

Dissociation, Traumatic Attachments, and Self-Harm: Eating Disorders and Self-Mutilation

Sharon K. Farber

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Abstract Self-harm, such as eating disorders and self-mutilation, represents dissociated compensatory attempts to serve self-regulatory functions. Self-harm develops when the child who has become attached to those who have inflicted pain and suffering maintains that attachment by inflicting pain on himself. Brain imaging studies have found that the communication pattern between parent and child shapes the way the child's attachment system adapts to experiences with the attachment figure, literally hardwiring the child's brain. The good news is that a safe and secure attachment is very good medicine and can rewire the brain. An attachment-based multi-phase approach to treatment is presented.

Keywords Self-harm · Attachment · Dissociation · Eating disorder · Anorexia · Bulimia · Self-mutilation · Pain · Self-regulation · Trauma

Introduction

People who live with self-harm (scratching, picking at, burning, or cutting the self, binge eating, purging, self-starvation, or even compulsive body piercing, and tattooing) usually cling to it ferociously, and they have little ability to think and reflect about it. Through research and clinical practice, I have come to understand that self-harm behaviors develop when the child develops a disorganized attachment to those who have inflicted pain and suffering on him and then maintains that attachment by inflicting pain on himself (Farber 1995, 2000).

Acts of self-harm are generated out of dissociative experiences. In every act of self-harm there are at least two participating, but dissociated, self-states. There is the dissociated part of the self-being abused and another dissociated part doing the abusing (Sachs 2004). Dissociation makes possible the extraordinary feat of being prey and predator, masochist and sadist, all at the same time. This "inner predator" is a dissociated (split off) identification with the aggressor that maintains the attachment to the abusive or neglectful, but still loved parent. The patient usually experiences this inner predator as alien, as "not me" (Bromberg 1998). "It's like there's a monster in me urging me to stuff myself and make myself throw up." Or there is an external, seductive voice urging, "Go on, sweetheart. Cut yourself. It will make you feel so much better."

Self-harm can best be comprehended when attachment theory is integrated with concepts from psychoanalysis, the neurosciences, evolutionary biology, cognitive psychology, the psychobiology of trauma, and chaos theory. The key premise of attachment theory is that there is a biologically based attachment system characteristic of each species that attaches the newborn to its caretaker in order to protect it from predators in the environment (Bowlby 1969) and to promote the development of self-regulatory functioning (Hofer 1995). No matter which object relations theory we use (e.g., Fairburn's, Klein's, Winnicott's, Mahler's, Stern's, the Blancs', or Kohut's), we are really talking about how human beings become attached to their caretakers and subsequently to others. Attachment theory helps us understand how human beings can become so attached to pain and suffering that they cannot imagine living without it. It helps us understand how the dissociative processes resulting from trauma become wired into the brain to give rise to self-harm. Neuroimaging studies have found, however, that

S. K. Farber (✉)
142 Edgars Lane, Hastings-on-Hudson, NY 10706, USA
e-mail: Sharon_farber@psychoanalysis.net

psychotherapy can help in rewiring the brain (Roffman et al. 2005; Schore 1997), giving us hope about treatment. Successful psychotherapy has been correlated, not with a specific theoretical orientation, but with the “fit” between patient and therapist (Kroll 1993). This suggests that what is essential to the patient’s relinquishment of the attachment to pain and suffering is the development of a safe and secure attachment to the therapist. In fact, research has found that a good therapeutic alliance, which can be understood as a secure attachment, is the best predictor of a good treatment outcome (Holmes 1996).

Bowlby (1969) found that a secure caregiving relationship with at least one adult is central to healthy development. Infant primates have biologically based needs for proximity to an attachment figure (e.g., the mother or primary caregiver) in order for the infant to feel safe and for the caregiver to protect the infant from predators. The repetitive cycles of affect arousal, attunement, and regulation between infant and caregiver eventually establishes the infant’s attachment bond with the caregiver, which, at the most basic evolutionary level, improves the infant’s chance of survival. The earliest feeding experience is a prototype for the regulation of mutual mother–infant psychophysiological responses. The infant’s cries, including those aroused by hunger, constitute an attachment behavior (Nelson 2005), summoning the mother and stimulating the release of oxytocin, the hormone of love and attachment, into her milk (Angier 1994). As the infant sucks, both his hunger and the mother’s engorged breasts are relieved. When the infant is bottle-fed by an attuned caregiver, it is his relief of hunger, pleasure in feeding and being handled in a loving manner, and the caregiver’s pleasure in the experience that regulate the dyad’s sense of well-being. Such are the beginnings of attachment.

Bowlby (1973) proposed that children develop internal working models, or internal templates of the early attachment relationship between the infant, the caregiver, and other significant others in the household. A secure working model helps the child to develop a basic sense of trust that allows him to tolerate separations, regulate affect, mature in a healthy way, and thrive in other future attachments as well. If attachment is insecure, the development of healthy behaviors (e.g., play, exploration, social interactions, self- and interactive-affect regulation, and sexuality) will be impaired. The infant’s earliest experiences of attunement and repair of misattunement mold his developing ability to regulate and care for himself and affect whether he feels deserving or unworthy of good care. Bowlby (1973) explored the possibility that insensitively attuned caregiving interactions from the primary caregivers could cause the infant to develop multiple incompatible internal representations of self and attachment figures instead of unitary or cohesive attachments. Although he did not use

the language of dissociation, Bowlby was suggesting that there was a relationship between attachment processes and dissociation (Howell 2005).

At the mental level, the attachment system establishes an interpersonal relationship that helps the infant’s immature brain use the mature functions of the parent’s brain to organize his own regulatory processes. Mutual face-to-face interactions such as gazing and touching are especially important in shaping the right orbital frontal cortex, centrally involved in attachment functions and in regulating bodily states such as eating, sleeping, heart rate, breathing, body temperature, and growth hormones (Farber 1995, 1997, 2000; Hofer 1995). When these interactions are disturbed, they become encoded as interactive representations and are later manifested as failures of affect regulation (Schore 1997). A review of the literature on traumatic attachment and its connection with self-harm will be given, followed by a clinical presentation illustrating these theories.

Traumatic Attachment

Dissociation refers to a discontinuity in mental functioning that underlies panic disorders, post-traumatic stress disorders, dissociative disorders, borderline, and narcissistic personality disorders (Bromberg 1998; Howell 2005; Siegel 1999). Trauma is the consequence of the nervous system’s response to events that are so unfathomable that they fragment the mind (Farber 2000), separating and compartmentalizing cognition from affect (psychological dissociation) and psyche from soma (somatic dissociation) (Nijenhuis 2004; Scaer 2005). Howell (2005) puts it another way, saying that trauma refers to events that could not be assimilated, and defines trauma simply as the events that cause dissociation. When the child dissociates and internalizes a dissociated identification with the aggressor (Siegel 1999), he becomes attached to the figure who is the source of trauma. This attachment is split off from the conscious working model which represents the parent as good (Bretherton 1995). When the child develops multiple, segregated incompatible models of attachment (Blizard 2003), incoherent or unstable internal working models—Disorganized attachment—Can readily be activated in subsequent close relationships.

Ainsworth and colleagues (Ainsworth et al. 1978) originally studied and classified mother–infant interactions in the first year of life as “secure,” “avoidant,” and “resistant/ambivalent” attachments, based on observation of behavior in the strange situation, involving 3-min separations and reunions between caregiver and infant in a clinic waiting room. The avoidant infant maintains a distant proximity to the parent and seems to have a dismissive stance toward attachments, a pattern associated with

parents who are emotionally unavailable, imperceptive, rejecting, and unresponsive (Main et al. 1985). The resistant/ambivalent child protests being separated, but cannot be pacified when reunited—An attachment pattern associated with parents who are inconsistently available, perceptive, and responsive, and who tend to intrude their own states of mind onto those of the child. Although there is limited empirical evidence that avoidant and resistant/ambivalent attachments are significantly related to later maladaptation (Fonagy 2001), clinical evidence suggests there is an association. As a clinician, I have found that at times even brief separations and parental misattunement or neglect, usually not thought to constitute trauma, are experienced by some as traumatic and become associated with self-harm. This clinical observation is supported by recent neuroscientific findings (Schore 1997; Siegel 1999).

In addition, Main and Solomon (1986) later described a “disorganized” attachment, which is associated with the caregiver’s maltreatment or gross insensitivity and communications in the first years of life (Main and Morgan 1996). Disorganized attachments can be found in 5–10% of the clinical population and in up to 89% of maltreated infants (Steele and Steele 2007). Because frightening or disorienting experiences are internalized, insecure-disorganized children seemed disoriented, showing no coherent pattern of response, freezing and collapsing to the ground or leaning vacantly against a wall when reunited. At the extreme end of this category are those children who experience physical or sexual abuse (Farber 1995, 2000; Siegel 1999). When the caretaker who is meant to protect the child preys upon him instead, this presents the child with the impossible dilemma of wanting to be comforted by the caretaker while being terrified of being annihilated by the caretaker. This annihilation anxiety (Hurvich 2003) causes the infant to freeze in a trance-like stillness, the beginning of a tendency toward dissociation (Perry et al. 1995). The infant’s dissociative processes seem linked to the caregivers’ own unresolved traumas, losses, and dissociation interacting in a self-perpetuating loop with the ongoing dissociative processes in the infant’s mind, creating a predisposition to respond to later life stressors with dissociation (Liotti 1995, 2006; Lyons-Ruth 2003). In the Adult Attachment Interview, incoherent or discontinuous narratives are signs of disorganized attachments in adults (Main et al. 1985). Kroll (1993) states that the disorganized adult:

suffers from the inability to turn off a stream of consciousness that has become its own enemy, comprised of actual memories of traumatic events, distorted and fragmented memories, intrusive imageries and flashbacks, dissociated memories, unwelcome somatic sensations, negative self-commentaries running like tickertape through the mind, fantasized and feared

elaborations from childhood of the abuse experiences, and concomitant strongly dysphoric moods of anxiety and anger (p. xv).

Attachment and Self-harm

Many who have developed traumatic attachments are predisposed to violent behavior toward others (largely males) and/or themselves (largely females) (Farber 1995, 2000; Fonagy and Target 1995; Lyons-Ruth and Jacobwitz 1999). A study of adolescent separation anxiety found that self-destructive tendencies emerged in early adolescence in response to separations (Hansburg 1986). The frequency of self-mutilation in adolescents in residential treatment was found to increase significantly when a staff member announced that he would be leaving his job (Rosen et al. 1990). More severe separation and attachment difficulties than *are* normal were found in eating disordered patients, who seemed to make no cognitive distinction between brief, everyday leave-takings and more permanent breaks, reacting to both as if they were abandonments (Armstrong and Roth 1989). Similarly, Chassler (1997) found that anorexia and bulimia were linked with feeling unwanted. Eating disordered patients demonstrated significantly higher levels of dissociative psychopathology than comparison subjects, which seemed specifically related to their propensity for self-mutilation and suicidal behavior (Demitrack et al. 1990). These findings are supported by Farber’s (1995) study in which the chronicity of severe bulimic behavior was found to be predictive of self-mutilation. Both forms of self-harm were associated with early childhood dissociation and ongoing dissociation in adolescence and adulthood. Self-harm seemed to be used to defend against and adapt to the disturbing aftereffects of body-focused trauma (sexual and/or physical abuse; medically/surgically related trauma).

Self-regulation and Self-medication

Self-harm patients have failed to develop critical ego functions, including signal anxiety, transitional object development, and a cohesive sense of body self, along with problems in self-regulatory functioning (Farber 2000). They suffer extremes of affect, either not feeling emotions at all or feeling overwhelmed by them. They are alexithymic, having difficulty in identifying, expressing, and regulating emotions, experiencing them instead as somatic or physical events (Deutsch 1959; McDougall 1989; Taylor 1987; Taylor et al. 1991). When feeling intensely anxious, angry, numb or deadened, they may turn to self-harm in order to regulate and medicate themselves, in much the same way a toddler may turn to his transitional object

(Winnicott 1953) when feeling lonely and anxious. Just as addicts self-medicate to regulate difficult affect states (Khantzian 1985), self-harm can be understood as the attempt of desperate people to interrupt or terminate intolerable affect states or states of consciousness. Painful acts of self-harm can terminate intolerable anxiety, replacing it with a welcomed depersonalized state, usually accompanied by a state of derealization. When these dissociated states eventually induce an intolerable feeling of being painfully alone and apart from others, self-harm can terminate that state as well. It has been suggested that individuals may mutilate and starve themselves, gorge themselves with food, and purge in order to alter levels of serotonin, the “feel good” brain chemical (Kohl et al. 2004; Simeon et al. 1992; van der Kolk et al. 1991; van der Kolk 1994; Winchel and Stanley 1991; Wurtman et al. 1981). For these patients who have developed with a distorted body image, self-harm can also serve to differentiate body boundaries, differentiating inner from outer and self from other (Farber 1995, 2000; Krueger 1989).

The following are a few of the responses of individuals who have been asked what self-harm does for them (Farber 1995, 2000):

I feel stress and panic inside. I eat to vomit...The vomiting helps the panic and constant running feeling.

I starve myself and then eat a regular meal and throw up. I take lots of laxatives, diuretics and enemas all the time, so nothing stays in me. Sometimes I freak out and take ipecac and get deathly sick. Then sometimes I start all over again...then I get a tranquil feeling and relax.

(Re. cutting) It's someplace you go when you're about to get too angry or too sad—Nowhere land.

I eat to numb when feelings are overwhelming. Sometimes bingeing is a lesser alternative to self-mutilation.

I pick at scabs on my head...I find the activity soothing and am trance-like while doing it.

Projective Identification, Enactments, and Reenactments

The prey/predator or safety/danger dialectic comprises the world view of self-harm patients (Farber 2000; Grotstein 1993). Dissociation underlies their projective identifications, as well as their reenactments of early attachment trauma both in the transference/countertransference and on their bodies (Bromberg 1998; Farber 2000, 2003, Farber et al. 2007; Howell 2005; van der Kolk 1988, 1989). For example, a sexual abuse survivor might shove food into her

mouth as others shoved a penis, fingers, or other objects into her body. Then as the identification shifts to the abused part of herself, she may vomit the food to rid her body of those things that were inserted by force. Or she may penetrate her flesh with a razor blade, lit cigarette, or fingernails, as her abuser penetrated her.

Reenactment is a two-person phenomenon in which the patient gets stuck in repeating the same past traumatic experiences, casting the therapist in various transference-like roles that reflect the childhood attachment patterns that have become internalized as fragmented parts of the personality. To greater or lesser degree, there is the predatory abuser and the helpless victim; the parent who neglected the child and the child who was neglected; the omnipotent rescuer and the entitled child who demands to be rescued, and in cases of sexual abuse, the seducer and the seduced (Davies and Frawley 1994; Farber 1997, 2000; Miller 1994). The therapist is cast in roles which can alternate in a confusing and provocative sequence that evokes intense counter-transference feelings, rendering the therapist incapable of thinking about what is happening and inclined to act on these feelings. The patient's dissociation can actually induce a parallel dissociative process in the therapist (Bromberg 1998). As the patient projects dissociated aspects of him or herself into the therapist, this fragments the mind of the therapist who momentarily loses the ability to think, contain, and reflect upon the patient's experience (Bromberg 1998; Howell 2005). The therapist then may mindlessly retaliate against the patient, which can destroy the treatment. If this occurs, and if the therapist can genuinely acknowledge and apologize for his or her own role in the enactment, this allows the patient to acknowledge his or her own role, and the treatment may be saved.

Successful treatment, therefore, depends upon the development of a secure attachment to the therapist, which supports the re-acquisition and re-integration of projected parts of the self, necessary for self- and mutual affect regulation and for the resolution of trauma and intrapsychic conflict (Bromberg 1998; Farber 2000; Howell 2005; Steiner 1996). Only then can the patient mourn the losses in her life.

The therapeutic process offers a microcosmic picture of attachment and separations, disruptions and repairs, with a rhythm of regular sessions punctuated by endings and breaks analogous to the strange situation. An attachment-focused approach to treatment can engage the patient in examining the patient-therapist relationship, thus helping the patient explore and rework his or her internal working models. It is the significant interactions between patient and therapist, especially those passionate moments in enactments, that ultimately lead to structural changes in the patient's personality (Farber 2000; Loewald 1960). In those indelible moments when the patient is moved or shaken by

the therapist's passion and discovers that they both can weather the storm, the patient can know that it is possible to find love and safe harbor in another human being.

Attachment-based Multi-phase Treatment

Give sorrow words; the grief that does not speak
Whispers the o'erfraught heart, and bids it break.
Shakespeare, *Macbeth*, Act 4, Scene 4

Although recent attachment research supports the view that the development of a healing narrative is the key task of psychotherapy, there is a lot of preparatory work to be done with self-harming patients before they can "give sorrow words." The therapist will need to model reflective functioning for the patient and will need to evoke the patient's interest in the therapist's mind (Farber 2000; Steele and Steele 2007). A successful treatment outcome will provide newer, more flexible working models and a greater ability for reflective thinking (Farber 2000; Fonagy et al. 2002; Steele and Steele 2007). Treatment must be a phase-oriented process, undoubtedly long-term, and roughly divided into three phases with considerable overlap (Howell 2005; Farber 2000, 2004). The first is carefully stabilizing the patient and reducing the potential lethality of the self-harm. The therapist must be firm but flexible about boundaries, inviting the patient to use him as a secure base and transitional object (Winnicott 1953) as needed, for phone contact in off hours and vacations. The second is desensitizing traumatic memories to reduce dissociation, integrating the dissociated parts of the self, and carefully building ego functions (Blanck and Blanck 1974). The third is the intrapsychic work of mourning, resolution, reconsolidation, and reconnection. This is possible only when a secure attachment to the therapist has developed, as the case below will demonstrate.

The Case of Joanie

Joanie, a brilliant scientist, has been in treatment with me for over 8 years, initially twice, then once a week, and currently every 3 weeks by telephone. Her history suggested that as a child she had developed three very frightening internal working models (mother, father, and maternal grandmother) that contributed to her disorganized attachment and dissociative tendencies.

In the initial consultation, it was apparent that Joanie's level of attachment was a combination of disorganized, avoidant, and resistant/ambivalent attachment patterns. She sought treatment at age 30 because she was afraid she would act on impulses to cut herself, something she had

done from early adolescence until several years ago. She was also something of a compulsive eater. She had been hospitalized in college and had had several psychotherapies in which her therapists insisted that she stop cutting or they would not treat her. She agreed but cut herself anyway. Her husband knew about her cutting when they married. Although it lessened in frequency, he finally told her that he could no longer stand it. Fearful that he would leave her, she resisted her impulses but had been tormented the past few years by seductive images and thoughts of cutting or burning herself. A dissociated little voice said, "Go ahead, do it. It'll make you feel so much better. He doesn't have to know." It was a promising sign that hurting herself had diminished during her marriage and that she had actually stopped despite her strong impulses to do so, suggesting that her attachment to her husband had become somewhat more important than her attachment to self-harm.

During our first meeting, I observed her great anxiety, avoidance of eye contact, flat affect, discontinuities in her narrative, and shifts in and out of trance-like states. Midway, she became more animated and cohesive, and by the time the session was over, was surprised to find that she felt quite good. As she told me more about how cutting had helped her to feel better, finding that I was very interested in understanding this was a great relief to her. The part of her that wanted to be understood prevailed over the dissociated self-state that wanted to cut, explaining in part why Joanie did so well in therapy in a way that surprised us both. It felt like magic and she wanted to understand scientifically how and why the magic worked. I suggested that when she had an urge to hurt herself, that she call me instead, and even if I could not speak with her when she called, I would call back as soon as I could. I explained that this might help her through the hardest times until her next appointment. She could not imagine anyone so responsive to her because her earliest needs for comfort were not heeded. In fact, Joanie seemed to have been a "cork child" (Tustin 1986), used to plug up the hole of her mother's depression and comfort her. Her mother told her that her conception was an "accident" because her father had not wanted children. Joanie remembered lying in her crib, crying because the doll that she slept with had fallen to the floor, and she knew better than to call out for either parent to retrieve it. Her mother would not get up to fetch her doll but might get up and take Joanie into bed with her, sending her furious husband to sleep in another room. Joanie felt safe and could fall asleep next to her mother's warm body; her father in turn ignored Joanie when she was very young. She remembered her father telling her that children are very "beatable," which frightened her, as did the shadows in her room which looked like a large terrifying thing lurking over her bed. In treatment, she came to realize that

the thing that hovered over her was her father, wanting to kill her as soon as she was born, perhaps before.

She remembered that when she was five or six, her mother was tickling her in bed. She often tickled her until she wet herself. Joanie was crying “no, no, stop,” when suddenly her mother pinned her down and fondled her genitals, saying that they should get naked together. Joanie immediately became frozen, immobilized (freezing is an adaptive response to an encounter with a predator when the fight or flight options are not possible. The perceptual experience is that of dissociation; see Howell 2005; Scaer 2005). After this incident, she never called out to her mother at night; she stayed up reading with the lights on, or curling up on the floor with the dog. They did, however, continue bathing together until early adolescence, when Joanie wanted her privacy. She had to lock the bathroom door to keep her mother out. Once, her mother even picked the lock to get in. Due to fear of abusing her own child, Joanie grew up determined that she would never have a baby.

Her mother confided in her about going with Joanie’s father to parties where they watched pornographic films with other couples. There was sexually suggestive wallpaper in one of the bathrooms. There was reason to suspect that there may have been more extensive sexual abuse, perhaps by others, especially her maternal grandmother. Although she spoke warmly of her, recalling that she enjoyed playing at her grandmother’s house because she was more relaxed about messes than her mother, she would at times become terrified when her grandmother seemed to change suddenly into someone else, with a strange unfocused look in her eyes. Her grandmother told Joanie that she had been sexually abused by her neighbors and repeatedly told her a folk tale story about a huge billygoat who ate children and crunched on their bones.

The wishes to merge with and be separate from her mother created an impossible dilemma, from which dissociation initially became an escape and later became woven into the fabric of her developing personality. When Joanie was ten, her father took an overdose of prescription medication, prompting her mother to pay more attention to him than to Joanie, who soon began sticking herself with pins and then cutting herself. Her parents were furious when they found out and warned her not to tell anyone. It did not succeed in getting them interested in why she was doing this. Later she came to understand that the violence and drama of inflicting physical pain on herself was part of her dissociated *modus operandi*, using her body to speak of the depth of her psychic pain. Her *modus operandi* was not successful so she had to “up the ante” and use her body to speak much louder. Superficial cutting escalated into cutting herself more deeply and burning herself with cigarettes, and by age 18, she was cutting or burning

herself at least weekly. When the doctor who stitched her up at the hospital said she had to go into psychotherapy, her parents had to tolerate it. In her first year of college, she sunk her teeth into her studies, as she put it, continuing to isolate and mutilate herself. One evening she cut herself brutally enough that she was hospitalized in the university hospital’s psychiatric ward. When family therapy was recommended, her parents refused.

We came to understand that cutting herself was, at times, an enactment of her wish to cut the tie to her mother (Farber 2000; Tillman 1999; Woodruff 1999). It also allowed her to protect her father from her rage by enacting her hateful wishes toward him (and his toward her?) on her own body, a means of regulating her overwhelming negative affect. Later, when she had problems in her marriage, she would cut herself when feeling angry at her husband. She voiced her fear that she was crazy. I told her that although the reasons were not yet clear, I was sure that underneath there was some “method to her madness” which we might come to understand better in time.

After the first session, the impulse to cut herself receded, as did the schizoid dissociated quality of her relatedness and her somewhat discontinuous narrative. I can only attribute this remarkable change to her having felt profoundly held and contained as a result of my listening, interest, and empathy. At work she hid herself less in her lab, and tentatively began to join others at lunchtime in the cafeteria, and scientifically began testing her hypothesis that no one could be trusted (her mother had always told her that no one outside their nuclear family was to be trusted). Within weeks, this woman who had never really had a true friendship and often had to take a fast-acting anti-anxiety medication just to make routine phone calls began to relax a bit. Her eating normalized effortlessly.

I challenged her to use her mind in a new and different way. While growing up, doing well academically and making her parents look good were the priorities, not how she used her mind. As a scientist she immediately became fascinated by the connections I helped her make, and in time, she began making connections herself through writing down her thoughts and feelings during very difficult times (Farber 2005). The regular and reliable experience of being listened to, taken seriously, and coming to understand the connections between her thoughts, feelings, and behavior were for her the ingredients that made magic. As a child she tried to use language to express herself and communicate with her parents, but did not succeed, through no fault of her own. Having then turned to her body to express what she needed to say, she came to believe that there was no other way to live. When I pointed out to her that she did, in fact, have the ability to withstand the impulse to hurt herself, she was astounded, because she had not realized that her willingness to stick it out was both

an ability she had and a choice she had made, and that she could get even better at it.

When I suggested that when she felt like cutting herself, she call me instead and we could talk about how she was feeling, she resisted for several months because she did not believe I genuinely meant it. She was sure that my offer was some clever technique that I got from a psychotherapy manual. She could not understand that it could be both an expression of my genuine concern as well as something I believed would be therapeutic. That was too ambiguous a concept to wrap her mind around, but I challenged her to try. She began to imagine calling me when she was feeling the impulse to hurt herself, using me as both a safe haven and as a transitional object (Winnicott 1953). Soon after imagining it, she did call, trembling with anxiety. She was feeling an unbearable murderous rage at her husband. She was not afraid that she would cut herself but that she might do something terrible to him. We talked, and she was surprised at how quickly she calmed down. I suggested that writing down her thoughts and feelings when she felt so enraged might help the feelings become more bearable. She began to do this and quickly made connections between previously disconnected cognition and affect. As writing became an extension of the holding environment and the secure base (Farber 2005; Winnicott 1965), to her surprise, her thinking began to shift from dichotomous black- and white thinking to a tolerance for ambiguity.

She came to recognize that after her father's suicide attempt, when he took her mother away from her, her self-injury was a bodily expression of the murderous rage at him that she could not tolerate feeling. His act threatened her with losing both of her parents, and her own survival was also threatened. In treatment she realized that she had wanted him to die and had wanted to stick a knife in him. What she no longer enacted violently on her body was brought into the transference and analyzed. Shortly after beginning treatment, there were many recurrent violent, chaotic dreams that reflected her traumatic attachment patterns. She wrote about them, then told me about them. Often a woman was burning her with cigarettes or molesting her; sometimes I was the woman molesting her. There were terrifying dreams of swimming in her parents' pool filled with insects and worms. Sometimes she dreamed she was in my house, snuggling in bed with me. In her mind I alternated between holding her and abusing her. There were several dreams of having sex with her husband, having an orgasm, and then he turned into her mother. There were dreams and hypnogogic hallucinations about something lurking near her crib, wanting to kill her. The dreams *eventually* became more benign. As treatment progressed, and the therapeutic attachment bond became stronger, I increasingly rescued her from disaster in her

dreams, indicating that she was beginning to move toward a more "earned secure" style of attachment.

During her treatment, Joanie subjected the numerous hypotheses that comprised her paranoid world view to the scientific method. She discovered that some people can be trusted, that many people like her, that she can have friends, that sometimes just being with people is so much fun, that she trusts me completely (almost), and this therapeutic process (enough) that she no longer has to test it with the scientific method. The more attached to me she became, the more painful were the disruptions of treatment when I was away on vacation. She always gratefully accepted a telephone number where I could be reached if necessary. It has never been necessary.

Joanie cut herself once while in treatment but recalled it as an accident while slicing vegetables. She did not feel it and only realized what she had done when she heard a "ping" sound. "A 'ping' sound?" I asked, curious because cutting oneself with a knife does not really make noise. "Yes," she said. "Was it really a 'ping' sound," I asked, "or was it, perhaps, a 'ping' feeling, a sensation?" She gasped, "Yes, that's what it was, a 'ping' feeling, like a mild electric current, coursing through my body." We discovered that she had been so enraged at her husband that she could not stand it. Cutting herself "accidentally" did not "count" as cutting herself. There were two other times when she tried to hurt herself, when my husband's medical crisis disrupted our treatment schedule and rendered me less attuned to her than usual. She managed "accidentally" to slam the car door on herself twice in 2 weeks. Distraught and anxious, I could not contain and reflect on my countertransference anger at her. When I came to understand my role in this enactment, and we could talk about it, the damage was repaired. When she came to understand why I had become angry at her, she then could acknowledge how enraged she had been at me but had dissociated these feelings. She had felt that she was competing with my husband for my attention, just as her father had competed with her for her mother's attention. She was amazed that each of us could become so angry with the other and that we could talk about it, and it was all right. She also understood that although I was not the perfect therapist she wanted me to be, I was, as Winnicott (1965) said about mothers, "good enough." And she found that several other imperfect people in her life were also good enough. She began to grieve over that which she never had in her life, over what she once had but lost, over what might have been but was never to be, and over what happened to her that should not have happened.

Joanie's relationship with her husband improved, and to her surprise and mine, this woman who said that she would never have a baby for fear that she would abuse her child, found herself wanting to have a baby. I suggested that they

post-pone this decision until she had ample time to consider it in her treatment. Nonetheless, she and her husband decided that she would stop using birth control, which she came to understand as an acting out of her wish to be independent and not need me so much. She quickly conceived but miscarried. Her grief was profound, and we were both struck that she had developed the ability to tolerate it. Despite her fears, she soon became pregnant again. The first trimester was marked by fears of losing the baby, and then later amidst the excitement of tracking the fetal development, there were occasional revisitings and further working through of past traumas.

She has become a devoted mother, committed to meeting her infant's needs even when it required that she revisit her painful past (Benedek 1959). Joanie realized that she wanted to raise her daughter amidst her large extended family, and so she and her husband decided to move back to the area where they were both from, where her parents still live, over a thousand miles away. She knew she would have to forge a new relationship with her parents, which had been estranged and avoidant, a process that is continuously evolving. She even has begun to respond differently and empathically to her father as a result of realizing that he is a very anxious and rigid man.

This leave-taking was a deeply emotional process for us both, happy and sad at the same time. Once again, Joanie's skin began speaking for her, erupting suddenly and dramatically in hives and other rashes, trying to communicate something to herself about her anxiety about the impending geographic separation from me. Her treatment, initially on a twice a week basis, then once a week, has continued successfully by telephone. When she is in my area when attending a conference or on vacation, we have a face-to-face session, a very emotional session for her. As she turns onto my street, she is always surprised by the depth of emotion that wells up in her.

Conclusion

All successful psychotherapies, whether supportive, psychoanalytic, cognitive or systemic, depend upon the support that comes from a strong attachment to the therapist (Farber 2000; Holmes 1996). Support, comprised of the therapist's regularity, reliability, and attentive presence, helps the patient feel that there really *is* somebody there for her, one of the most critical functions of the therapist. As Holmes (1996) has said so eloquently,

The very word *support* has music hall overtones, evoking the image of a truss, a cumbersome and noncurative holding operation, much inferior to a definitive hernia repair. . . . (support) may be

compared with invisible foundations upon which all buildings rest, and the external buttresses that some, especially those in poor condition, require. . . Support often makes its presence known by its subsequent absence. Only when our lower limbs or the foundations of our dwellings develop problems do we become grateful for the support they normally provide (pp. 117–121).

When there really *is* somebody there for her, the patient need not turn to her own body to feel better (Farber 2000). At the heart of psychotherapy is a safe and secure human attachment that has the potential to alter and even repair the attachments to pain and suffering encoded in the brain of those who harm themselves. It was the powerful attachment relationship that usually hovered invisibly in the background, and rose occasionally to the foreground, that enabled Joanie to move from an alexithymic to an emotionally expressive way of relating to her emotions, using words as symbols and metaphors to regulate her moods, emotions, physiological states, and states of consciousness. The intimacy of the attachment relationship can provide a corrective emotional experience (Loewald 1991) for patients who fear that intimacy will engulf and swallow them whole, whose solution had previously been an endless oscillating flight from attachment. It is the intimacy of the attachment in psychotherapy that is the key to the development of more autonomous functioning and intimate relationships.

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Author Biography

Sharon K. Farber Ph.D., is in private practice in Hastings-on-Hudson, NY. She has taught at the Cape Cod Institute, schools of social work, medical schools, and training institutes. She is the author of *When the Body Is the Target: Self-Harm, Pain, and Traumatic Attachments*, several journal articles and a book in progress.