something that you have any control over, the little control that I had I exercised and I feel good about that.

J: It sounds like you are feeling quite misunderstood?

R: I do, you know I'm not a stupid person, I'm an intelligent person and I know that if you take a sharp object and you put it on your skin you are going to hurt yourself and cause yourself damage and I'm the kind of person that will cut a tomato and cut it so carefully, I've always protected my body so this is a huge turnabout for me, and I've never felt this way before, and people around me just can't understand me, why didn't you just come and talk to me, because I didn't want to, I actually wanted to hurt myself, it's not that I thought I didn't really want to hurt myself I really wanted to talk to you but you probably didn't want to talk to me so I'll hurt myself anyway, it's not that, I want to hurt myself and it's much easier to hurt myself than to go and speak to somebody, I actually want someone to find me I want it to be successful, and this is something that I don't have control over and I think only my mom understands it because she's been treated for depression before, but she's never cut herself but she's taken overdoses and I feel that a lot of, even that patients who don't have those urges, don't understand, and they get cross with me because I cause a disturbance in the ward, I mean I can remember when I was in Ward 7, the first time when I cut myself and I cut myself so badly that I really wanted to die, nobody know me, it was my first night there and I walked into the room where everyone was sitting and this one guy said, "the stupid, bloody bitch that they've just brought in has caused such a scene by cutting her wrists", you know, and I said, "excuse me I'm the stupid, bloody bitch" and he felt so bad and we actually became quite friendly after that and he apologised to me but that's how they perceive it, they see you as somebody with the nurses all running around you wanting to be whipped off to hospital and it's not like that, maybe it's like that for some people, but it's not like that for me, it's like I almost go into a trance, it's almost like there is another me doing it, I'm calm and I'm cool and I'm happy and I'm relaxed and I don't sit there shaking and nervous, it's just a relaxed thing and that is scary, because it's almost like you are being possessed.

J: I'm just wondering, in terms of what you mentioned, that people think that the cutting is attention seeking, do you think that would have some impact on your experience of not cutting? Do you think it would influence it in any way?

R: I actually get even more attention when I don't cut than when I do, because when I don't people are relieved and are eager to talk to me, people want to spend time with me and when I do they get annoyed with me and they want to put me to bed on some kind of tranquilliser as soon as possible, um obviously logically, it is a desire for attention, um, because I have needs inside of me and I have lots of problems inside of me and I need attention but it's not a conscious act of I want the nurses to run around after me now and I want everyone to feel sorry for me so I'm going to cut myself, it's not that kind of attention seeking, it's not a cutting drive, a conscious decision that I want everybody to feel sorry for me, it's more of a I need

help and I don't know how else to do it and this is going to make me feel better, and it doesn't.

J: It's interesting, that you make the connection on your side that if you don't cut you'll get more attention.

R: I did, for the first time I got more attention, I got an hours attention of someone really wanting to help me and of somebody being nice to me and the experiences when I've cut myself have not been pleasant, people have been annoyed with me, people have been abrupt with me, they've pulled me around with antiseptic and stitches and things like that so it was a comforting kind of attention that I got when I actually went and didn't cut myself and that would probably make me go back again, because it was actually, I wouldn't say pleasant but nicer than the pain, so anyone that thinks that you cut your wrists just for the attention, I don't think its true. You inadvertently get the attention and sometimes it not even nice, I mean the day that I cut my wrists so badly, I was waiting for an hour and a half with my hands like this, while they were trying to get transport for me cos they weren't prepared to hire an ambulance because I'm a state patient and then when they eventually got a guy he drove like a maniac and was as rude as all hell to me and when I got to the Jhb Gen, they weren't prepared to wait for the plastic surgeon so they just stitched and the doctor who saw me the other day said they really should have used a plastic surgeon, now I've got ugly scars when I could have had thin scars so it wasn't a pleasant experience, so they're right, to want that kind of attention seeking they must be crazy. What happened yesterday was still not pleasant and I really think I've conquered the desire, no, I don't think I've conquered the desire cos I still think I'm going to feel like it, but I think I've conquered the actual doing of it, I think I'll be able to go to whoever is on duty and say, I need help.

J: So it sounds like you have a plan of action if that does happen.

R: Well. I've actually set myself a step by step thing of what I will do, the first thing I'll do is get as far away from the bathroom as I can, the second thing I'll do is find somebody, the third thing I'll do is say I feel like cutting myself please help me and that's my plan of action and I'm going to do it that way every time, until it becomes a routine for me cos I need routine in my life, um, so and that's given me a lot of security having a plan, having a sort of an action plan, even if its only three small steps.

J: Tell me more about the security.

R: I think like for example if you take men that are in battle they have a certain routine that they know that that's the plan of action, so I need the security in knowing that when the time comes and I feel that way I don't have to think too much, I know exactly what I can do because thinking flusters me and makes me agitated and makes me more hyper and makes me more panicky, so if I reach a situation where I've got a step, one, two three, and I can just do it, I feel more secure, its like CPR, if you know CPR and I've had to resuscitate one of my kids, if you know CPR and you know it backwards, when the time comes then you do it by route, if you don't know it that well then you panic, the same thing for me, its like my own little CPR, my own ABC, I know what I'm going to do, I'm going to leave the bathroom and go to sister and confess what I'm feeling, and that helps me and I repeat it to myself three times a day, that's just what I do, I feel good.

J: So its almost like a ritual for you?

R: Ja, cos I think its only when and I've also asked everybody please not to leave their razors out and they've all locked them away and when I want to shave my legs, they won't give me a razor, if I want to shave my legs, my mom's got to come and watch me, it sounds really ridiculous but it is necessary.

J: Anything else that you'd like to add?

R: No, not really

J: Well, I'd like to say thanks very much, this has been very helpful, its given me a better understanding of your experience. Did you find this interview helpful at all, any suggestions or comments that you'd like to make?

R: Ja, it actually has been very helpful, because I've put some things in perspective that I didn't even realise I thought, I've clarified a lot of things in my mind which I knew were there but which I've never spoken about and that always helps.

J: Can I ask what some of those things are?

R: Well, I've reaffirmed that I can, that I've got affirmation from the sisters and that its good to go and see them and I reiterated that my mother was devastated by my attempted suicide and I've confirmed that there are good things in my life like my children and my mom and getting a car again so those kinds of things, and I've also realised that not everybody doesn't understand, there are people that do understand and it just confirmed it by saying it again and ja its been good for me I hope it helps you too.

J: Any suggestions that you'd like to make?

R: No, I just think that your questions are quite difficult to answer (laughs), but ja, they are very thought provoking which is obviously what they need to be, it would be no use if I didn't think about what I had to say.

PROTOCOL ONE

NATURAL MEANING UNITS (Respondent R)

1

- that's what happened yesterday
- I cut myself on 4 occasions
- on each of those occasions I've had no desire to go and ask somebody for help
- I am under threat that if I do it again I'm being transferred
- that obviously motivates me to go for help
- its always precipitated by feeling panic
- I got really panicked and I started thinking about hurting myself
- I thought I'm going to go and speak to somebody
- I went to the office and I spoke to the sister on duty
- I was very honest with her
- I said I feel like cutting my wrists, and I need to talk to you
- we sat and chatted for about a half an hour
- I couldn't specify why I wanted to do it
- there was nothing that had set me off
- there was no particular reason why I wanted to do it
- just an overwhelming feeling
- she kept asking me if I could clarify what particularly had made me want to do it
- I just felt hopeless, I felt scared, I felt alone, just felt desperate
- we started discussing the problems in my life

2

- losing everything, my car being repossessed today, having to move back and stay with my parents, having to move from Durban to Joburg, leave my boyfriend and my friends behind and my two kids
- I'm missing my two kids dreadfully
- just in discussing those problems I generally felt, gradually felt panic subside
- once the panic had subsided then the desire to cut my wrists subsided.

3

- I stopped feeling so alone because there was somebody who was genuinely interested in what I was saying
- hearing myself express myself and all the reasons that I had not to do it, like my children and my boyfriend and the desire to build myself up again
- when you are alone and you just go and do it
- you don't think of any positives, you just think of all the negatives
- when you are with somebody you suddenly start seeing a few positives
- the reasons that you want to do it the reasons that provoke you to do it are actually, could actually be positives
- the reason that I'm missing my children is actually a reason not to do it because if I do it and I get it right I won't see them again
- my car has been repossessed, if I cut my wrists and die I'll never have the car again

- in verbalising it you start to realise all those negative reasons are actually positives and reasons not to do it rather than to do it.
- I think for me there's been two definite desires
- there's been a desire to die and there's been a desire to hurt myself

4

- this is the first time that I've ever spoken to somebody and stopped myself
- on all four other occasions I've just gone and done it.

5

- at this point in my life I just feel extremely alone eventhough I have people around
- I feel lonely
- its hard to describe its just an emptiness inside
- I feel like I'm in this black hole
- I can't get rid of it
- I start off at the top of the hole where I can still see the light and there's no desire to hurt myself and slowly I sink until I reach the bottom of this hole
- I reach the bottom of that hole through a process of *thinking and thinking and thinking* and thoughts becoming worse and worse in my mind and probably becoming bigger and bigger and bigger
- somehow just speaking to her yesterday pulled me back up to the top of the hole a bit
- she made the problems seem a little bit smaller
- she didn't say anything, she just said that must be hard, that must be difficult
- she didn't offer advice
- just the fact that someone was interested lifted me out of the hole
- another part of me seemed a little bit more realistic instead of these big black monsters that I can never cope with
- it worked for a while
- last night I had a run in with somebody here and I had the desire to kill myself again
- I didn't go and talk to anybody, I sat outside and did nothing

6

- if I do it again they are going to go and transfer me to Sterkfontein
- at the moment I'm living under threat
- I'm a bit worried, concerned, that's one of the major reasons that I'm not hurting myself
- not the fact that I'm losing the desire to but the fact that I'm so scared that if I do hurt myself they are going to transfer me out of here
- this is my only hope

7

- I'm usually a very independent, competent person
- I'm not prescribed to very easily and generally I work my own problems out in my mind
- what I was looking for yesterday was just a bit of sympathy

- I wasn't really looking for some advice because I know the answer, I know what I have to do
- I know I have to get round here, then I have to get a job, I have to save a bit of money for a deposit on a flat and a deposit for a car, I have to get a car and then I can have my kids with me again
- I don't know what to do about the boyfriend situation but I'm also realistic enough to know that if it has to end it has to end
- I actually do know what to do
- they become dragons in my mind and because I can't do it all now
- I want things to be right and I want them to be right now
- because they can't all be right now, I'm frustrated
- I really don't need somebody to say to me x, y, z, this is what you need to do
- I just need somebody to understand that I feel out of control

8

- maybe feel like I'm not crazy, because you start to think you're crazy, I feel totally out of control
- there's not one aspect of my life that I actually hold in control at the moment
- to have someone who knows that that my feelings are real
- to acknowledge that it's right to miss your boyfriend and it's right to miss your children
- that it's acceptable to feel lonely and scared and crazy
- you feel that you are not crazy that you are actually just a mixed up person at the moment who has a lot of stress on their plate and all your reactions are justified
- it gives you a kind of affirmation.

9

- you become very negative in this kind of situation
- you feel like nothing you do is right
- nothing you have done is right because otherwise you wouldn't be in such a situation
- it makes it like you're okay to feel that way
- it makes you feel like a better person
- what we all look for in life is affirmation and getting it in our job and getting it in our role as parents
- I'm not getting it in any of those sources at the moment
- I'm not getting any positive strokes from my job, from a relationship with a man, from even a relationship with my children because they are not with me
- I have to get it from here and the way that I'm getting it is she really made me feel like I'd achieved something by not going and cutting myself
- by coming and talking to her, by calming myself down and I did it, she didn't do it
- she made that very clear to me she was just the bouncing board
- I did it all by myself, I spoke my way through it, I got to the point where I could say I'm okay, I can walk away now
- I had actually done it
- she wasn't this magical person who waved her wand and took away all my bad feelings
- she was just a person sitting there, agreeing with me

- she said to me, "that's all we want you to do, we just want you to come and talk to us and talk your way through it and I'm very proud of you"
- that made me feel good

10

- a lot of it revolves around the fact that they said to me if I did it again I'm going to be transferred
- I'm scared of that so a lot of it is based on fear of being transferred, but not all of it
- some of it is also based on the desire to stop doing this to myself
- it doesn't look nice
- it doesn't feel nice
- unfortunately logic doesn't prevail at the time of cutting

11

- until such time as I can not have the desire to hurt myself, I won't be well
- I won't have worked through my problems
- I won't have worked through my guilt and my hurt and what ever is going on inside of me
- I will only start feeling good about myself when I reach that point when I don't want to hurt myself anymore
- I'll know I've dealt with big issues
- I don't want to hurt myself because in the back of my mind my sort of real self says, you don't want to die
- although sometimes I don't enjoy life, I mean I really want to die
- what you really want is to stop hurting yourself
- to stop scarring yourself
- to be a whole person again
- to lead a normal life
- to get out of this place as a whole person and as a happy person and to be able to cope with life again
- I've always coped with life
- my parents got divorced when I was nine and since then things have not been easy for me, I've always coped
- this is the first time that I've had the desire to hurt myself
- I know I won't get back to my normal self until I can say I don't want to hurt myself anymore
- I know that once I've reached the point I can say I really don't want to hurt myself anymore, I know I've made progress.

12

- at the moment I feel out of control
- I'm not in touch with my normal feelings
- the feelings that I'm feeling now I'm not used to feeling
- I'm used to feeling panic where I'm used to feeling calmness, I'm used to feeling control and I feel out of control now, I'm used to feeling confident and I'm feeling scared and anxious at the moment

- for me to be my whole self again I need to regain my confidence and to regain my passion for life
- I'm a very passionate person and I've lost that in all ways
- I've lost the desire to get up and look pretty
- I only get up and do it because I know I must
- I've lost the desire to eat and I've always enjoyed food, even though its been healthy food, I've lost the desire to brush my teeth
- stupid things
- I have to regain all those needs again to be a whole person
- I'm just not me
- its like this foreign person is living in my body and it tells me to do things that I would never do

13

- I was taking like ten to fifteen Syndol a day just to get through the day
- its also not me but the cutting being the biggest thing
- I don't even feel it when I do it, its like I go into a trance and this other person cuts
- I've got to lose that person and let my old self back

14

- I felt like I'd temporarily taken back a little bit of control
- I felt very sad but I felt calm
- I went and cried a lot but maybe out of a sense of relief
- I wouldn't say that I suddenly started feeling good and doing cartwheels around the passage and said yay I've achieved something
- but I did feel like I had achieved something
- I'd broken a cycle which has been a self destructive cycle
- I felt that I'd kept to the bargain
- I made a bargain with them that I won't do this again and that if I do I'm going out
- I'd stuck to the bargain and it was very difficult, it was very difficult
- It would have been easier to cut myself, that's what is so ironic

15

- approaching somebody that I don't know with a feeling that is very personal, on subjects that are very personal
- the biggest thing was facing the risk of rejection, going and saying I'm really feeling down, I'm feeling like hurting myself, I really need to talk to you
- on one occasion I've had someone saying to me go and have a good cry and you'll feel better
- that was a form of rejection
- the relief of having this person really interested and concerned and available
- I didn't know whether she would be
- I didn't know whether she'd say oh here we go again
- I sensed a level of intolerance in people and so I was scared
- I was also scared of revealing more of myself because I feel so vulnerable at the moment

- I feel so open and like people are probing into parts of me that I don't really want them to but I know they have to
- its very hard to go in there and bare your soul
- its easier to go off in the corner and hurt yourself

16

- being honest about things that you really don't want to be honest about
- saying things that you know are going to not make you look so good
- discussing painful things
- everytime I have to sit down and discuss myself it opens up wounds, it brings back pain
- I see cutting myself as an escape to facing my own pain
- if I hurt myself outside it will distract me from the inner pain
- now I'm happy to do the reverse and then to expose the inner pain to avoid the outer pain
- it would sound weird to someone who doesn't have the desire
- its easier to get into a bath and cut than to sit down with someone and discuss why you want to
- its just easier when you're in this state of mind
- I think when you are in a normal state of mind the thought of cutting is horrific and you'd much rather talk over a cup of coffee and a cigarette
- the way I feel right now is not normal
- I also have a lot of guilt over a lot of things that I've done
- its almost like punishing myself
- you can't really punish yourself by talking things out and having the person make you feel better

17

- I've never felt like this before
- I've never wanted to do myself harm
- I've never had to face such emotions before so I can't really compare it
- it feels like its a totally unique experience for me
- I can almost relate it to being a child and having done something wrong and knowing that your parents are coming home and you re going to have to tell them
- it would be easier to try and hide what you've done but you know you've got to face a broken window
- you know you've got to face your parents and you know in that case that they will be angry
- I'm scared sometimes that when I go and tell people what I'm feeling they will be angry
- they never are yet I always feel scared
- I always expect them to be angry
- I go in and say I'm feeling suicidal and I need to talk to you I always expect them to say to me don't be ridiculous
- that's the reaction I've got from lay people so have a cup of tea and have a cigarette and don't be ridiculous
- I'm trying to uncondition myself from that kind of thinking
- it is scary but I'm actually going to stay with it

- sometimes the desire to hurt myself is just too great

18

- there have been two different sensations for me, two different ways of thinking
- the first time I cut my wrists it was a definite desire to die
- the second and third time were to hurt myself
- my approach and my feelings have changed
- I really really wanted to kill myself
- I still feel the desire to die but I don't want to kill myself anymore
- I'm just wanting to get better already

19

- when I cut my wrist to die the last thing I would have done was to go to someone cos they would have stopped me
- it was almost like a ritual for me, run the bath, relaxed about it, this is what I want to do, thank goodness it will all be over
- the last thing I wanted to do was to attract attention to myself
- I was actually angry when I was found
- angry when I was stitched
- angry when it was stopped
- really frustrated that I didn't get it right
- now I almost want somebody to walk in before I start and say what are you doing?
- it would be so much easier if they came to me
- I don't cut as deep
- I don't get the same satisfaction
- when I try and cut my wrists to die I never felt anything
- it didn't hurt at all and the blood didn't worry me at all
- the cuts were bad, I mean one cut was so bad that I could move my finger and see the tendon moving, I could have fitted two fingers into it quite easily
- it was very very deep
- the blood rushing out of it actually made me feel good
- the latest one, they are small cuts and yet they hurt like hell when I did them
- I suddenly got all panicked, maybe I am going to cut too deep
- the way of thinking has changed
- its more shifted from this desire to die to a desire to just hurt myself to try and rid myself from some of this inner pain

20

- if I do kill myself I'm going to let everybody down
- I'm letting myself down
- I'm letting God down
- I'm taking away the precious gift of life which other people fight for and go through hideous chemical things to stay alive another 6 months
- I want to just throw it out the window and that's presumptuous of me

21

- talking to my mom and seeing the absolute distress on her face when she saw what I'd done and realised that she could have lost me
- she was distraught
- her saying to me if this is how distraught I feel can you imagine how distraught your children would feel took away that desire
- I really want to get better and I know I can't do that if I die
- its just a shift in thinking
- maybe a lot of what I'm experiencing is biochemical
- the medicine just started to make me feel a bit better
- not better enough to not want to hurt myself but better to not to want to die

22

- my mom arrived at the hospital, not during visiting hours
- she just arrived, and my mom is not a timid person but she's not usually all that pushy but there was no ways she was not letting them not let her see me
- she just came and held me
- she wasn't cross with me or anything
- she cried her eyes out
- she said to me you are so important to me you are probably the most important thing in my life at this point in time and I can't imagine what I would do if you died
- I would never see you grow up to fulfil your dreams
- you would cause me absolute heartache
- I was shocked at her reaction

23

- I 'd imagined she'd be a bit unhappy
- I didn't think she would feel such intense grief when I hadn't even got it right
- it really was a shock for me
- I felt so guilty when I saw her
- in that sort of distorted way of thinking I imagined that she would be at my graveside and say she did have a hard life so I can actually understand why she did it, I'll miss her but she's probably happier now
- to see her totally devastated just over an attempt made me realise if I had really got it right she would have been finished
- I was amazed at the reaction, there was no anger, there was no judgement there was just this absolute sadness and such intense feeling from her that she had almost lost her baby
- I started relating it to how I might feel if I had lost one of my children
- I could relate, I would be devastated
- I would be devastated if I lost my child in an accident, but if my child took their own life I don't think I'd ever recover
- I think that made me realise how selfish suicide actually is

24

- I think in general I'm a lot calmer since the medication
- I used to suffer from panic attacks
- often my anxiety would go up and I'd cut myself

- this would be precipitated by a panic attack
- after the panic attack I would just say I can't go through this again
- now that the panic attacks are under control and also now that they are isolating what they think I have I'm sleeping a lot better
- so I'm feeling more rested
- sleep deprivation I think is one of the worst things for depression
- I'm sleeping better so I'm feeling better
- I'm hardly having panic attacks so I'm feeling a whole lot better in that way
- although I feel depressed I don't have that anxiety and that anxiousness and that I don't know what to do and the only option is to hurt myself
- I've lost that
- I think that's what made me able to go to this lady and speak to her
- I'd had my medication at about 1:00 and it had included one of the medications that does calm me down so maybe that's what helped
- its just the medication is balancing me a little bit
- I'm thinking a little bit more rationally and emotionally
- I realise I've got to break the cycle
- you hurt yourself, then you feel guilty about hurting yourself then the guilt grows and makes you more depressed
- you become more depressed so you hurt yourself again and you feel guilty about it and so you go
- your depression leads you to this point where you feel absolutely desperate so you hurt yourself and then you get guilty which brings you right back to the depression
- I just know yesterday that I actually had to break that cycle
- I had to do it, if not for me, for my mom and for my kids
- they say you've got to do it for yourself but I actually don't think that that is true
- if you are not feeling so good about yourself then its more than fair to shift your goal onto somebody else
- at the moment I don't want to live for myself so I'm living for my mom, she needs me

25

- I don't think it was an immediate disappearance of the panic I think it was a gradual relaxation
- when you get this panicky feeling and you get panic attacks you get very tense
- when I got into the nurse's office I was shaking and breathing fast
- I didn't have a panic attack but it was there, it was starting
- I just felt my body generally relaxing and my breathing calming down and then my hands stopped shaking and my neck stopped twitching and my heart stopped racing
- it didn't happen and then gradually as I sort of spoke
- the more I spoke the calmer my body became
- for me a lot of it is how my body is feeling although I know your mind is controlling your body
- when my body is agitated, when my legs won't sit still and my hands are shaking and I can't breathe properly that starts to put thoughts in my mind
- what can I do where can I run, what must I do, there's no out for me
- the only thing I can do is hurt myself

- the relaxation was gradual and it took a long time, I mean I was in there for about an hour
- with every vent it got better
- that thought went away and with every less shaking that I had the thought went away until eventually I was relaxed and I felt okay
- I didn't feel happy but I felt I could walk away and not hurt myself

26

- her definite affirmation of her saying to me "you've done a good job, you did the right thing" and I hold onto that
- the average man in the street is petrified when you say something about feeling suicidal
- now that I've seen her response, how calm they are and how good they are I know I could do it a lot easier
- its like the first time you dive into a swimming pool you are terrified of the water being cold, the second time its not quite as cold and the third time its not cold at all
- the first time you drive a car on a public road by yourself, everytime it gets easier until it becomes second nature to you
- I think it is the same on this side, the first time I had to go to somebody and tell them how I was feeling I was very anxious
- I know that if I got another feeling I could go quite easily even if it wasn't the same person
- I'm hoping that with that ability to speak becoming easier and ability to approach them becoming more relaxed, I'm hoping that the desire to hurt myself will go
- I don't know if it will work that way
- I hope so cos I don't want to go home with that desire
- unfortunately I still know, if I'm honest that probably 60 % of the reason that I haven't cut myself is that there was no blade available to me
- the last time I did there were two razors lying in the bathroom
- I now know an easy way to break the razor and get the blades out
- I don't try and cut myself with the double blade in the plastic razor because it doesn't work but I've worked out such an easy way to snap it and get the two blades out
- yesterday there was no blade available to me and I know no one will give me so I didn't have much choice but to talk about it

27

- if there had been a razor available it would have been a three way choice of either cut myself and be transferred or go talk to someone
- I would have had to choose between how strongly do you feel about staying in this ward, how much do you want to cut yourself
- I probably would have cut my legs where no one could have seen it
- I know this is so obvious (*indicating wrists*) and if I bleed heavily and I have to have stitches then I have to tell them
- I've got to the way of thinking, I'll cut my legs just little cuts just enough so that it bleeds, but that it is not deep enough for stitches, and when I put my pants on then no one will know
- but I can't get my hands on a blade so it's not really an option

28

- I just think that its very important to me that people understand especially people close to me that this is a disease and not an attention seeking thing
- my boyfriend has got quite intolerant with me quite a few times and said to me, "if you do this again I'm not going to give you any attention"
- medical aids recognise depression but society doesn't
- its been very important to me that people around me that are close to me understand that I don't have ultimate control of this at the moment
- I will eventually
- at this moment in time I'm like a puppet in a way and its a horrible feeling
- everyone wants me to get better but there is nobody that wants me to get better more than me
- people hate seeing me this way, but I think that there's nobody that hates it more than me
- I can't wait to just feel normal again to just use a razor to shave my legs
- people need to be compassionate because its a horrible feeling
- its not something that you have any control over
- the little control that I had I exercised and I feel good about that

29

- I'm not stupid person, I'm an intelligent person
- I know that if you take a sharp object and you put it on your skin you are going to hurt yourself and cause yourself damage
- I'm the kind of person that will cut a tomato and cut it so carefully
- I've always protected my body so this is a huge turnabout for me
- I've never felt this way before
- people around me just can't understand me, why didn't you just come and talk to me, because I didn't want to
- I actually wanted to hurt myself
- its not that I thought I didn't really want to hurt myself I really wanted to talk to you but you probably didn't want to talk to me so I'll hurt myself anyway, its not that
- I want to hurt myself and its much easier to hurt myself than to go and speak to somebody
- I actually want someone to find me
- I want it to be successful, and this is something that I don't have control over
- I think only my mom understands it because she's been treated for depression before
- she's never cut herself but she's taken overdoses
- I feel that a lot of, even that patients who don't have those urges, don't understand
- they get cross with me because I cause a disturbance in the ward
- when I was in Ward 7. the first time when I cut myself and I cut myself so badly that I really wanted to die, nobody knew me it was my first night there
- I walked into the room where everyone was sitting and this one guy said, "the stupid, bloody bitch that they've just brought in has caused such a scene by cutting her wrists"

- I said, "excuse me I'm the stupid, bloody bitch" and he felt so bad and we actually became quite friendly after that and he apologised to me
- that's how they perceive it, they see you as somebody with the nurses all running around you wanting to be whipped off to hospital
- its not like that
- maybe its like that for some people, but its not like that for me
- its like I almost go into a trance
- its almost like there is another me doing it
- I'm calm and I'm cool and I'm happy and I'm relaxed
- I don't sit there shaking and nervous, its just a relaxed thing
- that is scary because its almost like you are being possessed

30

- I get even more attention when I don't cut than when I do
- when I don't people are relieved and are eager to talk to me, people want to spend time with me
- when I do they get annoyed with me and they want to put me to bed on some kind of tranquilliser as soon as possible
- obviously logically, it is a desire for attention because I have needs inside of me and I have lots of problems inside of me and I need attention
- its not a conscious act of wanting the nurses to run around after me and wanting everyone to feel sorry for me so I'm going to cut myself, it's not that kind of attention seeking
- it's not a cutting drive, a conscious decision that I want everybody to feel sorry for me
- its more of a I need help and I don't know how else to do it
- this is going to make me feel better
- it doesn't make me feel better

31

- for the first time I got more attention when I didn't cut
- I got an hours attention of someone really wanting to help me and of somebody being nice to me
- the experiences when I've cut myself have not been pleasant
- people have been annoyed with me, people have been abrupt with me, they've pulled me around with antiseptic and stitches and things like that
- it was a comforting kind of attention that I got when I actually went and didn't cut myself
- that would probably make me go back again
- it was actually, I wouldn't say pleasant but nicer than the pain
- anyone that thinks that you cut your wrists just for the attention, I don't think its true
- you inadvertently get the attention and sometimes it not even nice
- the day that I cut my wrists so badly, I was waiting for an hour and a half with my hands like this, while they were trying to get transport for me
- they weren't prepared to hire an ambulance because I'm a state patient
- when they eventually got a guy he drove like a maniac and was as rude as all hell to me

- when I got to the Jhb Gen, they weren't prepared to wait for the plastic surgeon so they just stitched
- the doctor who saw me the other day said they really should have used a plastic surgeon, now I've got ugly scars when I could have had thin scars
- it wasn't a pleasant experience
- they're right, to want that kind of attention seeking they must be crazy
- what happened yesterday was still not pleasant
- I've conquered the desire
- I don't think I've conquered the desire cos I still think I'm going to feel like it
- I've conquered the actual doing of it
- I'll be able to go to whoever is on duty and say I need help

32

- I've actually set myself a step by step thing of what I will do if I want to cut
- the first thing I'll do is get as far away from the bathroom as I can
- the second thing I'll do is find somebody
- the third thing I'll do is say I feel like cutting myself please help me
- that's my plan of action
- I'm going to do it that way every time until it becomes a routine for me
- I need routine in my life
- that's given me a lot of security having a plan, even if its only three small steps

33

- men that are in battle have a certain routine that they know that that's the plan of action
- I need the security in knowing that when the time comes I don't have to think too much, I know exactly what I can do
- thinking flusters me and makes me agitated and makes me more hyper and makes me more panicky
- if I reach a situation where I've got a step, one, two three, and I can just do it, I feel more secure
- its like CPR, if you know CPR and you know it backwards, when the time comes then you do it by route
- if you don't know it that well then you panic, the same thing for me
- its like my own little CPR, my own ABC
- I know what I'm going to do
- I'm going to leave the bathroom, go to sister and confess what I'm feeling, and that helps me
- I repeat it to myself three times a day
- I feel good

34

- I've also asked everybody not to leave their razors out and they've all locked them away
- when I want to shave my legs they won't give me a razor
- if I want to shave my legs my mom's got to come and watch me
- it sounds really ridiculous but it is necessary

35

- I've put some things in perspective that I didn't even realise I thought
- I've clarified a lot of things in my mind which I knew were there but which I've never spoken about and that always helps

36

- I've reaffirmed that I can
- I've got affirmation from the sisters
- its good to go and see them
- I reiterated that my mother was devastated by my attempted suicide
- I've confirmed that there are good things in my life like my children and my mom and getting a car again
- I've also realised that not everybody doesn't understand, there are people that do understand
- it just confirmed it by saying it again
- its been good for me

37

- your questions are quite difficult to answer
- they are very thought provoking
- it would be no use if I didn't think about what I had to say

PROTOCOL ONE

RE-ARTICULATION OF NMU's FROM A PSYCHOLOGICAL PERSPECTIVE (Respondent R)

1

- R commented that she had inhibited the urge to self-mutilate the day prior to the interview
- R has previously cut herself on 4 occasions
- On each of those occasions R has had no desire to request help from another person
- R is under threat that if she does cut again, she will be transferred
- This possibility motivates R to go for help
- R's need to cut is always precipitated by feelings of panic
- R became panicked and started thinking about hurting herself
- R sought somebody to speak to
- She spoke to the sister on duty in the duty room
- R was very honest with her
- R told her that she felt like cutting herself and expressed her need to talk
- They spoke casually for about a half an hour
- R couldn't specify why she wanted to hurt herself
- R could not identify a precipitant nor think of a reason
- R was aware of an overwhelming feeling
- The sister kept enquiring about a possible precipitating factor that could have lead to this feeling
- R just felt hopeless, scared, alone and desperate
- R and the sister began discussing the problems in R's life

2

- R was distressed about her current life circumstances and stressors
- R felt like she was losing everything
- R was missing her two children
- While discussing the problems R gradually felt the panic subside
- Once the panic had subsided then the desire to cut her wrists also subsided

3

- R stopped feeling so alienated because there was another person who seemed genuinely interested in what she was saying
- Being able to express herself and talking about her children and boyfriend gave R the desire and motivation to get better
- When R is alone she acts impulsively
- When R is alone she doesn't contemplate the positives, only the negatives
- When R is with another person she suddenly becomes aware of a few positives
- R reframes the negatives as positives
- R reframes her missing of her children as a reason not to hurt herself because if she cut her wrists successfully she wouldn't ever see them again
- R reframes the repossession of her car by stating that if she cuts her wrists and dies she will never have the car again

- R considers verbalising her feelings and thoughts as helpful in reframing the negatives to positives
- R identifies two definite desires - to die and to hurt herself

4

- This is the first time that R has ever spoken to somebody and inhibited her cutting behaviour
- On all four previous occasions R has chosen to cut herself

5

- R feels extremely lonely at present even though she has people around her
- R finds the feeling hard to describe, it is just an inner emptiness
- R feels like she's in a black hole
- R can't get rid of the hole
- R begins at the top of the hole where she can still see the light and there's no desire to hurt herself and slowly she sinks until she reaches the bottom of this hole
- When R is at the bottom of the hole, she thinks continuously and the thoughts become worse and more unsolvable
- R equates speaking to the sister with being pulled back up to the top of the hole
- The sister made the problems seem less overwhelming
- The sister empathised with R's situation
- The sister didn't offer advice
- The concern of another person aided R in lifting herself out of the hole
- R felt that a part of her seemed a little bit more realistic in contrast to other parts of her which are filled with big black monsters that she can never cope with
- It worked for a while
- Last night R had a fight with somebody on the ward and she had the desire to kill herself again
- R chose not to go and talk to anybody, instead she sat outside and did nothing

6

- R fears that if she does it again she will be transferred to Sterkfontein
- R feels like she is living under threat at present
- This leaves R feeling worried and concerned and this is one of the main reasons that she is not hurting herself
- R does not believe she is losing the desire to cut but rather that she is scared of being transferred out
- This ward is R's only hope

7

- R describes herself as a very independent and competent person
- R is not prescribed to easily and generally prefers to work her own problems out in her mind
- All R was looking for yesterday was a bit of sympathy
- R wasn't really looking for advice because she knows the answer, R knows what she has to do

- R knows she has to become better in this ward, then she has to get a job, save a bit of money for a deposit on a flat and a car. R then has to get a car and then she can have her children living with her again
- R is unsure what to do about her relationship but is also realistic about the possibility of it ending
- R actually knows what to do
- The problems become dragons in R's mind because she can't rectify them presently and all at once
- R likes things to be solved instantaneously
- Instantaneous solutions are not possible and this leaves R feeling frustrated
- R doesn't need somebody to tell her in detail what she needs to do
- R just needs somebody to understand that she feels out of control

8

- R begins to think she's crazy because she feels out of control
- There's not one aspect of her life that R actually feels in control of presently
- R just wants to have someone who acknowledges her reality and feelings
- R wants someone to acknowledge that its appropriate to miss your boyfriend and your children
- R wants someone to acknowledge that its acceptable to feel lonely, scared and crazy
- R realises that she is not crazy, but rather just a mixed up person at the moment who has a lot of stressors on her plate
- R perceives her reactions to be justified
- When R's situation is acknowledged she feel affirmed

9

- R feels very negative in this kind of situation
- R feels like nothing she does was or is right
- This feeling is reinforced for R because of the situation she is in at present
- Affirmation allows R a better sense of self
- R believes that affirmation is what we all look for in life, from our jobs and as a parent
- R states that she is not receiving it from any of those sources at present
- R is not getting any positive strokes from her job, from a relationship with a man, nor from the relationship with her children because they are physically far away
- R believes she has to get it from the ward and the way that she is getting it is through talking to the sister
- The sister made R feel like she'd achieved something by not going and cutting herself
- The decision to approach her, talking to her and calming herself down were all seen as R's own achievements, not the sister's
- The sister made it very clear to R that she was just the facilitator
- R did it all by herself by speaking her way through the feelings until she reached a point where she felt more contained
- R had reached this point herself
- R did not view the sister as a magical person who waved her wand and took away all R's bad feelings

- The sister was just a person sitting there, agreeing with and acknowledging R
- At the conclusion of the discussion the sister reaffirmed R's decision to come and talk
- The reaffirmation made R feel good

10

- Much of R's inhibitory behaviour revolves around her fear of being transferred
- R is scared of being transferred which accounts for some of her motivation to refrain from cutting but not all of it
- Some of R's motivation is also based on the desire to stop doing this to herself
- R believes it doesn't look nice
- R says it doesn't feel nice
- Although R can think about it logically in retrospect, at the time of cutting logic doesn't prevail

11

- Until such time as R can stop having the desire to hurt herself she won't consider herself well
- Until then R won't have worked through her feelings of guilt, hurt and other internal issues of turmoil
- R will only start feeling good about herself when she doesn't have the urge to hurt herself anymore
- At this point R will know she's dealt with big issues
- R don't want to hurt herself because in the back of her mind her real self reminds her of her wish to live
- R sometimes doesn't enjoy life and at times really wants to die
- R tells herself that what she really wants is to stop hurting and scarring herself
- R wants to be a whole person again
- R wants to lead a normal life
- R wants to get out of the ward as a whole and happy person and to be able to cope with life again
- R has always coped with life
- R's parents got divorced when she was nine and since then things have not been easy for her but she has always coped
- This is the first time that R has had the desire to hurt herself
- R is convinced that she won't get back to her normal self until she can state that she doesn't want to hurt herself anymore
- Once R has reached the point of not wanting to hurt herself then she will know she's made progress

12

- Presently R feels out of control
- R is not in touch with her normal feelings
- R is not used to feeling the emotions she is experiencing at present
- R is feeling panic where she is used to feeling calmness, R is used to feeling control and feels out of control now, she's used to feeling confident but is feeling scared and anxious presently

- For R to be her whole self again she needs to regain her confidence and her passion for life
- R is usually a very passionate person but has lost that in many ways
- R has lost the desire to get up and look pretty
- R only gets up and grooms herself because she knows she must
- R has lost the desire to eat and she has always enjoyed food, even though its been healthy food, R has lost the desire to brush her teeth
- R considers her loss of desire to maintain herself to be a stupid thing
- R has to regain all those needs again to be a whole person
- R doesn't feel herself
- R feels as though a foreign person is living in her body and it is telling her to do things that she would never have previously done

13

- R was taking ten to fifteen Syndol a day just to get through the day
- The cutting also feels foreign to her
- R doesn't feel the cuts, its like she goes into a trance and this other person cuts
- R has to lose that person and let her old self back

14

- R felt like she'd temporarily taken back a little bit of control following the talking
- R felt a mixture of sadness and calm
- R cried a lot which she attributes to feeling relieved
- R did not feel jubilant but did feel like she had achieved something
- R had broken a cycle which has been a self destructive
- R felt like she'd kept to the bargain that she wouldn't cut again
- It was very difficult to keep to the bargain
- Ironically it would have been easier to cut herself

15

- R was approaching somebody that she didn't know with feelings that are personal, on subjects that are personal
- R's biggest fear was facing the risk of rejection
- R experienced a vulnerability in approaching someone and exposing her inner feelings and making her need to talk known
- On one occasion R has had someone telling her that she would feel better after a good cry
- R interpreted this response as a form of rejection
- R was relieved at having someone really interested, concerned and available
- R initially had doubts as to whether the sister would be emotionally available
- R worried that the sister might be dismissive and intolerant
- R sensed a level of intolerance in people and this left her feeling scared
- R was also scared of revealing more of herself because she felt so vulnerable at that time
- R feels exposed and as if people are probing into parts of her
- R would like to resist the probing but knows it has to be done
- It was very hard for R to go into the dutyroom and bare her soul
- It would be easier to withdraw into the corner and hurt herself

16

- R struggled with being honest about things that she didn't really want to be honest about
- R struggled with saying things that she knew might show her in a negative light
- R struggled with discussing painful things
- The act of sitting down and discussing herself opens up wounds and brings back pain for R
- R perceives cutting herself as an escape from facing her own pain
- If R hurts herself externally it will serve to distract her from the internal pain
- Presently, R is content to do the reverse, to expose the internal pain to avoid the external pain
- R believes it would sound weird to someone who doesn't have the desire
- Its easier to get into a bath and cut than to sit down with someone and verbalise why she wants to cut
- R attributes the ease of cutting to a particular state of mind
- R believes that when you are in a normal state of mind the thought of cutting is horrific and that one would much rather talk over a cup of coffee and a cigarette
- R states that the way she feels presently is abnormal
- R carries much guilt over numerous things that she's done
- Cutting serves the function of punishing herself
- R can't punish herself by verbalising her feelings and having the other person acknowledge her pain

17

- R has never felt like this before
- R has never wanted to do herself harm
- R has never had to confront such emotions before so she can't compare it to anything else
- This feels like a totally unique experience for R
- R can relate it to being a child and having done something wrong and knowing that her parents are coming home and that they will have to be told
- It would be easier to try and hide what she has done but she knows she has to face the consequences of her actions
- R knows that she has to face her parents and she knows in that situation that they will be angry
- R is scared that if she verbalises her feelings openly other people will respond with anger
- Other people never are angry yet R always anticipates the anger and feels scared
- R will verbalise her suicidality and her need to talk to another person and she anticipates a dismissive and degrading response
- The response R has received from lay people has been dismissive and degrading
- R is trying to uncondition herself from anticipating that kind of response
- This is scary for R but she will persevere
- Sometimes the desire to hurt herself is overwhelming

13

- There have been two different sensations for R, two distinct ways of thinking
- The first time R cut her wrists it involved a definite desire to die

- The second and third time were rather to hurt herself
- R's approach and feelings towards cutting have changed
- Initially R wanted to kill herself
- Presently R still experiences the desire to die but doesn't want to kill herself anymore
- R is motivated to get better

19

- When R cut herself to die the last thing she would have done was to approach someone because they would have stopped her
- Cutting took on a ritualistic quality for R where she would anticipate the ending of her pain
- R did not want to attract attention to herself
- R felt angry when she was found
- R felt angry when she was stitched
- R felt angry when it was stopped
- R felt frustrated that she didn't get it right
- Now R wants somebody to walk in prior to her cutting and enquire of her what she is doing
- It would be much easier if the others sought her out
- Presently R doesn't cut as deep
- Nor does R attain the same levels of satisfaction
- Previously when R cut to die she did not experience pain and the blood did not concern her
- The cuts were deep, and damaging
- The blood rushing out of the cuts made R feel good
- Recently the cuts have become smaller and are excruciating
- R suddenly panicked, she was afraid that she may be cutting too deep
- R's way of thinking has changed
- The thinking has shifted from a desire to die to a desire to hurt herself in order to try and rid herself from her internal pain

20

- R believes that if she does kill herself she will let everybody down
- R will let herself down
- R will let God down
- R will be taking for granted the gift of life
- R believes that this would be presumptuous of her

21

- Conversing with her mother and seeing the intense distress on her face when she realised that she could have lost R made an impact on R
- R's mother made R aware of the impact of her behaviour on both herself and R's children
- This awareness reduced R's desire to cut
- R is motivated to get better and she realises that that is impossible if she dies
- R has experienced a shift in thinking
- R wonders if her experience is due to biochemical imbalances

- The medicine has started to make R feel slightly better
- R still has a desire to hurt herself but not to die

22

- R's mother arrived at the hospital but not during visiting hours
- R's mother was determined to see her child
- R's mother came and held R
- R's mother wasn't angry with R but rather very distressed and tearful
- R's mother emphasised how important R is and how devastated she would be if R died
- R's mother feared that she would never see R grow up to fulfil her dreams
- R would cause her mother absolute heartache if she died
- R was shocked at her reaction

23

- R had expected that she'd be a bit unhappy
- R didn't anticipate her mother's intense grief despite even in the face of R not having succeeded
- R's mother's reaction was a shock for R
- R was filled with guilt when she saw her mother
- In a distorted way of thinking R imagined that her mother would rationalise her suicide and believe her daughter to be better off dead
- R's mother's devastation over the attempt made R realise the impact a successful suicide would have on her mother
- R was amazed at the reaction, and at the intense emotion and sadness at almost having lost her baby as opposed to the expected anger and judgement
- R began considering how she might feel she had lost one of her children
- R could identify with this and realised that she would be devastated
- R would be devastated if she lost her child in an accident, but didn't think she would ever come to terms with it if her child committed suicide
- This made R realise how selfish suicide actually is

24

- R attributes her calmness to the medication
- R used to suffer from panic attacks
- Often when R's anxiety increased she'd cut herself
- The desire to cut would be precipitated by a panic attack
- Following the panic attack R would feel unable to go through the experience again
- R is sleeping far better now that the panic attacks are being controlled and R's problem is in the process of being isolated
- R is feeling more rested
- R believes sleep deprivation to be one of the worst things for depression
- R attributes her improved state to her improved ability to sleep
- R also attributes her improved state to the lessening in panic attacks
- Although R feels depressed she doesn't experience the anxiety and helpless feeling that previously led to cutting
- R has lost that
- R thinks the calmness enabled her to go to the sister and verbalise her feelings

- R took her medication earlier on in the day and it had included an anxiolytic which she believes may have helped her to remain calm
- R perceives the medication as balancing her
- R feels more rational in her thinking and emotions
- R realises she has to break the cycle
- R describes the cycle as cutting herself, feeling guilty about cutting herself, the guilt growing which then leads to increased feelings of depression
- The increased feelings of depression result in feelings of desperation which lead to more cutting which results in further guilt
- R just knew the other day that she actually had to break that cycle
- R chose to do it if not for herself then for her mother and her children
- R has been told to do it for herself but this doesn't resonate for her
- R chooses to shift her goals onto another because she does not feel good about herself at present
- Presently R has little motivation to live for herself so she is choosing to live for her mother whom she says needs her

25

- R describes the panic as gradually relaxing rather than disappearing immediately
- R becomes very tense when experiencing the panicky feeling and panic attacks which follow
- When R entered the nurse's office she was shaking and breathing fast
- R felt the initial stages of a panic attack building
- R felt her body generally relaxing and her breathing calming down
- R did not have a panic attack
- The more R spoke the calmer her body became
- R is very aware of how her body is feeling although she believes one's mind controls one's body
- Thoughts are put into R's mind when her body becomes agitated
- R begins to feel trapped and helpless
- The only solution seems to be to cut herself
- The relaxation was gradual and lengthy but as R verbalised her feelings so she felt better
- As the shaking decreased so the thoughts disappeared until R eventually was relaxed and felt all right
- R didn't feel happy but was contained enough to walk away and not cut herself

26

- The sister's definite affirmation of R was something R holds onto
- Lay people are petrified when someone verbalises suicidal feelings
- The sister's calm and positive response made it easier for R to verbalise her feelings
- R likens her experience to the first time one dives into a swimming pool and one's fear of the water being cold, the water becomes progressively warmer with each successive dive
- R likens her experience to the first time one drives a car on a public road by oneself, everytime it gets easier until it becomes second nature

- The first time R had to go to somebody and tell them how she was feeling she felt very anxious
- R believes that if she experienced the feeling again she could approach another person quite easily even if it wasn't the same person
- With that ability to verbalise her emotions becoming easier and the ability to approach another being less stressful, R is hoping that the desire to hurt herself will dissipate
- R has doubts as to whether it will work that way
- R does not want to return home with the desire to cut
- R admits that a large portion of the reason that she hasn't cut herself is due to there being no blade available to her
- The last time R did cut there were two razors lying in the bathroom
- R knows an easy way to break the razor and remove the blades
- R doesn't try to cut herself with the double blade in the plastic razor because it doesn't work but she's worked out an easy way to snap it and get the two blades out
- The other day there was no blade available to R and she knew that no one would give her one so she didn't have much choice but to talk about it

27

- If there had been a razor available it would have been a three way choice of either cutting herself and being transferred or going to talk to someone
- R would have had to choose between how strongly she felt about staying in the ward and how much she wanted to cut herself
- R probably would have cut her legs where no one could have seen it
- R knows her wrists are too obvious and that if she bleeds heavily and has to have stitches then she has to disclose to the ward
- R has adopted a way of thinking that she'll cut her legs with little cuts just enough so that it bleeds but doesn't need stitches, and when she puts her pants on no one will know
- R can't get her hands on a blade so it's not an option for her presently

28

- Its very important for R that people understand, especially people close to her, that the cutting is a disease rather than attention seeking behaviour
- R's boyfriend has become quite intolerant with her on numerous occasions
- R finds it strange that medical aids recognise depression but that society doesn't
- Its been very important for R that people around her that are close to her understand that she doesn't have ultimate control of the condition at the moment
- R believes she will eventually have control
- Presently R feels like a puppet and describes it as a horrible feeling
- Everyone wants R to get better but there is nobody that wants R to get better more than herself
- People hate seeing R this way, but R thinks that there's nobody that hates it more than her
- R desires to feel normal again and to just use a razor to shave her legs
- R expects compassion from people because its a horrible feeling that she is experiencing

- R feels as though she has no control over it
- The little control that R had she chose to exercise by verbalising her emotions and feels good about that

29

- R does not consider herself to be a stupid person, but rather an intelligent person
- R knows the consequence of taking a sharp object and putting it on her skin, hurt and damage
- R cuts a tomato very carefully
- R has always protected her body so this behaviour is unfamiliar for her
- R has never felt this way before
- People around R don't seem to understand her and ask her why she didn't come and talk to them
- R didn't want to talk to them
- R actually wanted to cut herself
- R did not have an urge to verbalise her feelings and nor did she fear rejection
- R wanted to cut herself and found it to be much easier to cut herself than to verbalise her feelings to another person
- R wants to be found
- R wants the suicide attempt to be successful and feels as though she does not have any control over this
- R believes that only her mother understands the feelings because she's been treated for depression previously
- R's mother has never cut herself but she has taken overdoses
- R believes that patients who don't have the urge to cut don't understand
- The patients become angry with R because of the disturbance that she creates in the ward
- R was placed in Ward 7 following the first time she cut herself with the intent to die
- Nobody knew R, it was her first night there
- R walked into the room where other patients were sitting and overheard one of the patients swearing about her and expressing anger towards her behaviour
- R confronted him and he regretted his outburst, they became quite friendly after that
- R believes that the other patients perceived her as wanting to be the centre of the nurses attention
- R states that that is not her intention
- R concedes that maybe that's some peoples' intention but not hers
- R describes feeling like she is entering into a trance
- R feels like there is another person doing the cutting
- R feels calm and relaxed when cutting
- R doesn't feel and nervous when cutting
- This scares R because she equates such an experience with being possessed

30

- R gets even more attention when she doesn't cut than when she does
- When R doesn't cut people are relieved and are eager to converse with her, people want to spend time with her

- When R does cut people become annoyed with her and want to medicate her and put her to bed as soon as possible
- To R it appears obvious that logically such behaviour is a desire for attention because R has needs and numerous problems internally and needs attention
- Its not a conscious act of wanting to be the centre of attention or wanting sympathy
- R describes it rather as a way of making herself feel better and as a cry for help because she does not know how else to request the help
- The cutting doesn't make her feel better

31

- For the first time R received more attention when she didn't cut
- R received the attention of someone who was concerned, empathic and nice to her
- R's experiences when she has cut herself have not been pleasant
- People have responded with annoyance, abruptness and roughness
- The attention that R received when she chose not to cut herself was comforting
- The inherent comfort would make her choose that option again
- R wouldn't describe it as pleasant but it was nicer than the pain
- R refutes anyone who thinks that people cut just for the attention
- R has inadvertently received attention when she has cut and its not been pleasant
- When R cut her wrists so badly she had to wait for a long time with cut wrists while transport was organised for her
- The hospital refused to hire an ambulance because R is a state patient
- R describes the person who transported her as driving like a maniac and being extremely rude to her
- On arriving at the Jhb Gen, the staff weren't prepared to wait for the plastic surgeon so they stitched R themselves
- R has subsequently been to'd that a plastic surgeon should have been called in to prevent the ugly scarring that she now has
- R describes it as an unpleasant experience
- People are right, to want that kind of attention seeking one must be crazy
- Talking to the sister was also not pleasant
- R thinks that she's conquered the desire
- R doesn't think she's conquered the desire, she still thinks she may have the urge
- R has conquered the acting out of the urge
- R thinks she'll be able to go to whoever is on duty and request help

32

- R has set herself a step by step plan of action of what she will do if she has the urge to cut
- R's first step will be to get as far away from the bathroom as she can
- R's second step will be to find somebody
- The third step is to verbalise that she feels like cutting and to ask for help
- This is R's plan of action
- R will follow this plan of action every time until it becomes a routine for her
- R needs routine in her life
- Having a plan of action has given R a feeling of security

33

- Men in battle have a certain routine which makes up their plan of action
- R needs the security in knowing that when she feels like cutting she doesn't have to think too much, rather she has a structured plan to follow
- Thinking only serves to create more inner chaos for R
- Having a structured three step plan to follow makes R feel more secure
- R likens her plan to CPR, if one knows it backwards then one can do it by route when a crisis arises
- If one doesn't know CPR backwards then chaos ensues
- R's likens her plan of action to her own CPR, her own ABC
- R can anticipate what she will do and this is helpful for her
- R will leave the bathroom and go to sister and confess her feelings
- R repeats it to herself three times a day
- R feels good

34

- R has also requested that everybody keep their razors locked away
- When R wants to shave her legs, she won't be given a razor
- If R wants to shave her legs her mother is required to come and watch her
- R worries that this may sound ridiculous but states that it is necessary

35

- R has put things in perspective that she was unaware of prior to the interview
- R has clarified numerous things in her mind which she was aware of but had never verbalised

36

- R has reaffirmed that she can inhibit her cutting behaviour
- R has received affirmation from the sisters on this
- R's experience of verbalising her feelings with the sister has been a good one
- R has reiterated her mother's devastation at the attempted suicide
- R has confirmed the good aspects of her life which involve her children, her mother and getting a car again
- R has realised that there are those people who will understand her
- Verbalising has served to confirmed things for R
- The interview was a good experience for R

37

- R found the prompts difficult to answer
- R found the prompts to be thought provoking
- R believes it would be pointless if she didn't think through what she had to say

PROTOCOL TWO

INTERVIEW WITH RESPONDENT H

Tell me about the times that you wanted to cut but chose not to. You could think back to a specific incident to help you in answering the question. In your description comment on as many aspects of the experience as you can. The purpose is to obtain as full a description as possible.

H: Okay, I have to think about this carefully before I answer this. The times, I think that there have been a lot of things involved in my decision not to cut, for one thing, I must admit that the medication did calm me down so, it did reduce that state of anxiety where I just had to do something drastic. I've found I've started practising a new technique which may also not be all that wonderful but it certainly helps as far as cutting myself, I would, when I thought about how I felt when I cut myself it was like an instant tranquilliser, it calmed me down as soon as I cut, so what I'd try and do is at a point where I felt that I'd had to do something drastic I would try and imagine giving myself an anaesthetic and I would sit there and think of this anaesthetic and picture giving myself an injection and then just think about this feeling of calmness and you know like just before surgery you've had your pre-med and you are just feeling so relaxed, so I'd try and think of that feeling and then eventually I'd start relaxing and it would start numbing those feelings of absolute self-destruction, and that's what I do and then eventually I'd be calm and, look, not happy, I wouldn't be jumping around, but I would still be upset about whatever it was but I knew I'd passed that point of wanting to cut.

J: Can you tell me what gave you the idea to start using this technique?

H: I tried to think, you know it was very hard trying to explain to people when they said but why do you cut, and it got really hard to try and explain to them so I ended up spending time thinking of how I can try and explain to them how it feels, what builds you up to do it and how it feels and while I was thinking of all these things I was thinking how does it actually make me feel, and it was just that thought that it was like taking a tranquilliser except it worked so quickly and I thought well, I don't just have access to tranquillisers so that counts that out I can't just do that, there must be some other thing I can do to get that same feeling, and I tried to remember the times in my life where I felt so calm and relaxed and I thought, ja when I've had pre-meds just before an operation, something like that and that's the feeling, I just feel so drowsy and relaxed and well its the same kind of feeling it works almost as fast, literally as fast, so obviously I'm not going to rush out and try and obtain anaesthetics and all that stuff so I thought well let me try and do it mentally, because this cutting is a mental thing, its not really the cut that is in my blood stream and suddenly calms me down, its a mental thing, so surely if I could do that mentally, if I could try and picture mentally jut this anaesthetic.

J: Do you find that there are times when it works better and times when it doesn't work as well and what the difference would be?

H: Um, the times when I find it harder to put into practice is when things have been building up, say I've been having a problem at home about certain things and it gets worse and worse and ends up in a fight and I realise that nomatter what I say they are not going to understand what I'm feeling and then its almost overwhelming that feeling

just to go and cut, just to go and do it, I'm in such a state so its when something has really been building up and up over a long time and it just snaps.

J: Pressure cooker?

H: Ja, those times are hard to resist.

J: And then do you ultimately end up cutting at those times?

H: Sometimes, sometimes, if I ever am going to do it that would be when I do it but really I can honestly say over the last few years its been maybe once in a year.

J: How long have you been using this technique for?

H: Hm, about three or four years.

J: Can you tell me a little bit more about the feeling straight after you've given yourself that message, I know that you said you feel very relaxed and like you do just after you've had pre-med, can you tell me a bit more about the feelings in detail?

H: Um, the one thing is that I have to put myself in a situation, like I can't actually sit with the people that I may be cross with and put it into practice, I have to just get up and leave and go somewhere on my own and where its quiet and then for a while I'm obviously wrestling with this thing and thinking you know just to cut is really a quick fix and then I think no, stop, do the other thing and I have to really cut myself off, this part might not be good, I don't know but I actually think of those people who have upset me and they are the ones I first have to deaden in my mind. When I say deaden I don't mean sit there and picture them dead, not in that way but I have to just think they are the ones who are mad or they are the ones who are being unreasonable or something and then just get them out of my mind, why should they be doing this to you and so I sort of push them out of the way in my mind and then concentrate on that.

J: And what does it feel like while you're doing that, putting it into practice, is there anything in particular that you can identify?

H: Its as scary as when you're going to have an operation, you are scared because you think is this going to work? What if I just can't do this and my heart will be racing and I'll be uptight and afraid and that.

J: Tell me about the fear, just the fear that it might not work, anything else as well?

H: Um, I think its just really that I'm afraid that I might not be able to hold onto it, that I might get it right and something might happen and I won't be able to.

J: So it feels very fragile.

H: Ja, it does.

J: Are there any other feelings that you feel?

H: The only thing is that I know I have to do it and I just think I have to do this because if i don't I am going to go crazy, I'll go and look for a blade or a piece of glass or something and just, ja do something drastic, (unclear) try and grab hold of all this anger and these things that are flying around me to try and grab hold of them all.

J: When you say other things that are flying around what would those things be?

H: Um, I guess things like wondering if its worth doing anything, I start to think well, this is at times when I am really terribly upset then I do start thinking that it would just be easier to, not bother with glass or thoughts of anaesthetics and maybe just to end it for once and for all.

J: So there is almost a crossover from just cutting to actually committing suicide?

H: Ja.

J: Lets go back to when you do put the anaesthetic imagery into place and tell me a bit more about how it feels just after you've done that.

H: Um, I always do feel very tired because for a while I still have to find something to do with the horrible feelings, as I say I feel calm and I start feeling less upset about what's just happened but what I've got to keep doing is pulling my mind back because every now and again I'll start thinking, ja but you know what really hurt me was when they said this this and that and then I have to think no, no, no, don't let them get out of hand and I almost like have to think, well I've got to anaesthetise each little area, after that I just feel like really tired, and really, when I say detached, I don't mean detached from reality around me, I feel detached from what has upset me.

J: It's like the emotions have been cut off?

H: Ja, that's the main thing, ja just feeling tired, but then you know I'll start playing with my dog, or take him for a walk or something and as I said cut off the things, the areas that have upset me.

J: Its interesting that you mentioned your dog - do you find that your dog helps you to try and stop cutting?

H: Very, very, very much so. I think he was the one, also one of the main factors that made me feel like I had to, apart from this difficulty of trying to explain to people why and what for and all the rest, I mean I did have to start thinking of ways I could try and explain to them why but at the same time, having my dog, and I thought I am very, I love animals, I'm just crazy about animals, and I'm very close to this dog and when I'm upset he gets quite distressed and comes and sits right next to me and all the rest of it and I think I can't do this to him even, because he loves me and he's here to support me and I can't do this to him and that's also what made me think I do have to, apart from finding a way to explain it to people, I have to find some other way of being able to put into practice a way of stopping it and ja, my dog helps.

J: And I noticed that you mentioned quite a few times needing to find a way of explaining to people what is happening for you, why is that?

H: Well, you know in summer if I have short sleeves on, I've got scars on the inside of my arm and as much as I try and not let them see, there is going to be a time when I stretch out to get something to drink and people will see it and say ooh what happened to you here, and obviously when it is people I really don't know that well I end up having to lie and make up some story which I hate doing because I don't always remember the story, when its with people I know I sort of feel I need to explain to them and I find people get confused and bewildered when I started to tell them and they couldn't believe what I did behind the scenes, um, also even when I've seen doctors and they've noticed it and asked me, you know, what happened here and the first time I lied, I made up some excuse that something had happened and I'd gotten these cuts and he looked at me and said this down here is different stitching to that one so and I can see that this one was done at a different time and I ended up having to just tell him what happened and I was embarrassed, I was embarrassed.

J: You've mentioned quite a few things, the medication, the anaesthetic imagery, your dog, is there anything else that you find helps you and that you draw on not to cut?

H: Not really other people, um, I do know one thing they cannot understand it and they don't accept it and they think its, but when I do it and they find out they almost shun me in a way, they get angry, they go around saying, she's not stupid, what kind of person does that and so I start thinking well how'm I going to hide it from them and then in summer the pool and everybody is swimming and I can't go out with a long sleeved thing on and if they see it how are they going to treat me, so I guess in a way, other people, it does worry me. I also do know that if I do get to a point where I do

cut I can't just make a little scratch, I have to get the whole anger out of me and its going to be bad and I probably will need stitches and then I think well, I've got to go and find some place to get somebody to put stitches in me.

J: So it becomes quite an effort.

H: Ja, it does, eventually I just say, oh, well, with all those factors coming into play, I just, its a lot easier to practice the anaesthetic story.

J: When you do the anaesthetic story, are there any particular sounds or noises or sensations that you can think of?

H: The one thing I do try and do is put myself in a real life situation as if I am lying in the theatre and I do get that hospital smell and mostly I've come across kind doctors before an operation and I try and think of them, their faces and everybody there and as I say the hospital smell.

J: Tell me bit more about the kind doctors, do they say anything?

H: Ja, mostly the experience I've had is when they come chat to you or they joke with you a bit and I, its very hard to put me under anaesthetic I end up having to have huge quantities because the quantity doesn't work and I just lie there and then they'll end up teasing me or just joking with me so I just try and think of all these people being kind and saying don't worry its going to be okay and the nurses saying you're going to be fine and all the rest of it.

J: Any other sensations?

H: Just a warm feeling, I just start to feel warm, warm inside.

J: (Unclear).

H: When I get really uptight I start to feel cold and I get shaky and that sort of thing, and its like when I have had an anaesthetic and I start getting that warm sensation inside and relax and I just sort of imagine this whole warm feeling just taking over completely and I usually imagine the whole thing out, for instance when I'm groggy, where its sore, where I've been stitched, but I still also during the process imagine them cutting out the things that's, which is what I do I think about say whatever has just happened say its been a row with my dad or something to do with his drinking or my brother's nasty comments or whatever, I picture that as being the sore that the doctors actually cut out and ja its still a bit sore but the stitches will come out and I'll be fine.

J: Do you find that you ever draw on experiences in therapy or the therapist's face in an attempt to stop the cutting?

H: I must be honest, its not the therapist I'm seeing now only because I'm not fully comfortable with him as yet, its not his fault but prior to him I had two very, very good therapists, um the one I had for quite few years and she left and that was quite devastating, I was just lucky that the therapist who took over from her, he was also fantastic and was very much like her and he was fantastic so, and I had him for a few years, so when he left I was devastated, so I'm not quite comfortable with my new therapist because he is very different to them but I do picture those two previous therapists' faces as being part of the whole thing. Sometimes I also, if I'm really struggling to get it right, I picture my dog sitting outside the door waiting for me like he waits for me if I go out, he'll just lie at the gate, he won't move, or at the front door, he won't move until I'm back and then if I'm struggling to get myself calm and I'm starting to really go with the idea of cutting, then I imagine myself back in this theatre situation and I imagine him lying at the door waiting and this usually makes me feel okay, I've got to do this to stop.

J: You say it has quite a calming effect on you, can you tell me a little bit more about that calming effect?

H: Um, I think, um, its, the calmness is, you know like if you've got toothache, it really it hurts and the hurts I'm experiencing from the people who've hurt me is there, but if you know when you have that tooth pulled and the abscess drained its still tender there but you feel better, that terrible toothache is gone, its the same kind of feeling I imagine between, as soon as I've succeeded in getting rid of that offensive part I just naturally start relaxing, if the pain is no longer there, its still sore but its going and I just feel this calmness at last, its out of there, its, that's about all.

J: Like the toxin has been removed?

H: Ja, and I do feel calm, I do feel tired afterwards, I must say that's one thing, I don't exactly feel full of energy and that, I'm always a bit tired but then I go and have a cup of tea.

J: What do you think the tiredness is about?

H: I think all the emotional stress and strain, I think its the whatever has upset me, its that build-up of emotion, and I always feel tired after that and then I do feel a bit tired after I've put this whole thing into practice because I've had to really concentrate and picture the whole thing bit by bit, but its not a horrible tiredness, its a relaxing tiredness, its like if you've really worked hard in the garden and you come inside and you are bushed, but in a nice way.

J: I was thinking when you visualise yourself in the operating theatre its almost like you surround yourself with nice images, of kind people, gentle people, people who are helpful and soothing, and like your dog, is there anything else that you incorporate into that scene that's particularly soothing?

H: Um, no, I think its mostly just the knowledge that I'm going to feel better after the process and also that there are these kind people around me, they make me feel safe, now I know in reality I can die during an operation but obviously I'm not going to try and put that into it either.

J: Tell me more about the safety.

H: Um, I think its the people that I imagine that are there with me, um, I don't normally just make up fictitious people I try and think back in my life to people who have always sort of been there for me or people I've met who've been really kind people and people I've really liked and trusted, I bring them into that situation and picture them all in there as well, everybody in there, I have to picture them as being the nice, kind people. Because I know that if I started bringing horrible people its not going to work so I picture these people and they are all there and I just feel safe, I just know nothing's going to happen. Nothing bad will happen, and they'll be there when I wake up and my dog and they are just kind to me and somehow that kindness makes you feel safe.

J: Is there anything else that you wanted to add, anything else that you thought of while we were talking?

H: Um, the one thing that I have finally noticed that this has really taken years and years and years to finally come out into the open in my mind and that is the people who have upset me and the people who have contributed to my life being, um, distressing and depressing and whatever else, um, its always been family strangely enough, its not strangers, its not outsiders, its been my immediate family who've caused all these big unhappinesses and the first thing they would run me down and say terrible things to me and even worse things about coming to Tara and being a dropout and a washout and all the rest of it and I used to get terribly hurt, I still do but what has finally come out

after all these years, my sister is an alcoholic, my brother's second marriage is a nightmare, my dad is an alcoholic, they are the people who caused the most trouble in my life and I look at them and I think so I couldn't have been that bad because I'm not an alcoholic, I haven't gone through two marriages that have been disastrous, um, and instead, before I just used to think it is all me, they are right, I'm a terrible person and cut myself to ribbons, I deserve this I am so, but now I've been able to see, hang on a second here, they are the ones with the biggest problem, their lives are in a shambles, but they wouldn't go for help, see, none of them would go for help, its, and so its made me feel a bit better about myself, made me feel a little bit more powerful and I've realised, hey, you've got the problem not me.

J: Its quite a realisation to come to and I'm just wondering what impact that realisation might have had on your experience of not cutting?

H: It has played a part, but um, there are obviously still other times when I'm in the middle of a row and I get, I'm frustrated and I would consider just cutting, just to get out of this frustration and this anger, so its not as if that realisation that in fact they've got the problems more than what I have, that has helped a lot.

J: Can you define in what way?

H: Because I don't feel that I have to punish myself, before whatever they said to me I believed and I thought I must go now and punish myself, I'm useless, I'm worthless, I'm rubbish, I need to be punished, I shouldn't be here on this earth, but it hasn't been the only thing, as I say I still get in a fight and out of sheer frustration I want to go and cut, so its been those two things, they've both played a part.

J: Okay. I think that was pretty much everything, unless there was something else that you wanted to add.

H: No, I don't think so, just to make it clear that just because they're alcoholics and have relationship problems, that wasn't what cured me of cutting, not at all, it just did have some influence at certain times but there are still, even now, after I realised that, that there are still many times that I wanted to cut because I would be losing control.

J: Its interesting that you use the phrase 'cured you of cutting', is there anything that you'd say has actually cured you of cutting?

H: I shouldn't have said cured me of cutting, it's still something that I have to fight although as the years go on its less and less so I can't remember when last I actually had to fight it. I feel it is going away, it really is going away, I haven't cut in years.

J: Would you say its going away because you've now got a technique?

H: Ja, and the technique has worked so many times, occasionally it hasn't but I know how many times it has worked and the times it hasn't worked I can see what went wrong, I gave way, but it does work and so I still feel that I do have that option which for me is an option, because people have said go and write it down, write your feelings down, play the piano, that doesn't work because I would go and play the piano and make mistakes and feel even worse so none of that works for me, never, maybe for some people but not for me. I'd probably end up breaking the piano, so this is the one that's not destructive.

J: How are you feeling right now?

H: No, I feel fine, I do feel fine.

J: How did you find the whole interview generally, was there anything particularly difficult for you?

H: Well, what would worry me is that I used the word cured, I don't know if cured is the right word, maybe I'm heading to a stage where I will be cured of my self-

mutilation forever but maybe at the moment I should rather think of someone like the person who is a recovering alcoholic, you know, that sort of thing.

J: (Unclear).

H: I think it would because I can't be certain that maybe at some stage there could be a huge family blow-up and then I would feel like how could I have said I was cured.

J: It sounds like having said you were cured has made quite an impact on you and I'm wondering if you can tell me a bit more about that.

H: I think just because I feel we all have our little downfalls somewhere along the road, we all have our moments where we, maybe when our resistance is low and at a particularly low ebb in our lives and maybe something else will happen that will just be the last straw and if at that moment I couldn't control myself I'd be very disappointed thinking that I had said I was cured but look what I've gone and done. I feel I must allow myself to accept that there could be times where I might, as I said at a particularly low ebb, I could make a mistake, I could slip up, but I know I wouldn't slip right back into that whole cycle again, that I do know, maybe I could say I'm cured of that, it won't be a revival of the whole cycle it would be a one off mistake in my mind that is how I might see it. In fact that is another thing, when I ever have slipped up its been very superficial, it has not been like before where I've actually had to really do damage to finally, now its a little scratch, I can put a bit of Germoline and vitamin E oil on and its disappeared.

J: So it sounds like the technique has impacted on how deep you go?

H: It has, it has, because even when I do now scratch sometimes, I'll stop right in the middle of it and think no (unclear).

J: Okay, well this has been really, really helpful for me, I hope its been okay for you.

H: Yes, it has, absolutely and I can say as well, although it is time to stop now, that the time that I actually sit there concentrating on this whole thing, that helps too because I have now taken my mind completely away, I'm now I'm thinking of something else and not thinking about what those people have said or what happened, I'm now thinking of something else.

J: It distracts you?

H: Yes, it distracts me completely so that also pushes the thoughts further away. Okay.

PROTOCOL TWO

NATURAL MEANING UNITS (Respondent H)

1

- I have to think about this carefully before I answer this
- there have been a lot of things involved in my decision not to cut
- the medication did calm me down
- it did reduce that state of anxiety where I just had to do something drastic
- I've started practising a new technique
- which may also not be all that wonderful
- it certainly helps as far as cutting myself
- when I thought about how I felt when I cut myself it was like an instant tranquilliser
- it calmed me down as soon as I cut
- at a point where I felt that I'd had to do something drastic I would try and imagine giving myself an anaesthetic
- and picture giving myself an injection
- just think about this feeling of calmness
- like just before surgery
- you've had your pre-med and you are just feeling so relaxed
- I'd try and think of that feeling
- eventually I'd start relaxing
- it would start numbing those feelings of absolute self-destruction
- eventually I'd be calm
- not happy
- I wouldn't be jumping around
- I would still be upset about whatever it was
- I knew I'd passed that point of wanting to cut

2

- it was very hard trying to explain to people when they said but why do you cut
- I ended up thinking of how I can try and explain to them how it feels
- what builds you up to do it
- how it feels
- I was thinking how does it actually make me feel
- it was like taking a tranquilliser
- except it worked so quickly
- I don't just have access to tranquillisers so that counts that out
- there must be some other thing I can do to get that same feeling
- I tried to remember the times in my life where I felt so calm and relaxed
- when I've had pre-meds
- just before an operation
- that's the feeling, I just feel so drowsy and relaxed
- it's the same kind of feeling
- it works almost as fast, literally as fast
- I'm not going to rush out and try and obtain anaesthetics and all that stuff
- I thought well let me try and do it mentally

- cutting is a mental thing
- its not really the cut that is in my blood stream and suddenly calms me down
- if I could try and picture mentally jut this anaesthetic

3

- the times when I find it harder to put into practice is when things have been building up
- I've been having a problem at home about certain things
- it gets worse and worse and ends up in a fight
- I realise that nomatter what I say they are not going to understand what I'm feeling
 - its almost overwhelming that feeling just to go and cut, just to go and do it
- I'm in such a state
- its when something has really been building up and up over a long time
- it just snaps

4

- those times are hard to resist

5

- if I ever am going to cut that would be when I do it
- over the last few years its been maybe once in a year

6

- H has been using this technique for about three or four years.

7

- I have to put myself in a situation
- I can't actually sit with the people that I may be cross with and put it into practice
- I have to just get up and leave
- go somewhere on my own
- where its quiet
- for a while I'm obviously wrestling with this thing
- thinking you know just to cut is really a quick fix
- then I think no, stop, do the other thing
- I have to really cut myself off
- this part might not be good
- I actually think of those people who have upset me
- they are the ones I first have to deaden in my mind
- I don't mean sit there and picture them dead
- I have to just think they are the ones who are mad
- they are the ones who are being unreasonable
- then just get them out of my mind
- why should they be doing this to you
- I push them out of the way in my mind

8

- its as scary as when you're going to have an operation

- you are scared because you think is this going to work
- what if I just can't do this
- my heart will be racing
- I'll be uptight and afraid

9

- I'm afraid that I might not be able to hold onto it
- I might get it right and something might happen, and I won't be able to

10

- I know I have to do it
- I have to do this because if I don't I am going to go crazy
- I'll go and look for a blade or a piece of glass
- and do something drastic
- try and grab hold of all this anger
- and these things that are flying around me
- to try and grab hold of them all

11

- I wonder if its worth doing anything
- at times when I am really terribly upset I do start thinking that it would just be easier to, not bother with glass or thoughts of anaesthetics
- maybe just to end it for once and for all

12

- I always do feel very tired
- I still have to find something to do with the horrible feelings
- I feel calm and I start feeling less upset about what's just happened
- I've got to keep pulling my mind back
- every now and again I'll start thinking you know what really hurt me was when they said this this and that
- then I have to think no, no, no,
- don't let them get out of hand
- I've got to anaesthetise each little area
- after that I just feel really tired
- I feel detached from what has upset me

13

- that's the main thing, just feeling tired
- I'll start playing with my dog or take him for a walk
- cut off the things the areas that have upset me

14

- I think the dog was the one, also one of the main factors that made me feel like I had to
- apart from this difficulty of trying to explain to people
- I did have to start thinking of ways I could try and explain to them why
- I love animals

- I'm just crazy about animals
- I'm very close to this dog
- when I'm upset he gets quite distressed and comes and sits right next to me
- I can't do this to him
- he loves me and he's here to support me
- I have to find some other way of being able to put into practice a way of stopping it
- my dog helps

15

- in summer if I have short sleeves on, I've got scars on the inside of my arm
- as much as I try and not let them see, there is going to be a time when I stretch out to get something to drink
- people will see it and say ooh what happened to you here
- when it is people I really don't know that well I end up having to lie and make up some story
- I hate doing that because I don't always remember the story
- when it's with people I know I sort of feel I need to explain to them
- I find people get confused and bewildered when I started to tell them
- they couldn't believe what I did behind the scenes
- even when I've seen doctors and they've noticed it and asked me
- the first time I lied
- I made up some excuse that something had happened and I'd gotten these cuts
- he looked at me and said this down here is different stitching to that one so and I can see that this one was done at a different time
- I ended up having to just tell him what happened
- I was embarrassed, I was embarrassed.

16

- not really other people
- they cannot understand it and they don't accept it
- when I do it and they find out they almost shun me in a way, they get angry
- they go around saying, she's not stupid, what kind of person does that
- I start thinking well how'm I going to hide it from them
- in summer the pool and everybody is swimming and I can't go out with a long sleeved thing on
- if they see it how are they going to treat me
- other people, it does worry me
- if I do get to a point where I do cut I can't just make a little scratch
- I have to get the whole anger out of me
- it's going to be bad
- I probably will need stitches
- I've got to go and find some place to get somebody to put stitches in me

17

- with all those factors coming into play it's a lot easier to practice the anaesthetic story

18

- I do try to put myself in a real life situation
- as if I am lying in the theatre
- I do get that hospital smell
- mostly I've come across kind doctors before an operation and I try and think of them
- their faces
- everybody there

19

- the experience I've had is when they come chat to you or they joke with you
- its very hard to put me under anaesthetic
- I end up having to have huge quantities because the quantity doesn't work
- I just lie there and then they'll end up teasing me or just joking with me
- I just try and think of all these people being kind
- saying don't worry its going to be okay
- the nurses saying you're going to be fine

20

- a warm feeling, I just start to feel warm, warm inside

21

- When I get really uptight I start to feel cold
- I get shaky
- when I have had an anaesthetic and I start getting that warm sensation inside and relax
- I just sort of imagine this whole warm feeling just taking over completely
- I usually imagine the whole thing out
- when I'm groggy, where its sore, where I've been stitched
- I still also during the process imagine them cutting out the things
- say whatever has just happened, say its been a row with my dad or something to do with his drinking or my brother's nasty comments
- I picture that as being the sore that the doctors actually cut out
- its still a bit sore but the stitches will come out and I'll be fine.
- instead of me doing the cutting someone else is

22

- its not the face of the therapist that I'm seeing now only because I'm not fully comfortable with him as yet
- prior to him I had two very, very good therapists
- the one I had for quite few years and she left and that was quite devastating
- I was just lucky that the therapist who took over from her, he was also fantastic
- I had him for a few years, so when he left I was devastated
- he was very much like her
- I'm not quite comfortable with my new therapist because he is very different to them - I do picture those two previous therapists' faces as being part of the whole thing

- if I'm really struggling to get it right I picture my dog sitting outside the door waiting for me like he waits for me if I go out
- he'll just lie at the gate, he won't move, or at the front door
- he won't move until I'm back
- if I'm struggling to get myself calm
- I'm starting to really go with the idea of cutting
- I imagine myself back in this theatre situation and I imagine him lying at the door waiting
- this usually makes me feel okay
- I've got to do this to stop

23

- like if you've got toothache, it really it hurts
- the hurts I'm experiencing from the people who've hurt me is there
- when you have that tooth pulled and the abscess drained its still tender there
- but you feel better
- that terrible toothache is gone
- its the same kind of feeling
- as soon as I've succeeded in getting rid of that offensive part I just naturally start relaxing if the pain is no longer there
- its still sore but its going and I just feel this calmness
- at last its out of there

24

- I do feel calm
- I do feel tired afterwards
- I don't exactly feel full of energy
- I'm always a bit tired
- I go and have a cup of tea

25

- all the emotional stress and strain makes me tired
- whatever has upset me
- that build-up of emotion
- I do feel a bit tired after I've put this whole thing into practice because I've had to really concentrate and picture the whole thing bit by bit
- its not a horrible tiredness, its a relaxing tiredness
- like if you've really worked hard in the garden and you come inside and you are bushed
- but in a nice way

26

- I think its mostly just the knowledge that I'm going to feel better after the process also that there are these kind people around me
- they make me feel safe
- I know in reality I can die during an operation but obviously I'm not going to try and put that into it either

27

- I think its the people that I imagine that are there with me
- I don't normally just make up fictitious people
- I try and think back in my life to people who have always sort of been there for me people I've met who've been really kind people
- people I've really liked and trusted
- I bring them into that situation and picture them all in there as well
- everybody in there
- I have to picture them as being the nice, kind people
- if I started bringing horrible people its not going to work
- I picture these people and they are all there and I just feel safe
- I just know nothings going to happen. Nothing bad will happen
- they'll be there when I wake up
- and my dog
- they are just kind to me and somehow that kindness makes you feel safe

28

- this has really taken years and years and years to finally come out into the open in my mind
- the people who have upset me and the people who have contributed to my life being, um, distressing and depressing and whatever else
- its always been family strangely enough
- its not strangers, its not outsiders
- its been my immediate family who've caused all these big unhappinesses
- the first thing they would run me down and say terrible things to me
- even worse things about coming to Tara
- being a dropout and a washout
- I used to get terribly hurt, I still do
- what has finally come out after all these years, my sister is an alcoholic, my brother's second marriage is a nightmare, my dad is an alcoholic
- they are the people who caused the most trouble in my life
- I look at them and I think so I couldn't have been that bad
- I'm not an alcoholic, I haven't gone through two marriages that have been disastrous
- instead, before I just used to think it is all me
- they are right, I'm a terrible person and cut myself to ribbons
- I deserve this
- they are the ones with the biggest problem
- there lives are in a shambles
- but they wouldn't go for help
- its made me feel a bit better about myself
- made me feel a little bit more powerful
- and I've realised you've got the problem not me

29

- It has played a part
- there are obviously still other times when I'm in the middle of a row
- I'm frustrated and I would consider just cutting

- just to get out of this frustration and this anger
- that realisation that in fact they've got the problems more than what I have, that has helped a lot

30

- I don't feel that I have to punish myself
- before whatever they said to me I believed
- I thought I must go now and punish myself
- I'm useless, I'm worthless, I'm rubbish, I need to be punished
- I shouldn't be here on this earth
- it hasn't been the only thing
- I still get in a fight
- out of sheer frustration I want to go and cut
- its been those two things, they've both played a part

31

- just to make it clear that just because they're alcoholics and have relationship problems, that wasn't what cured me of cutting, not at all
- it just did have some influence at certain times
- but there are still many times that I wanted to cut because I would be losing control

32

- I shouldn't have said cured me of cutting
- it's still something that I have to fight
- as the years go on its less and less so
- I can't remember when last I actually had to fight it
- I feel it is going away, it really is going away, I haven't cut in years

33

- the technique has worked so many times
- occasionally it hasn't
- I know how many times it has worked and the times it hasn't worked I can see what went wrong
- I gave way
- but it does work and so I still feel that I do have that option
- people have said go and write it down, write your feelings down, play the piano
- that doesn't work
- I would go and play the piano and make mistakes and feel even worse
- none of that works for me, never
- maybe for some people but not for me
- I'd probably end up breaking the piano
- so this is the one that's not destructive

34

- what would worry me is that I used the word cured
- I don't know if cured is the right word
- maybe I'm heading to a stage where I will be cured of my self-mutilation forever

-maybe at the moment I should rather think of someone like the person who is a recovering alcoholic

35

- I can't be certain that maybe at some stage there could be a huge family blow-up then I would feel like how could I have said I was cured

36

- I feel we all have our little downfalls somewhere along the road
- we all have our moments where we, maybe when our resistance is low, a particularly low ebb in our lives
- maybe something else will happen that will just be the last straw
- if at that moment I couldn't control myself I'd be very disappointed
- thinking that I had said I was cured but look what I've gone and done
- I feel I must allow myself to accept that there could be times where I might, as I said at a particularly low ebb, I could make a mistake, I could slip up
- I know I wouldn't slip right back into that whole cycle again
- maybe I could say I'm cured of that, it won't be a revival of the whole cycle
- it would be a one off mistake in my mind
- when I ever have slipped up its been very superficial
- it has not been like before where I've actually had to really do damage
- now its a little scratch
- I can put a bit of Germoline and vitamin E oil on and its disappeared

37

- even when I do now scratch sometimes, I'll stop right in the middle of it and think no

38

- the time that I actually sit there concentrating on this whole thing, that helps too
- I have now taken my mind completely away
- I'm thinking of something else
- not thinking about what those people have said or what happened

39

- it distracts me completely
- that also pushes the thoughts further away

PROTOCOL TWO

RE-ARTICULATION OF NMU'S FROM A PSYCHOLOGICAL PERSPECTIVE (Respondent H)

1

- H has to consider the question carefully and understand it before she answered it
- There have been numerous aspects involved in her decision not to cut
- The medication has calmed her
- The medication reduces her state of anxiety which causes her to feel overwhelmed
- H has started practising a new technique
- H has some doubts about the technique
- It helps her to control the urge to cut
- Cutting has served as an instant tranquilliser for H
- Cutting calms her down
- When H has felt overwhelmed she visualises giving herself an anaesthetic
- H would visualise giving herself an injection
- H would try to focus on feeling calm
- H likens the feeling to that experienced just prior to surgery
- H compares the feeling to having pre-med and feeling very relaxed
- H tries to focus on and recall that feeling
- After some time H would begin to feel relaxed
- Feeling relaxed would serve to numb the need for absolute self-destruction
- After some time H would feel calm
- H would not be feeling happy nor active
- H would still be upset about whatever it was that had distressed her
- H would have passed the point of feeling overwhelmed and needing to cut

2

- H felt misunderstood by other people in explaining her need to cut
- H wanted to be able to convey to other people her feelings associated with cutting
- H wanted to be able to explain the precipitating factors involved
- H tried to understand how it made her feel
- H experienced it to be like taking a tranquilliser
- Cutting, however, worked more quickly for H than a tranquilliser
- H didn't have access to tranquillisers and so had to discard that option
- H was convinced that there must be another way of achieving the same feeling offered by tranquillisers
- H tried to remember the times in her life where she felt extremely calm and relaxed
- H began focusing on the times when she had received pre-med, just prior to an operation
- H recalled feeling drowsy and relaxed at that time
- H identified these as being the feelings that she was seeking; and the effect occurred almost instantaneously
- H did not believe buying anaesthetic medication to be the option
- H decided to try and re-create the feeling in her mind
- H rationalises that cutting impacts on the mind rather than on the bloodstream
- H recognises that it is the impact on the mind that calms her
- H believes that visualising the anaesthetic would work in a similar way to the cutting

3

- H finds this technique harder to implement when emotions have been building up
- When there are conflicts at home which escalate and result in a fight, H realises that despite what she says she will still be misunderstood emotionally
- H experiences feeling overwhelmed by the intense need to cut
- H becomes very distressed when conflicts have escalated over a long period of time
- H seeks a release at these times

4

- H is very tempted to cut at these times

5

- If H could specify a time when she was most driven to cut, it would be then
- Over the last few years H's need to cut has lessened to once in a year

6

- H has been practising this technique for about three or four years.

7

- H has to ensure that the circumstances are right
- H has to physically remove herself from the people who have made her angry
- H has to be alone in a tranquil place
- H does spend some time wrestling with her emotions and her need to cut
- At this point she views cutting as a quick fix
- H has to refrain from thinking about cutting and instead focus on her technique
- H tries to separate herself off emotionally from those people who have upset her
- She experiences doubts about doing this
- H visualises those people who have upset her and tries to deaden them in her mind
- H views these people as the bad or unreasonable ones
- H tries to dismiss them from her mind
- She wonders why they choose to distress her

8

- H feels as fearful about practising this technique as she does about having an actual operation
- Her fear is around whether the technique will work or not
- She has concerns that she may not be able to succeed
- Her heart beats fast and she feels tense and afraid

9

- H fears that she may be unable to hold onto her present state of mind
- H fears achieving the sense of calmness and then suddenly losing it

10

- H is convinced that she has to follow through with the technique
- H fears that if she doesn't she may become too overwhelmed with emotion
- H fears that she may look for a blade or a piece of glass
- H fears that she may lose control

- H tries to contain her anger and the numerous other emotions that she is feeling

11

- H starts doubting herself and the value of the technique when she becomes distraught
- H begins to contemplate suicide

12

- H always feels very tired following visualisation
- H still has a need to control the unpleasant feelings
- H feels calm and less overwhelmed
- H tries to control and contain her thoughts
- At times she begins ruminating about the recent conflict and her resulting hurt
- H then engages in thought stopping in an attempt to control her thoughts
- H tries to anaesthetise each little area
- This process leaves her feeling emotionally drained
- H feels detached from the conflict

13

- Tiredness is the main thing that H is aware of feeling
- H spends time playing with her dog
- H attempts to cut off the areas which have upset her

14

- Her dog is one of the main factors that H tries to refrain from self-mutilatory behaviour
- Another reason involves her difficulty in trying to explain her behaviour to people
- H had to start thinking of ways in which she could explain herself and her behaviour to others
- H is very fond of animals
- H feels emotionally connected to her dog
- When she is upset he becomes distressed and appears to have a need to comfort her
- H doesn't like distressing her dog
- She believes that he loves her and is here to support her
- For these two reasons H had to find an alternate way of dealing with her self-mutilation
- H finds her dog very helpful in this regard

15

- H has scars on the inside of her arm which are exposed in summer if she has short sleeves on
- Although H tries to hide the scars there are times when this is difficult
- People see the scars and become curious
- If H is not that well acquainted with the people she usually lies
- H hates lying because she doesn't always remember what she has said
- If H is well acquainted with the people she feels obligated to tell them the truth
- People respond with bewilderment and confusion
- Doctors have also noticed and enquired about the scars
- The first time H lied about how she had obtained the cuts

- The doctor noticed that the stitching was not uniform
- H felt obligated to tell the doctor the truth
- H was extremely embarrassed

16

- H does not make use of other people in refraining from self mutilation
- Other people are not understanding nor accepting of it
- They respond by shunning her and becoming angry
- They respond by belittling her
- H becomes preoccupied with hiding the scars from them
- H worries about summer when everybody is swimming, H can't go out with a long sleeved shirt on
- H worries about people's responses to her if they see the scars
- In that way other people do influence H's decision not to cut
- H realises that if she does need to cut she will need to do more than just a scratch
- H will have to exorcise all the anger out of herself
- S' anticipates that she will inflict a lot of damage
- H anticipates that she will probably need stitches
- She will have to seek medical attention for her wound

17

- It becomes simpler not to self mutilate

18

- H tries to put herself in a real life situation
- H visualises herself lying in the theatre
- H recalls the hospital smell
- H visualises the caring doctors she has come into contact with previously
- H visualises their faces
- H visualises people around her

19

- H recalls previous good experiences where the doctors have joked and chatted with her
- H needs large quantities of medical anaesthetic for it to have an effect
- The doctors joke with H about this
- H tries to visualise these people being empathic and caring
- H visualises the doctors and nurses reassuring her

20

- H begins to feel warm inside

21

- When H feels very angry she begins to feel cold inside and starts to shake
- When H has had an anaesthetic she starts to feel that warm sensation inside and relaxes
- H imagines this warm feeling engulfing her
- H imagines the operation in detail
- H imagines the grogginess and pain of the wound

- H imagines the sensation of the stitches
- H imagines the doctors cutting out areas of pain
- H associates the area being operated on with the recent argument with a family member
- Someone else is now doing the cutting instead of her
- H still experiences pain but believes that the stitches will be removed and that she will feel healed

22

- H does not visualise the face of her present therapist
- H is not fully comfortable with him at present
- Prior to him H had two consecutive therapists with whom she felt very comfortable with
- H felt devastated when the first one left after a few years
- H had a further good experience with the therapist that took over
- H felt devastated when he also left
- Both therapists were similar
- H experiences her present therapist as different to the previous two
- H feels uncomfortable with this difference
- H visualises the two previous therapists' faces when using her technique
- When H feels like she is struggling with the process, she visualises her dog
- The dog is visualised as waiting for her outside the operating theatre
- This is similar to how he waits for her by the gate when she goes out
- he'll just lie at the gate, he won't move, or at the front door
- The dog makes her feel valued and important
- When H visualises the dog waiting for her this calms her
- H also visualises her dog in an attempt to inhibit her self-mutilatory impulses when the urge becomes strong

23

- H attempts to explain the calmness by comparing her emotional pain to a dental procedure
- H compares the ache of a toothache to the hurt she experiences when there is conflict in the family
- H compares the feeling of tenderness following a dental procedure to her emotional feelings following the visualisation process
- The ache is reduced to a slight tenderness and this leaves her feeling calmer
- H attempts to rid herself of the offensive parts
- H relaxes spontaneously if the pain is no longer present
- H begins feeling calm when she realises that the intensity of the pain is reducing
- It is important for H that the pain is no longer a part of her

24

- H feels both calm and tired afterwards
- H has low energy levels following the visualisation process
- H attempts to counter the tiredness with a cup of tea

25

- H attributes the tiredness to emotional stress and strain
- H also attributes it to the recent argument which has distressed and angered her
- H also attributes it to the build-up of emotion
- H attributes it also to the concentration and attention to detail
- H experiences the tiredness as relaxing rather than horrible
- H compares the tiredness to that of working extremely hard in the garden
- H views the tiredness in a positive light

26

- H finds the knowledge that she will feel calmer after the process to be helpful
- H finds visualising the people around her to be helpful
- H associates the sympathetic people around her with safety
- H knows that in reality she can die during an operation
- H tries to put aside this awareness

27

- H tries to visualise people that she knows
- H tries to visualise supportive, sympathetic, trustworthy and likeable people
- H visualises the people with these attributes collectively
- If H visualised unpleasant people the process would not work for her
- H is certain that nothing bad or hurtful will happen
- H anticipates that these people will be available when she awakens
- H also anticipates that her dog will be present when she awakens
- H associates the kindness and empathy with safety

28

- It has taken H a long time to realise that the people who distress her and make her life painful are family members
- It is not strangers or outsiders who cause her immense sadness
- Family members belittle her and are nasty and denigrating
- H responds by feeling terribly hurt
- H realises that family members have flaws of their own
- Family members are held responsible for causing the most trouble in H's life
- This realisation allows H to stop feeling bad about herself
- H is aware of the difficulties that she does not have
- Previously H would accept all the blame
- This would result in H cutting herself severely
- H used to believe that she deserved it
- H believes now that the family members have the biggest problems
- H is aware that none of them would seek psychological intervention
- This realisation boosts H's self-esteem and makes her feel more empowered
- H perceives her family as very clearly having the problem

29

- This realisation has played a part in inhibiting H's self-mutilatory behaviour
- H stresses that if she is embroiled in an argument she may become frustrated and feel misunderstood
- This frustration could lead to H considering cutting herself

- Cutting would serve as an outlet for her frustration and anger

30

- H no longer has the urge to punish herself
- Prior to this H would take on the family members' projections
- She believed she was worthless and this would result in her punishing herself
- H stresses that this is not the sole reason for her inhibition of her self-mutilatory behaviour
- H still becomes involved in an argument and out of sheer frustration has a need to cut herself

31

- H needs to stress that she gives little credit to her family for the inhibition of her self-mutilatory behaviour
- The realisation of their flaws did have some influence, however
- There are still times at present when H feels the need to cut
- H associates this urge with feeling like she is losing control

32

- H states that she is not cured of cutting
- H still has to fight the urge to cut herself
- As the years have passed so the urge has lessened for H
- It has been a long time since H has had to fight the urge
- H feels like the urge to fight is receding over time

33

- H says the visualisation technique has worked more often than not
- H has been able to understand the times that it hasn't worked
- H feels that the technique offers her an option
- People have suggested other options but none of these offer H any relief
- H is adamant that these options don't work for her
- H thinks that the options may be helpful for others
- H anticipates that she may become more destructive if she followed these options
- H perceives her visualisation technique as non-destructive

34

- H regrets using the word 'cured'
- H believes that she may be heading to a point of being cured in the future
- At present she compares herself to a recovering alcoholic

35

- H worries that there may be a huge family altercation at some point
- H would feel humiliated at having said she was cured

36

- H predicts that there will be times when her emotional resistance is low
- H is concerned that something could happen that might be too overwhelming
- If H was unable to control herself at this time she would feel disappointment at having said she was cured

- H would be disappointed at her own sense of powerlessness
- H has a need to allow herself the space to accept that she could resort to self mutilation at a difficult time in her life
- She is aware that she would not be slipping all the way backwards
- H feels she might be cured of slipping all the way back
- H would view it as a one off mistake
- When H has resorted to cutting it has been very superficial
- It is not like the previous damage she would have inflicted
- Now it is a minor scratch which does not need medical intervention

37

- H is sometimes able to inhibit her behaviour in the middle of scratching by means of thought stopping

38

- H finds that concentrating on the visualisation process serves as a distraction
- H is no longer dwelling on what other people have said or done to her
- By means of the visualisation process H is able to focus on other thoughts

39

- H is able to push the hurtful thoughts away from her mind

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