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Cutting and self psychology : an exploratory analysis

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CHAPTER I

INTRODUCTION

The purpose of this study is to explore the relationship between cutting and the psychological theory of self psychology. The study used a qualitative method to analyze a possible connection between self psychology and the behavior of cutting. Eight qualitative interviews were conducted to look into possible deficits in self-structure for those who engage in self-injury by cutting. It is the premise of this study that deficits in the tripartite self may lead an individual to cut. The twinship pole and the idealized parent imago poles of the self were specifically explored to determine if deficits in either of these poles may contribute to cutting.

It is imperative to explore etiologies of cutting behavior as it is a potentially dangerous practice used by many individuals for a variety of reasons. The more we can understand this behavior, the more effective our work can become with individuals who cut. Cutting is often associated with a diagnosis of Borderline Personality Disorder found in the *Diagnostic and Statistical Manual of Mental Disorders*, or as a coping mechanism in response to childhood trauma. However, these are not the only two causes of cutting behavior. Since prevalence rates of this behavior appear to be escalating, additional origins for cutting behavior warrant investigation.

Skegg (2005) reports, "5-9% of adolescents in western countries report having self-harmed within the previous year" (p.1471). Furthermore, Bowen & John (2001)

report prevalence in the year 1989 as being "222 per 100,000 for females and 167 per 100,000 for males." Given that cutting continues to be on the rise, it is crucial that cutting is explored more deeply. For example, Ross & Heath (2002) report 13.9% of students involved in their study sample of nonclinical participants engaged in self-mutilation, signifying the beginning of an epidemic. In determining the differences as to why certain individuals are drawn to self-harm, we can better understand our client's behaviors, thus allowing for more effective interventions. Warm, Murray & Fox (2002) note that self-harming behavior, "is still a practice that is often misunderstood by many clinical professionals" (p. 122). It is important that we gain a more comprehensive understanding about why there is an increase in instances of cutting, so that we may move towards effective modes of prevention and intervention, working to minimize this rising, dangerous and potentially fatal epidemic before it spirals out of control.

This study uses the theoretical framework of self psychology to explore factors that may lead an individual to cut. Looking at the problem through the lens of self psychology, one may begin to develop a greater understanding of the functions cutting may serve for an individual. This researcher posits that an individual may engage in cutting to fill a deficit in one or more of the three poles of the self described in Kohut's theory of self psychology (Flanagan, 2002). When the tripartite self remains fragmented, the lack of cohesion can become intolerable to the individual. For some, cutting may be used in an attempt to fill these deficits and control overwhelming emotional states.

Self psychological theory identifies the poles of twinship and idealized parent imago, along with the grandiose self as the tripartite foundation for adaptation. For the present study, the decision was made to focus on the poles of twinship and idealized

parent imago. These poles were chosen because it appears to this researcher that a lack of idealized parent imago or twinship may have a greater influence on cutting than lack of a grandiose self. It is vital for the individual to have strong and healthy relational connections with parental figures and peers. Without these selfobjects, the individual may lack cohesion. The self would be left with developmental deficits in self-structure that may lead to cutting.

Twinship pole defines a need to find others in the world like ourselves (Flanagan, 2002; Goldstein, 2001). This pole, "refers to the need to feel that there are others in the world who are similar to the self" (Flanagan 2002, p. 187). Individuals need to recognize others like them in the world, others (selfobjects) that they can identify with, and others that can truly accept them and understand who they are. When an individual lacks twinship, cutting may be used as a desperate attempt to fill this deficit. Through cutting, individuals who feel so intensely different from others may find something with which they can identify.

Idealized parent imago refers to the need "to see strength and wonder outside of the self, in others, in order to merge with their growth enhancing qualities" (Flanagan 2002, P. 185). Goldstein (2001) refers to this pole as the "archaic parental imago" the pole where "children exhibit a need to look to their parents as idealizable people who make them feel secure and soothed in relationship to parental perfection and power" (p. 82). For an individual having deficits in the pole of the idealized parent imago, they may feel they are left out there in the world with no one to turn to for safety and structure. An individual who has not been afforded a successful merger experience with a strong idealized other lacks the ability to self-sooth in a healthy manner. If they have not had a

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strong parental figure in their lives to provide safety and protection, the individual is unable to internalize these qualities. An individual who has not had the opportunity to take in the positive qualities of these selfobects may be left without safe, adequate coping mechanisms. In response, when faced with unbearable emotion, one may cut to fill this deficit within self-structure.

While cutting and other forms of self-mutilation have been explored by many researchers previously, the behavior continues to escalate. Since prevalence rates for cutting appear to be increasing it remains a topic deserving further exploration. While some research has been done looking into cutting and other forms of self-mutilation through various psychodynamic influences (Edge, 2003; Ettinger, 1992; Gardner, 2001; Lowenstein, 2005; Suyemoto, 1998; Yip et al, 2003), the focus on self psychology has been limited. This researcher has not found specific data linking cutting with self-deficits in the tripartite self. Investigating a possible link between self-cutting and a lack of twinship or idealized parent imago raises new questions for exploration. The aim of this project is to explore whether these elements of self psychology illuminate the functions, origins, or survival needs associated with cutting.

CHAPTER II

LITERATURE REVIEW

Overview of Cutting

As we explore the origins as to why individuals would choose to harm their own

bodies, it may be difficult for some to contemplate that this is in fact a coping mechanism

used by many people in response to numerous traumatic stressors or life events. Skegg

(2005) reports that while rates of self-harm differ widely between countries, "5-9% of

adolescents in western countries report having self-harmed within the previous year"

(p.1471). Furthermore, Bowen & John (2001) report prevalence in the year 1989 as being

"222 per 100,000 for females and 167 per 100,000 for males." Another study found the

prevalence of self-injury to be an alarming 54.8% among the respondents of a survey

dispersed at an all women's college in New England (Kokaliari, 2005). Also, this study

found that cutting was the most prevalent method of self-injury for this sample

(Kokaliari, 2005). At this point it appears to be well known that individuals will often use

cutting as a coping mechanism in response to trauma or as a symptom of Borderline

Personality Disorder found in the *Diagnostic and Statistical Manual of Mental Disorders*,

or as a combination of the two. Cutting, or other self-harming methods is often associated

with Borderline Personality Disorder, but there is discussion in the field suggesting

Borderline Personality Disorder as a Complex Post Traumatic Stress Disorder, since most

often those diagnosed with Borderline Personality Disorder have significant trauma

histories. This is why we may think of self-harm as being correlated with both a trauma history and Borderline Personality Disorder. For one demonstrating self-harming behaviors there is often an association with these issues of having experienced trauma, whether it be a one time sexual assault or a case where there has been an extensive trauma history.

Numerous previous works explore the issues of self-harming behaviors among survivors of childhood trauma, particularly child abuse and childhood sexual abuse. Studies mentioned here link the impact of child abuse to a later response of self-harming behavior, noting that the most commonly reported form of self-harm is self-cutting. Paivio & McCulloch (2003) discuss a link between childhood trauma and self-injurious behaviors, with alexithymia as a mediating factor between the two. That is, those experiencing difficulties with emotion regulation, specifically having deficits in identifying and labeling affective experience, who were victims of child abuse and/or childhood sexual abuse, are likely to engage in self-harm as a response to the trauma they endured (Paivio & McCulloch, 2003). This study also points out that cutting was the most frequently reported form of self-abuse and furthermore, the population being studied, college women, were the most likely population to engage in self-harm. That is, cutters tend to be females in this age range, intelligence level and socioeconomic status (Paivio & McCulloch, 2003). Findings of this study support a link between histories of childhood trauma and self-harm, with 41% of survivors reporting that they have engaged in self-injury (Paivio & McCulloch, 2003).

Corresponding to information by other researchers linking trauma experienced in childhood to later instances of self-injury, Skegg (2005) states that "reported motivations

for adult superficial self-mutilation included: to relieve tension, to provide distraction from painful feelings, as self-punishment, to decrease dissociative symptoms, to block upsetting memories, and to communicate distress to others" (p. 1473). These are reasons for self-injury often associated with a previous history of some form of childhood trauma. Farber (2006) describes the link between having been a victim of childhood trauma and later experiences of dissociation as an adult. Farber (2006) further explains that it is in these dissociative states that self-injury will occur, stating that "dissociation makes possible the extraordinary feat of being the victim and the victimizer all at the same time" (p. 1). Gladstone, Parker, Mitchell, Malhi, Wilhelm and Austin (2004) further speak to the connection of childhood trauma and self-injury, finding that the women in their study who had trauma histories became depressed earlier in life and were more likely to engage in deliberate self-harm. Favazza & Conterio (1989) found in one study that 62% of those who engage in repetitive self-cutting were also victims of childhood physical and/ or sexual abuse. Therefore, a connection can be made to the likelihood that those who have early traumatic experiences are more likely to engage in self-injurious behaviors in adulthood.

Focusing in on self-injury specifically in terms of adolescents, Conterio & Lader (1998) describe the reasons an adolescent would engage in self-harm much in the same way as described for adults. In both, self-injury was seen as a response to trauma. Strong (1998) addresses the phenomenon of adolescent self-injury similarly, making the link between childhood sexual abuse and a subsequent response of self-harm in adolescence, noting that 50% -90% of those engaging in self-harm that have been studied, report having been sexually victimized as children. In another study 30% of adolescents

described histories of physical abuse, while 26% of the adolescents involved in the same study described incidents of sexual abuse (Kumar, Pepe, and Steer, 2004).

Lowenstein (2005) further posits a possible cause of self-harming behavior in adolescents may be early separation from parents, bullying in school and sexual and/or physical abuse. Levenkron (2006) describes many case examples of young women who began to self-injure in adolescence, and gives several reasons for choosing a path of self-injury. Included in these reasons is negative parenting along a spectrum, so while perhaps some of the abuse described in the case examples provided in his book may not be as extreme as chronic physical and sexual abuse, Levenkron (2006) states "healthy parenting does not produce a self-mutilating child" (p. 47). Levenkron (2006) associates feelings of fear and loneliness with the adolescent who self-injures and believes that these feelings are grounded in the reality of the childhood experiences of the adolescent, whether those were trauma that is more difficult to recognize or instances of extreme, overtly recognizable trauma.

Self-harming behaviors are known to be one of the recognizable criteria for diagnosing Borderline Personality Disorder. Favazza (1998) contends that self-mutilation, "as a symptom, it has been typically regarded as a manifestation of borderline behavior and misidentified as a suicide attempt" (p.259). As stated in the *Diagnostic and Statistical Manual of Mental Disorders* (2000), "individuals with Borderline Personality Disorder display recurrent suicidal behaviors, gestures, or threats, or self-mutilating behavior (Criterion 5)" (p. 707). Furthermore, the *Diagnostic and Statistical Manual of Mental Disorders* (2000) indicates that "these self-destructive acts are usually precipitated by threats of separation or rejection or by expectations that they assume

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increased responsibility" (p. 707). In providing further evidence that self-injury is often associated with a diagnosis of Borderline Personality Disorder, Kokaliari (2005) found in her study that, "borderline pathology was a strong predictor of self-injury p<.005," (p. 75). Additionally, it is also known that those who are diagnosed with borderline personality disorder are often likely to have been victims of severe trauma.

Trippany, Helm, and Simpson (2006) put forward the idea that when looking at self-harm as a trauma reenactment in sexual abuse survivors, a different diagnosis may be more appropriate and less stigmatizing, serving to promote better treatment of the client. They postulate that if cutting was looked at as a reenactment of childhood sexual trauma, making the link between self-harm and earlier abuse, rather than as a personality deficit, more effective treatment could be embraced (Trippany et al., 2006). In this article, the authors refer to a potential new diagnosis of Complex Post Traumatic Stress Disorder as a more accurate diagnosis, recognizing the impact of significant early childhood trauma serving to validate the experiences of the trauma survivor (Trippany et al., 2006).

This is the idea previously put forth by Herman (1992) who listed criteria for a Complex Post Traumatic Stress Disorder. Under Herman's (1992) criterion 2, "alterations in affect regulation," self-injury is clearly identified as one of the five components in that category. Furthermore, Herman (1992) makes reference to the coping mechanism of self-injury. She explains this phenomenon as an "attack on the body" where, the child who was abused lacks any safe, adequate method of self-soothing. In an attempt to relieve feelings of intense pain, one must experience a "major jolt to the body" (Herman, 1992). She views self-injurious behavior as a way to release intense feelings of pain, a form of self-preservation that one needs in order to survive, but is at the same time ashamed of

her behaviors and will work diligently to hide the signs of self-harm from others (Herman, 1992).

Miller (1994) agrees with this idea that many traumatized women will keep their self-injury a secret; it is their private coping mechanism and they maintain a secretive relationship with self-harm as a method of self-preservation. Miller (1994) identifies what she terms as "Trauma Reenactment Syndrome" (TRS), "the key to recognizing TRS is the connection between an adult women's symptomatic behavior and her own unique story of childhood trauma; TRS women do to their bodies what was done to them in childhood" (p. 9). Often children are forced into secrecy about the trauma they continue to experience, thus internalizing feelings of shame and self-hatred. Many women who reenact these traumas on themselves are "reluctant to disclose their behavior, generally because they are ashamed and because such disclosers are frequently met with revulsion and condemnation" (Miller, 1994, p. 78). Hence, self-injury is both the result of the shame internalized throughout continuous childhood trauma and also the source of shame in their later adult lives. Paradoxically speaking, Miller (1994) describes this secret relationship with the self-injury as a necessary piece to keep trauma survivors connected to something, i.e. connected to their relationship with self-harm. Miller (1994) explains, "what keeps the TRS women separated from others is the very thing that makes her feel reassured that she is in a relationship: she has a relationship with the secret" (p. 81).

Previously this notion of hiding self-injury is how professionals have typically thought of the behavior; however this is in direct contradiction to the rising epidemic of cutting (Ross & Heath, 2002), where the behavior may be known among the peer group and perhaps that behavior is why that individual is accepted into the "clique." Conterio &

Lader (1998) observe that, often times an adolescent who resorts to self-harm is one who appears to be functioning at a normal level, or even perhaps beyond. As in, the adolescent who takes on more responsibilities than she should in the household, due to an unavailable parent, becoming parentified. At the same time this adolescent appears to the rest of the world to be cheerful and well rounded, hiding her emotional pain from others, perhaps achieving academically as a way to stay hidden; rarely is the teen who is doing well in school and staying out of trouble noticed by authority figures in a way that would raise alarm about that adolescent's mental health. Perhaps, cutting behavior is more a search for identity, rather than a direct response to abuse or a symptom of a more pathological diagnosis.

Conterio & Lader (1998) discuss adolescence as a time of striving for a stable sense of identity. The adolescent who engages in self-injury meets this identity formation process in an unhealthy, problematic way. It is their thinking that this adolescent, who has been deprived of a positive relationship with a primary parent with whom they can feel safe and secure, may act upon self-harming thoughts and self-injure, disrupting the normal course of separating and finding one's own identity since the process is interrupted by forcing others into a caretaking role and slowing the move to independence (Conterio & Lader, 1998). Given this, it seems that for the adolescent who injures as part of a peer group, these same struggles with identity formation apply, and perhaps they are seeking this parental caretaking from a group with whom they feel truly accepted. They may have found this acceptance in others who have had the same struggles and can identify with their pain and subsequent method of coping.

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Conterio & Lader (1998) point out that concern about self-harm is becoming more prominent as it appears more "normal" individuals are engaging in this behavior. Turning to a study about the frequency of self-mutilation in a community sample of adolescents, the idea is advanced that self-harm is becoming more mainstream in contemporary culture; it occurs in a more normative population. Ross & Heath (2002) argue that little is known about the occurrence of self-harm among community samples of adolescents; rather the research on adolescent self-harm has come primarily from adolescents seen at the emergency room or admitted to inpatient units after episodes of cutting. Within this sample of 440 high school students, 13.9% had reported engaging in self-mutilating behavior at least once, suggesting that self-harming behaviors is a significant problem affecting today's youth. Ross & Heath (2002) present this as "a behavior that is occurring in more than 1/10 of high school students," also noting that, "this prevalence is surprising given the normative nature of the population and serves to alert practitioners to the extent of self-mutilating behaviors in high school students" (p. 76). In fact, the rates of adolescent cutting are on the rise. We need to determine the causes of such an increase, with the eventual goal of determining effective intervention and prevention techniques.

Given that cutting is on the rise, edging towards epidemic proportions (Ross & Heath, 2002), one begins to question, are there other factors involved in self-harm? Questions for exploration include why is cutting on the rise among normative populations, could there be a "contagion effect" in play? From an outsider's perspective, it seems that in some ways it's almost "cool" to be cutting as there appears to be "cliques" or groups of peers who engage in cutting. They share their experiences of cutting, they understand why each other cut, if perhaps on a superficial level, and console

each other after one has engaged in the behavior. Therefore, is cutting always a response to trauma, or is one engaging in cutting to seek out an identity, craving to belong to a group, something that appears more powerful than the individual, somewhere one can go to feel safe and protected?

Further research suggests a growing prevalence of self-harming behaviors among nonclinical or normative populations. Klonsky, Oltmanns, and Turkheimer (2003) studied the prevalence of self-harm among a nonclinical sample of 1,986 military recruits. They report that about 4% of participants in their study reported having engaged in self-harm. Furthermore, Klonsky et al. (2003) state, "about one of every 25 members of a large group of relatively high-functioning nonclinical subjects reported a history of self-harm" (p. 1501). While this sample was taken from the military, thus all participants were over the age of 18, the study makes note that the typical age of onset of self-harm for this sample was between 14 and 24 years of age (Klonsky et al., 2003). In one study of the prevalence and functions/meaning of self-injury among college age women, Kokaliari (2005) also found a sub-group of respondents from the study sample that would fit into what is considered a normative or nonclinical population; some of those engaging in self-injury do not meet the criteria of a pathological diagnosis like Borderline Personality Disorder or have extensive trauma histories.

This age pattern coincides with the age range observed by Whitlock, Powers, and Eckenrode (2006) in their study of message boards on the internet used as a resource for support by those who engage in self-harm. The majority of individuals using the message boards as a way to communicate with others who engage in self-harm ranged in age from 12 to 20 years old (Whitlock et al., 2006). These message boards and other internet

resources are widely used by adolescents and others wishing to find support, help and share techniques. Given the idea that some may engage in self-injury as a way of seeking identity formation, Whitlock et al. (2006) point out that internet support may be valuable, "because healthy social and emotional development hinges on their ability to establish caring, meaningful relationships, to find acceptance and belonging in social groups and to establish interpersonal intimacy" (p. 415). However, this support can also yield negative consequences as the internet allows the adolescent an avenue to feel normalized in engaging in these dangerous behaviors and perhaps even encouraged to participate in self-harm. As Whitlock et al. (2006) state, "the adolescent drive to belong and the satisfaction that comes with associating with a community of similar others may inadvertently feed a fundamentally self destructive behavior for some participants" (p. 415). Further alarming information gathered by Whitlock et al. (2006) present that some of the message boards studied have "links to pro self-injury Web sites where internet users can purchase self-injury paraphernalia such as bracelets or clothing that signify self-injury status and cutting clubs have been rumored to be a growing form of friendship ritual" (p. 415). Findings in this study speak to the significance that cutting has in terms of identity formation and association with an accepting peer group.

Thus, viewed within the theory of self psychology, cutting may serve to fulfill developmental deficits of the tripartite self. The individual may use cutting as a developmental tool, developing an identity that comes to fruition through the use of cutting to fill gaps in their sense of self. One who self-injures may lack a cohesive sense of self, and therefore utilizes cutting in a destructive manner to achieve cohesion. Kettlewell (1999) articulates in her memoir describing her struggles with cutting, "I cut,

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and was made paradoxically whole" (p. 62). For the present project, the theoretical

framework of self psychology will be used to explore factors that may lead an individual

to cut. Looking at a developmental paradigm through the lens of self psychology one may

begin to develop a greater understanding into the functions cutting may serve for an

individual. This researcher proposes that an individual may engage in cutting to serve the

function of filling a deficit in one or more of the three poles of the self described in

Kohut's theory of self psychology (Flanagan, 2002).

Theory of Self Psychology

Viewing the behavior of cutting through the theoretical lens of self psychology,

one can begin to deconstruct the functions that cutting may serve for those who engage in

this and other forms of self-injury. Here the focus will remain on cutting, as it appears to

be the most common form of self-harming behavior (Paivio & McCulloch, 2003).

Flanagan (2002) describes self psychology as fitting into the "deficit model" of

psychopathology. That is, "psychological illness occurs when the legitimate

developmental needs of the three poles are not met with optimal empathy and optimal

frustration," (Flanagan, 2002, p. 191). To achieve this cohesive sense of self, each of the

three poles need fulfillment with selfobjects, preventing the self from becoming

fragmented (Flanagan, 2002). These selfobjects are explained by Patton & Meara (1996)

as "mental representations of the child and the parents that function to maintain the

infant's self-esteem and the cohesion of the self. In this way, the child is seen to have

self-selfobject relations" (p. 332). Although referenced in relation to infancy and

childhood, an important component of this theory is that selfobject needs remain

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important through the duration of the life span. As Elson (1986) illuminates, "Through adolescence and young adulthood, selfobjects continue to play an intense role in strengthening self-esteem and ideals. Indeed, the capacity to find and enjoy selfobjects, who either perform a confirming role or permit idealization, is evidence of health" (p. 16). Furthermore, Flanagan (2002) emphasized that while selfobjects are often human, they do not necessarily have to be, rather selfobjects can be any number of things, including, "art, literature, music, and a variety of symbols" (p. 181). With the fulfillment of these selfobject needs, the individual would develop into a healthy cohesive self through transmuting internalizations.

Transmuting internalizations are defined as "the process through which a function formerly preformed by another (selfobject) is taken into the self through optimal mirroring, interaction, and frustration" (Elson, 1986, P. 252). It is through this process of optimal frustration that transmuting internalizations occur and "selfobject functions are gradually taken over by the child, rendering the actual presence of the selfobject less vital or even unnecessary" (Goldstein 2001, p. 83). For a cohesive self to occur the tripartite self needs to be complete within these three poles of the grandiose self, the idealized parent imago and the twinship pole (Elson, 1986; Flanagan 2002; Goldstein, 2001). That is, "the tripartite self driven by ambition, pulled by ideals, and needing to recognize itself in similar others" (Flanagan, 2002, p. 174). In fulfilling the tripartite self, "these psychological functions were to respond to their need to be affirmed, admired, and stimulated, and to merge with the power and generosity of an idealized figure" (Elson, 1986, p. 9). Using this tripolar description of the self in the theory of self psychology to

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explore the gains of cutting for individuals engaging in this behavior, we can begin to develop a more informed understanding of the behavior.

To begin an identification of the three poles, the grandiose self is first described as needing positive mirroring selfobjects, objects that can reflect back to them all the special qualities they exhibit (Flanagan, 2002). Flanagan (2002) explains Kohut's description as, "the grandiose self, needs mirroring selfobjects, people who will reflect and identify its unique capacities, talents, and characteristics. The grandiose self is the self that wants to feel special and full of well-being" (p. 182). Patton & Meara (1996) explain, "the grandiose self-selfobject relationship is one in which the parents are perceived as part of the child and function as a mirror to reinforce its sense of greatness" (p. 332). In Goldstein's (2001) discussion of the grandiose self, it is emphasized that caregivers must be enthusiastic about even unrealistic imaginations of young children in the effort to nurture the grandiose self, then eventually this will result in a well developed self that will have transformed playful imagination into realistic and attainable goals. Flanagan (2002) emphasizes, "people with sound grandiose selves are vibrant, full of confidence, hopeful, ambitious, and productive" (p. 182). Flanagan (2002) identifies a potential downside if the grandiose self becomes too overwhelming and exaggerated. For instance, "a person who has become overly grandiose may feel so filled with energy and power that these become painful and frightening. The anxiety is akin to that experienced by people in manic states who feel they might burst or disintegrate" (Flanagan, 2002, p. 184).

Self psychological theory posits the idealized parent imago, as the second-universal selfobject need. It refers to the need "to see strength and wonder outside of the

self, in others, in order to merge with their growth enhancing qualities" (Flanagan 2002, P. 185). Goldstein (2001) refers to this pole as the "archaic parental imago" the pole where "children exhibit a need to look to their parents as idealizable people who make them feel secure and soothed in relationship to parental perfection and power" (p. 82). Patton & Meara (1996) illustrate, "the child constructs this selfobject to idealize the parental figures and to merge with them in times of stress" (p. 332). Like the pole of the grandiose self, the idealized parent imago helps the individual to maintain self-esteem and a cohesive sense of self (Patton & Meara, 1996). When this need has been met with optimal empathy and optimal frustration, that is, the parental imperfections are recognized appropriately, a gradual deidealization of the parents will occur and a healthy self will be the result (Goldstein, 2001). Through merger, positive qualities of the selfobject can be internalized within the self, such as calmness and competence (Flanagan, 2002). When there are selfobject's in an individual's life that one can idealize, mature qualities of the pole will develop and one will thrive on one's own qualities (Flanagan, 2002).

The third and final pole of the self in Kohut's tripartite self is that of the twinship pole. This pole defines a need to find others in the world like ourselves (Flanagan, 2002; Goldstein, 2001). Goldstein (2001) describes the need to fulfill this pole as, "a third way the child can acquire a cohesive self is through experiences with someone whom the child perceives as like him or her, someone with whom one shares a common humanity or kinship" (p. 82). This pole was not originally recognized by Kohut as a separate pole within itself, but later Kohut came to realize the value of having similar others in the world to further the development of a cohesive self. He came to identify twinship as a

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pole within itself. Twinship is viewed as a pole that carries just as much importance as the pole of either the grandiose self or the pole of the idealized parent imago (Flanagan, 2002). If one is fulfilled within this pole of twinship, mature qualities that develop are, "security and a sense of belonging and legitimacy" (p. 189). It is when there is deficits in twinship or either of the two aforementioned poles of the self that psychopathology and what Kohut terms as "disorders of the self" may arise (Kohut & Wolf, 1978).

Goldstein (2001) further describes Kohut's view that psychopathology stems from deficits within the self, "that is, gaps, missing, or underdeveloped elements in self structure that come about as a result of traumatic or severe and protracted empathic failures with respect to the child's emerging needs," (p. 43). Furthermore, Goldstein (2001) explains that it was Kohut's view that a disabling self-disorder occurs where at least two areas of selfobject needs are unfulfilled. If this view is adopted, cutting occurs because of deficits in the tripartite self in at least two of the three poles.

Kohut & Wolf (1978) provide examples of ways in which the poles of the self remain unfulfilled and therefore may lead to psychopathology,

> Some parents, however, are not adequately sensitive to the needs of the child but will instead respond to the needs of their own insecurely established self. Here are two characteristic illustrations of pathogenic selfobject failures. They concern typical events that emerge frequently during the analysis of patients with narcissistic personality disorders during the transference repetitions of those childhood experiences that interfered with the normal development of the self, We must add here that the episodes depicted in the following vignettes are indicative of a pathogenic childhood environment only of they form part of the selfobjects' chronic attitude. Put differently, they would not emerge at crucial junctures of a selfobject transference if they had occurred as the consequence of a parent's unavoidable occasional failure.

> *First illustration*: A little girl comes home from school, eager to tell her mother about some great successes. But the mother, instead of listening with pride,

deflects the conversation from the child to herself, begins to talk about her own successes which overshadow those of her little daughter.

Second illustration: A little boy is eager to idealize his father, he wants his father to tell him about his life, the battles he engaged in and won. But instead of joyfully acting in accordance with his son's need, the father is embarrassed by the request. He feels tired and bored and, leaving the house, finds a temporary source of vitality for his enfeebled self in the tavern, through drink and mutually supportive talk with friends. (p. 418).

It is through narcissistic injuries such as these that disallow the development of a healthy and cohesive sense of self. Without the fulfillment of these selfobject needs in each of the poles of the self, psychopathology is likely to develop. As Flanagan (2002) states, "the self psychological view of the etiology of these disorders is that severe deficits occur in the cohesion of the self when the mirroring, idealizing, and twinship needs of the developing individual have not been met due to chronic deprivation or severe trauma" (p. 191). Here the focus will be on how deficits in two of the three poles of the self may contribute to cutting. The poles of twinship and of the idealized parent imago where selected for examination to determine a possible link in one's likelihood of engaging in cutting when there are deficits in one or both of these poles of the self. These two poles where chosen for investigation as it appears to this researcher that a lack of idealized parent imago and/or twinship may contribute to cutting more greatly than lack of a grandiose self. In essence, could cutting be a mechanism through which to attempt to fulfill deficits within the twinship pole or the idealized parent imago pole of self-structure?

Perhaps cutting may serve to fill a deficit in the twinship pole of the tripartite self. Cutting may be addressing a developmental need that was not met in a healthy and positive way. The twinship pole, "refers to the need to feel that there are others in the world who are similar to the self" (Flanagan 2002, p. 187). Individuals need to feel that there are others like them in the world, others (selfobjects) that they can identify with, and others that can truly accept them and understand who they are. Cutting may be a way for individuals who feel so intensely different from others to find a group with which they can identify, a group that in their minds can understand and accept them. To have others that can show true empathy for perhaps their feelings of isolation and depression, engaging in cutting to become recognized by others who cut as a way to cope with emotional pain can serve to fill their deficit within the twinship pole. Perhaps the adolescent has attempted positive peer relationships, but has been rejected or hurt by those and is therefore drawn to a cutting peer group as an alternative, though dangerous, way to fulfill the need to have others with whom to connect.

The individual that lacks true twinship may be unconsciously drawn to find this twinship in anyway possible, including unhealthy and unsafe mechanisms. Twinship is such a vital part of human development that, "too much time without a feeling of twinship can make people feel like they are unraveling and losing touch with themselves" (Flanagan, 2002, p. 189). As a means to avoid these feelings one may cut, and therefore, achieve a sense of identity with others who cut. One may seek out these "intense twinship experiences with others in order to feel alive, connected, and affirmed" (Goldstein, 2001, p. 82).

While self psychology is not looked at as having specific developmental phases, Flanagan (2002) describes twinship needs as being particularly strong in adolescence. This idea also coincides with the fact that self-injury typically begins in adolescence. Twinship is a vital part of the tripartite self, that if, left unfulfilled, a lack of a cohesive sense of self will undoubtedly exist and an individual may continue to attempt to fill this deficit in problematic, self-destructive ways like cutting. To quote Flanagan (2002), "for some young people, the only twinship ever offered is on the street in gangs" (p. 195). Thus, it seems that this idea may be similar to cutting; perhaps identifying with a peer group that also cuts is the only mechanism available to some adolescents seeking out true twinship. Thus, for an individual who engages in the behavior of cutting, a developmental deficit in the twinship pole may be an underlying influence.

Many authors have posited connections between peer influences, cutting, and other forms of self-mutilation. Suyemoto (1998) speaks of this connection noting that adolescents may use cutting as a method for identity formation, "They are known as "cutters" and defined by this symptom" (p. 548). Suyemoto (1998) further argues that adolescents may use cutting to navigate the often difficult developmental tasks of adolescence, using cutting in an attempt to create a stable identity. "While it is probably true that the vast majority of self-mutilating adolescents have dysfunctional family backgrounds and greater psychological difficulties in general, it may not be true that the majority suffer from chronic psychological disorders, such as borderline personality disorder" (p. 551). Yip, Ngan, and Lam (2002) further referred to cutting as a response to negative peer interactions and cutting with other peers in a response to the distressing feelings caused by some peer interactions. For example, in the authors' study of

adolescent self-cutting behavior, one respondent spoke of the connection with other

cutters. "C attempted to establish a friendship by joining a companion in self-cutting. "At

school sometimes, I cut with my schoolmates. I might use self-cutting as a means to

advise my friend he should not use self-cutting to release unhappy feelings. We both cut

together. We wanted to release unhappy feelings" (p. 391). Yip (2005) additionally

makes reference to peers cutting together as a negative peer influence promoting cutting.

     The idea that those who cut seek out others with whom they can identify, and that

one may be influenced to begin cutting speaks to a possible "contagion effect" in the

etiology of cutting. Taiminen, Kallio-Soukainen, Nokso-Koivisto, Kaljonen, and

Helenius (1998) offer evidence about a "contagion effect" that may be occurring in

adolescent self-injury. Taiminen et al. (1998) found that contagion of deliberate self-harm

can be found within small groups of adolescent inpatients in their emphasis of small-

group rites and to maintain feelings of togetherness. In this study it was concluded that

most incidents of deliberate self-harm in closed adolescent units could be attributed to

contagion that can spread to those within the unit who have never previously engaged in

the behavior. Furthermore, Favazza (1996) makes reference to an epidemic of self-cutting

on a psychiatric inpatient unit. Adler & Adler (2005) further discuss the concept that

those who engage in the behavior of cutting seek out others who cut. Adler & Adler

(2005) describe "individual deviants, who are actors and objects of their behavior, yet

socialize with others like them" (p. 345). The "sociological spread," or contagion, that

occurs among cutters and individuals using other forms of self-injury is described as

"individual agents" who can act in their self-injury alone, but who also "associate with

subcultural colleagues and may even perform their deviant acts in the company of others"
(Adler & Adler, 2005, p. 347).

Similar findings are reported by Whitlock et al. (2006) in their internet study of
adolescent self-injury, where it was found that many adolescents use the internet to seek
out other cutters with whom they can connect with and seek out "cutting clubs" and
cutting paraphernalia. Furthermore Adams, Rodham, & Gavin (2005) also found that the
internet provided a safe place for individuals who cut to find support and similarity in
others who also engage in the behavior of cutting, noting that, "the internet might grant
the freedom to express a self that is considered to be unacceptable in real life" (p. 1295).

Yip, Ngan, and Lam (2003) discussed at length peer influences and cutting,
finding that peers influenced cutting in a number of ways. They found that adolescents
cut as a way to seek attention from peers, seek affection from peers, get a sense of
belonging from peers, model their peers, because they had low self-image and sought out
assurance from peers, and to gain support from peers (Yip et al., 2003). Yip (2005)
further emphasizes that negative peer influences can result in adolescent cutting behavior
when the adolescent experiences rejection, isolation, or over-enmeshment by peers. Yip
(2005) describes this as, "inappropriate peer influence in forms of peer rejection and
miscommunication, poor interaction with peers, problems in sex and courtship may
intensify the antecedents of adolescents" (p. 82).

As one looks to the problem of self-harming behaviors, like cutting, and its
relation to the school environment including its impact on the school environment and
conversely, the schools' environmental influence on those engaging in cutting, some
interesting observations can be made. These observations emphasize the impact that peers

have on whether or not an individual will choose to engage in the behavior of cutting. Hawton, Hall, Simkin, Bale, Bond, Codd, and Stewart (2003) recognize an interesting trend in adolescent self-injury. Hawton et al. (2003) found that self-harm was greatest during the school year and decreased significantly during the summer vacation months, along with the December and April holiday school vacations. Also, it was found that Mondays were the days that self-harm was most likely to occur, with Saturdays being the least, possibly speaking to interactions with school stress, and thus negative peer interactions, contributing to cutting (Hawton et al., 2003). Hawton et al. (2003) also noted that some groups of females found deliberate self-injury to be an acceptable means of dealing with distress. Best (2006) additionally speaks of the increasing problem of self-harm in schools, nothing that self-injury is increasing and therefore infiltrating the academic environment, while teachers and other school based staff have minimal resources to address this growing phenomenon.

Idealized Parent Imago and Cutting

Flanagan (2002) defines the idealized parent imago pole as, "the need to have someone strong and calm to idealize and merge with in order to feel safe and complete within the self," (p. 185). That is, for individuals to have a cohesive self, they need selfobjects which they view as strong and protective. They need to merge with these selfobjects as a source of safety and comfort. One who cuts may not have found a parental imago that provides the comfort and safety of a strong and protective parent (Conterio & Lader, 1998). Lack of fulfillment of the archaic parental imago may lead to "later tendencies to idealize others at the expense of one's own self-regard," and

"extreme dependence on others for the regulation of self-esteem," (Goldstein 2001, p. 85). This is similar to the explanation provided by Flanagan (2002), emphasizing the difficulties that can be encountered if the idealized parent imago pole is not fulfilled in a healthy and positively nurturing manner, "if others are idealized too much, the self can be left devalued, feeling little, worthless, and ashamed" (p. 187). It is the absence of positive parental role models, parents that can be idealized, or conversely a traumatic deidealization experience that can result in weakness in self-structure or narcissistic vulnerability (Goldstein, 2001).

Perhaps cutting allows a person to merge with a protective other. Given that cutting clubs are on the rise (Whitlock et al., 2006), it may be that a function for the individual who cuts is the support and comforting they receive from others who engage in the behavior. Cutters may find a selfobject whom they view as stronger than themselves; in a peer group that may have others who cut. Perhaps, if they view an individual who cuts as a survivor, and they cut, they may be consoled by this supposedly stronger, more powerful individual who cuts. To fulfill this pole of the self, the cutter may merge with the selfobject who also cuts or perhaps has self-injured in the past, but is now abstaining from the behavior. So, again it may be that cutting serves the function of fulfilling an aspect of the tripartite self that has been neglected. But by engaging in self-injury, one is using a harmful and dangerous practice for adaptation.

Many authors discuss the importance of positive parenting and parental influence in regards to working with adolescent client's who self-injure (Conterio & Lader, 1998; Frankel, 2001; Kohut & Wolf, 1978; Levenkron, 2006). Frankel (2001) explores in detail a case example describing his decision to tell his client's parents of her cutting, feeling

that they played a vital role in the possible causes, though unknowingly, and therefore in the treatment of the client and her symptom of cutting. Even if the individual who engages in cutting has not experienced severe trauma at the hands of their parents, it is noted that the cutter often has a background of parental deprivation. Self-injurers may cut in a hope of being rescued by a stronger other who can care for and protect them. For example, "our patients often explicitly acknowledge their desire for someone to swoop in and remove their pain. Some are seeking to attract the attention and care of someone who will nurture and protect them in ways their own parents did not" (Conterio & Lader, 1998, p. 139).

Levenkron (2006) speaks of the importance of the family system and its influence on the cutting behavior of one or more of the children involved. When there is a breakdown in the family system, where one or both parents become emotionally and sometimes physically detached from their parental role, the chances increase that their child may use cutting. Provided as examples of circumstances that may pull a parent from their child, thus removing them as a strong and reliable selfobject are, "financial stress, employment or unemployment stress, chronic illness or disability, emotional disorders like depression, alcoholism, drug abuse, marital incompatibility, divorce and death of spouse" (Levenkron, 2006, p. 126). Suyemoto & Macdonald (1995) also point out a systemic model that looks at cutting as a symptom manifestation due to a breakdown in familial or environmental factors. Furthermore, "the theoretical literature suggests that it is childhood experiences that take place within the context of the family and, in particular, within the context of the caregiving relationship that are most strongly associated with self-harm" (Gratz, Conrad, and Roemer, 2002, p. 128). For a child to

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develop into a thriving individual with a cohesive sense of self the parent needs to be in tune with the child's ever changing developmental needs. "The essence of the healthy matrix for the growing self of the child is a mature, cohesive parental self that is in tune with the changing needs of the child" (Kohut & Wolf, 1978, p. 417).

Favazza (1996) further contends that the absence of a strong parental relationship can lead to cutting among adolescents. Favazza (1998) notes that many individuals who cut express feelings associated with a "sense of abandonment." That is, "the inability during childhood to develop reliable, dependency relationships, with stable parental figures apparently resulted in an inability to establish separate, independent personalities during adolescence" (Favazza 1998, p. 166). Often individuals will utilize cutting as a method for expressing intense affect revolving around feelings of real or perceived abandonment (Suyemoto & Macdonald, 1995). Many individuals who cut will do so over conflict about separating from parents, and often report ambivalent relationships with their mothers (Suyemoto & Macdonald, 1995). Self-mutilators may experience loss by distant and emotionally unavailable parents and inconsistent "parental warmth" (Suyemoto, 1998). Suyemoto & Macdonald (1995) believe that family therapy interventions can be very effective in treating cutting, "as the patient needs to re-create the experience of merger in order to re-create the process of separation-individuation" (p. 170).

Yip (2005) further explores parental influences that may lead an individual to engage in the behavior of cutting, stating that parental rejection and "insufficient parental concern and problems in attachment during infancy and childhood" (p. 82) contribute to cutting behavior. Conversely, "supportive parental influence such as good parent-child

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communication, stable family life, parental appreciation and encouragement may reduce

antecedents of adolescents' self-cutting (Yip, 2005, p. 82). Additionally, when

intervening to prevent further instances of cutting, if parents respond to the adolescents'

behavior in an inappropriate manner, for instance with, "outburst of anger, frustration,

mutual blaming, parental conflict, labeling and withdrawal" the likelihood that the

adolescent with cut again increases (Yip, 2005). Yip et al. (2003) further discuss

attributing parental conflicts to cutting behavior among adolescents. In their study it was

reported that 35.48% of the study sample cut because of family conflict or familial

relationships. Reasons listed included, "releasing tension in conflict with parents, testing

family relationship, seeking attention and concern from parents, and releasing anger in

parental rejection" (Yip et al., 2003, p. 141). Some interventions discussed that could

help to decrease cutting involve work with the family such as, "let client understand her

role as daughter, improve parental skill and communication pattern, and teach and help

mother to reflect feeling" (Yip et al., 2003, p. 147).

Conclusions

To date, some research has been done looking into cutting and other forms of self-

mutilation through various psychodynamic influences (Edge, 2003; Ettinger, 1992;

Gardner, 2001; Lowenstein, 2005; Suyemoto, 1998; Yip et al, 2003). Largely the work

has focused on family systems (Conterio & Lader, 1998; Edge, 2003; Levenkron, 2006;

Yip, 2005) and object relations (Edge, 2003; Suyemoto, 1998). There seems to have been

less research in terms of looking into the etiologies of cutting through the lens of self

psychology. Suyemoto (1998) makes reference to the use of self psychology to explain

why an individual may engage in self- injury. In the interpersonal model of boundaries used to describe a function of self mutilation, Suyemoto (1998) uses self psychological influence to posit that self-injury may be a way to maintain boundary distinction between the self and others. Furthermore, a dissociation model rooted in self psychology sees cutting as a way to maintain a "sense of self or identity in the face of overwhelming emotion" (Suyemoto, 1998, p. 545). While literature reflects a focus on psychodynamic theories surrounding etiologies of self-injury, it appears further exploration is warranted. Additionally, while there is some discussion using self psychology, this researcher has not found specific data linking cutting with self deficits in the tripartite self. Therefore, it seems reasonable to investigate a possible link between self-cutting and a lack of positive selfobjects in either or both the twinship pole and/or the idealized parent imago pole.

Cutting is on the rise among non-clinical populations, in a way that almost normalizes the behavior, making it acceptable to cut as a coping mechanism, to fit into a group. It is imperative that we as a profession look into this dangerous practice. For example, Ross & Heath (2002) report 13.9% of students involved in their study sample of nonclinical participants had engaged in self-mutilation, thus, signifying the beginning of an epidemic. In learning more about why certain individuals may be drawn to self-harm, we may better understand our client's behaviors, thus allowing for more effective interventions.

As noted by Warm, Murray & Fox (2002), self-harming behavior, "is still a practice that is often misunderstood by many clinical professionals" (p. 122). Jeffery & Warm (2002) found similar evidence that many service providers, especially psychiatrists and medical workers, still have a limited understanding of self-injury. Other researchers

have found that the care received by those who self-injure needs to be investigated further, to determine more appropriate and effective interventions to decrease the instances of repeated self-injury (Blenkiron & Milnes, 2003; Crowder, Van Der Putt, Ashby, and Blewett, 2004; Dennis, Evans, Wakefield, and Chakrabarti, 2001). Furthermore, Barr, Leitner, and Thomas (2005) found that assessments made by those trained in working with individuals who self-injure were not occurring as often as needed when an individual presents with self-injury. Here, the researchers speak to the importance of having individuals properly assessed when they arrive for medical care due to self-injury.

Given the limited psychodynamic research on cutting specifically, especially when looking at cutting through a self psychological lens, along with the notion that the behavior appears to be on the rise and many professionals may misunderstand the behavior, it is vital that possible etiologies surrounding the behavior of cutting continue to be explored. What may work for a trauma survivor may not be beneficial to the cutter who may be cutting to fit into a group and establish an identity. It is important that we gain a more comprehensive understanding as to why there appears to be an increase in the instances of cutting, so that we may move towards effective modes of prevention and intervention, working to minimize this rising, dangerous and potentially fatal epidemic before it spirals out of control.

CHAPTER III

METHODOLOGY

This study details an exploratory investigation into the behavior of cutting and its relation to the theory of self psychology. Qualitative methods were used to gather data exploring a possible link between cutting and this psychological theory. In essence the researcher conducted eight qualitative interviews to determine if cutting behavior may possibly be a result of a deficit in one or more of the three poles of the self defined in the theory of self psychology. More specifically, the researcher looked into the poles of twinship and idealized parent imago to learn whether deficits in these poles were related to cutting. That is, does a lack in the twinship pole or the idealized parent imago pole contribute to the etiology of cutting?

<u>Sample</u>

This researcher attempted to recruit approximately twelve participants to interview. The sought participants consisted of clinicians having at least one year of experience working with individuals who currently engage in self-harm, specifically cutting, or have done so in the past. While even this sample size appeared relatively small in comparison to larger scale studies, time restraints were taken into consideration.

The sample was drawn from clinicians working in community mental health centers and other non-profit community programs. As the focus of the study is looking at

cutting through a developmental paradigm where there may be a deficit in one or more of the poles of the self, the recruitment process made an extra effort to seek out clinicians experienced in working with adolescents with these issues. Specifically, given the geographic location of the researcher, contact phone calls were made to the Child Guidance Clinic, part of Behavioral Health Network in Springfield, MA, and the Child and Adolescent Unit of The Brien Center, Mental Health and Substance Abuse Services of The Berkshires located in Pittsfield, MA. Recruitment also entailed contacting local clinicians at other community agencies that advertise working with adolescents. A snowball sample of some clinicians was obtained from therapists already participating in an interview. All research participants were taken from a community sample of clinicians working within Western Massachusetts.

Once initial phone contact was made to the prospective participant clinicians, information was given to each clinician informing them of the proposed research study. The details and purpose of the study were explained, in addition to informing the potential participants that the study is part of a requirement for the degree of Master in Social Work. If the clinician expressed an interest in participating in the study, a few preliminary phone questions were asked to determine eligibility. This was simply to determine if the potential participant was in fact interested and willing to participate in interviews about self-harming behaviors, specifically cutting and its possible relation to the theory of self psychology. The potential clinician participants were also asked how many years of experience they have in working with people who self- injure since a requirement of the study was to have at least one year of experience working with individuals who cut. If the clinician remained interested in participation in the study and

met the criteria of having at least one year of experience in working with individuals who self-harm by cutting, an interview was scheduled. The interview was scheduled at a mutually agreed upon time and location that respected the sensitive nature of the material being discussed. Interviews were scheduled at the office location of either the researcher or the clinician.

Following recruitment efforts, eleven prospective participants expressed an interest in volunteering for the study. Of those eleven, eight participants committed to the study. These eight expressed an interest in the topic and met the criteria of having at least one year of experience in working with individuals who engage in self-injury by cutting. All eight participants were Clinical Social Workers and held the degree of Master of Social Work. Attempts were made to recruit for diversity in terms of age, race/ethnicity, gender, years of experience working in mental health and years of experience in working with individuals who engage in self-injury through cutting. A broad range of ages of clinicians was obtained with the youngest clinician age 32 and the eldest age 56. Gender was more varied than race, with five women and three men participating in the interviews. However, seven of the clinicians were Caucasian with only one African America participant. As far as years of experience working in mental health and years of experience working with clients who self-injure through the use of cutting, it seems that the sample overall had a substantive amount of experience in both these areas. The clinicians interviewed appeared to have a wealth of experience and range of knowledge in the topic area. Years of experience working in mental health ranged from five to twenty-eight years, while years of experience working with clients who engage in the behavior of cutting ranged from two to twelve years.

<u>Data Collection</u>

Data collection consisted of utilizing a semi-structured, guided interview format. Interviews lasted approximately 45 minutes to 1 hour in duration, allowing for more information gathering as new concepts surfaced. Thus, while there was a specific set of questions covered, the qualitative design was flexible, allowing for more comprehensive data to be provided and collected. The flexibility also allowed for a higher level of comfort to be achieved between the participant and the interviewer, thus soliciting more accurate data from the interviewee. During the interviews, the research addressed two poles of the tripartite self; the pole of twinship and the pole of the idealized parent imago.

Interviews began with a presentation of the informed consent form (see Appendix A) and a discussion surrounding the confidential nature of the material being discussed. Upon initiation of the interview the participant was provided with an informed consent form. The participant was given an opportunity to read the form. After the clinician had enough time to read the form through carefully, the participant was allowed time to ask any questions they may have pertaining to the purpose and design of the study, or their involvement in the study. The researcher fully answered any questions raised by the participant. Once the participant felt satisfied with his/her understanding of the study and what was required, the participant was asked to sign the form. Signed informed consent forms were kept in a separate folder from the collected data to ensure that a clinician's name could not be connected to a particular case example. In order to safeguard confidentiality and protect any identifiable information about the case examples, the participants were asked to only to refer to the case example as "the client" and "he" or "she." Clinicians were also asked to disguise any identifying demographic data.

Clinicians were only asked to provide a brief summary of a case they have worked with in which their client has engaged in cutting.

After the procedure of the interview was addressed the actual guided interview process began. The interviews were semi-structured using a guided interview format (see Appendix B), aiming to retrieve the same themes of information. While dialogue was flexible as new information was provided, there were set questions used to ensure that the themes under investigation remained constant throughout the study. That is, research explored the theory of self psychology and how self-injurious behaviors, with a focus on cutting, may be conceptualized using this theoretical model. Five overarching questions were asked of every participant. During the interviews data were secured using a digital voice recorder, with the participants' permission. The data were digitally recorded and downloaded onto CDs.

Interviews started by gathering some basic demographic data from the clinicians. Participants were asked to provide their age, gender, race/ethnicity, discipline, degree, years of experience working in mental health and finally years of experience working with individuals who self-harm. From there, the participant was asked to provide a brief case example of a client they have worked with either currently or in the past. They were asked to select a case that they had fresh in their mind or worked with in great depth to ease the recall of information. After the participant provided a case example, they were then asked questions to relate this case to the theory of self psychology.

Clinicians were provided with a handout detailing twinship (see Appendix C), asked to review the handout and then discuss their identified case example in terms of twinship. Then, clinicians were given a similar handout that explained the pole of the

idealized parent imago (see Appendix D) and again asked to discuss the case example they provided in terms of this particular pole of the self. From these handouts describing this model of a developmental paradigm, clinicians were asked to consider how the twinship and the idealized parent imago poles of the self were expressed in cutting. Clinicians were then invited to describe how they typically view the behavior and what theoretical orientations they typically work from when addressing cutting.

Essentially five main themes where explored throughout the interview. The first theme was to explore a case example of an individual who engaged in self-injury using the method of cutting. Second, participants were asked to relate this case example to the twinship pole of the tripartite self, essentially describing peer relationships for this client. Third, participants were asked to describe the case example provided in terms of the idealized parent imago pole of the tripartite self, essentially describing relationships with either or both parents for this client. Forth, participants were asked to describe how they actually view the behavior of cutting, that is, what theoretical frameworks they typically work from when working with clients engaging in cutting behavior. Finally, participants were given the opportunity to discuss any additional areas they thought should be addressed in terms of cutting and the theory of self psychology, along with any information they wished to share about cutting overall for the purposes of this study.

Data Analysis

The information gathered during interviews was transcribed by the researcher and subsequently coded into specific themes. The typed transcription notes are identified by interview numbers 1 through 8. Five main themes for investigation were identified. These

themes included (a) overall case examples, (b) cutting and its relation to twinship, (c) cutting and its relation to the idealized parent imago, (d) how cutting is more typically viewed among professional clinicians, and (e) additional areas to further investigate regarding the behavior of cutting. The coding process provided information related to cutting viewed through the lens of self psychology. This resulted in an exploratory analysis of a developmental paradigm involving the theoretical concepts of self psychology. Specifically the twinship and the idealized parent imago poles of the tripartite self were explored. The data were used to determine if perhaps a deficit in one or both of these poles of the self may or may not lead an individual to cut for the purpose of fulfilling this possible deficit with a negative and harmful behavior.

CHAPTER IV

FINDINGS

Following are the results derived from eight qualitative interviews conducted to

explore the relationship between the psychological theory of self psychology and cutting.

Eight clinicians were interviewed, all having experience working with clients who engage

in self-injury, including cutting. Clinicians were asked to identify a case example of a

client they worked with who self-injured by cutting. The participants were asked to

provide a case example where they could recall enough details allowing the researcher to

identify possible connections with self psychology. Despite a variety of differences in the

case descriptions, many similarities where identified in terms of possible etiologies of

cutting behavior. Consistent with the premise put forth by the study, these similarities,

when looking through the lens of self psychology include an apparent lack of healthy

fulfillment in one or more poles of the tripartite self. Specifically, the twinship pole and

the idealized parent imago pole were explored for each of the case examples. Results

identified a connection between cutting and deficits in the twinship pole and the idealized

parent imago pole within self-structure.

Data retrieved throughout the study will be presented in the following categories:

(a) description of case examples; (b) twinship and its relationship to cutting; (c) idealized

parent imago and its relationship to cutting; (d) clinicians' views of how they typically

interpret cutting behavior; and (e) additional areas to be explored when researching cutting.

Description of Case Examples

Of the eight case examples provided by the clinicians interviewed all were female. Six case examples were young women ages ranging from 14 through 21. One client was 14 (interview 8), one 15 (interview 2), one 17 (interview 7), one 18 (interview 6), one 20 (interview 5) and one 21 (interview 3). The other two women were 40 (interview 1) and 44 (interview 4). While these clients continued cutting at the time they entered therapy, it was reported that both women began cutting in their late teens. Thus all eight case examples began cutting in adolescence. Of the teen and young adult women, all were in school with the exception of one case, the 21 year old. Among the two women in their forties one was a nurse (interview 1) and one was unemployed and receiving disability (interview 4), having been out of the work force for a reported 12 or 13 years. Of the eight case examples provided, seven had reports of a chaotic family environment and upbringing. These seven cases also had histories of sexual abuse by a relative, close neighbor, or family friend. One case, the 40-year-old nurse, had an unclear family history and background. Six of the cases have histories of psychiatric hospitalizations, partial hospitalization programs and placement in residential programs. Of the two remaining cases, the background of the 40-year-old client is unclear in terms of previous mental health admissions. The 14-year-old has not been hospitalized nor had an out of home placement to date.

Twinship and its Relationship to Cutting

During the eight interviews there were no positive reports regarding twinship experiences for any of the case examples provided. Many reported no friends, therefore a lack of twinship altogether. Others reported unstable or negative peer interactions and influences. Thus, it seems that for the eight cases provided, all lacked a healthy fulfillment of the twinship pole of the tripartite self. Of the eight cases, interviews 1, 3 and 6 reported that their clients were careful to hide their self-injury from others, thus it was their private coping mechanism preformed in isolation and away from peers or others. Two cases, interviews 4 and 5, also hid their cutting from peers, but were very vivid and open about their cutting with professionals. Interview 5 reported that the client came to one session "bleeding through her shirt." The three remaining cases shared their cutting behavior with others. Interview 7 reported that the client and her boyfriend would both cut, and though they would fight about the cutting it was something they shared. The client described in interview 2 was very open with her cutting, showing peers, teachers, and helping professionals. She reported having some peers that also cut. Interview 8 was also open with her cutting and knew of others in her school that cut.

Interview 1 stated that the client was "pretty isolated in terms of peer relationships." The clinician could not recall any relationships for this client outside of her marriage. However, the clinician did not feel this client missed having peers, in that, she was shy and quiet. Interview 6 reported that the client, "had one female friend, but the relationship ended." This client's only significant relationship may have been with a male that lived outside of town, but this relationship ended when the client took the bus to see him and he was not there to pick her up. Interview 4 reported that for this client,

"social relationships are very limited." This client has one friend, but it is a friend that is much older and also has "severe emotional problems." So, it seems that while this client may be getting some fulfillment in twinship, it may also be serving to foster negative or self-destructive tendencies. Since for this particular client, it is the emotional distress that she shares with her friend. Furthermore, this client does have a history of isolating herself, exhibiting signs of paranoia and hording. In interview 6, the client identified had, "no friends really, she was afraid that no one could ever relate to her, that she was so different from others." Interview 8 reported that her 14-year-old client had, "a really hard time with girlfriends, she really had no girlfriends." And finally during interview 3, it was reported that, "the client had a close relationship with siblings, but did not talk about any friends growing up." For these six cases it seems that a lack of friends, thus a lack of twinship is apparent, exhibiting a possible connection to their behavior of cutting.

For interview 2 and interview 7, these clinicians reported peer relationships fostering negative and harmful twinship connections leading to self-destructive behaviors. In interview 2, it was stated that this client can make friends quickly and easily, but it is always for the gain of something negative for either party. The clinician stated that, "she makes friends easily that she can get into trouble with that engage in the same negative behaviors." In addition to cutting, these behaviors include drinking, drug use, and other illegal activities. Often the cutting will occur when this client gets into a fight with her friends. Furthermore, "it is hard to say if the cutting is because of emotional pain, because some peers also cut. So, it could be somewhat of a contagion effect….but, there are more issues underlying." So, while this client has peer relationships, "peer relationships are not positive or strong." In interview 7, the clinician

reported that the client is, "socially inept." She does not appear to have friends currently, but there was a time when she was in foster care that it was very important for her to have, "relationships with her foster sisters." From this statement it appears that at one time the client was attempting to make strong twinship connections to fulfill possible deficits in this pole of the self. Now the client has one intense attachment that more than likely contributes to her self-injury. The clinician reports that, "this client has had a boyfriend for over one year and her entire world revolves around him." This client's boyfriend also engages in cutting. Informing that, "often times they will fight and then he or she will cut, then they will fight about the cutting. After the cutting episode there than appears to be a sense of calm. And then the cycle repeats." In this relationship, this client and her boyfriend are extremely close, to the point that they do not let others in. It seems to be an extremely enmeshed, potentially dangerous and destructive relationship. The clinician further reports that, "even though they are in separate schools, neither have relationships outside of theirs'." For both these cases, some twinship fulfillment is apparent in their interactions with peers. However, it does not appear to be fulfillment of the twinship pole in a healthy or positive sense. In fact, for these cases a deficit in the twinship pole is being compensated in a dramatically unhealthy manner, potentially leading to cutting.

Looking deeper into the peer interactions of the case examples provided, it seems there may be a link to borderline tendencies among some of the cases. For interviews 2, 3, 5, 7 and 8, the clinicians described some interactions with peers for these clients as having borderline traits. For these five case examples a further emphasis on difficulties within the twinship pole is warranted. Interview 2 describes the client using

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cutting as a reaction to a fight with a friend. This is synonymous with the push-pull

tendencies of an individual with borderline features. This client involves herself so

intensely with others that it becomes overwhelming and an explosive fight occurs. This

results in the friend vacating the relationship and the client cutting in response. This is

similar to Interview 3, where the clinician describes her client as basically a loner, but

occasionally getting into "antagonistic relationships." The clinician describes further,

"this client exhibits borderline tendencies, not saying that is her diagnosis, but it is that

idea where she would want people in her life, but push them away. Sort of the ….. I love

you….stay away."

In interviews 5, 7 and 8, these borderline features are described in terms of these

clients' interactions with boyfriends. During interview 5, the clinician described a

relationship that had terminated for the client. The clinician explained that when this

relationship disintegrated, "this sudden loss was too much for the client to handle and she

cut. It was a very co-dependant relationship. She could not picture her life without him

and was afraid that she would completely fall apart." The case described in interview 7

also talks about this intense connection to a boyfriend and no one else. Further detailing

that it is when the client and her boyfriend would fight, the cutting would occur. Finally,

the clinician participating in interview 8 described an intense relationship with a

boyfriend for this client. The clinician stated that the client claims she loves the boyfriend

and that their relationship is serious, "but does everything she can to get him mad at her.

She kisses other boys at school and will make sure that he finds out about it." These case

examples show unhealthy peer interactions that closely mimic characteristics of

borderline personality disorder. While there is evidence of twinship experiences they are

neither healthy nor positive. In fact the dysfunction apparent in the twinship pole for these cases would not allow for development of a cohesive sense of self. A result of unhealthy twinship could likely manifest itself in self-destructive behaviors like cutting.

Idealized Parent Imago and its Relationship to Cutting

For all eight interviews conducted there were significant difficulties in the case examples provided in individuals' relationships with either or both parents. There were many reports of severe difficulties in the clients' relationships with their mothers. Considering relationships with their fathers, many appeared to have non-existent relationships with their dads, rather than a relationship of direct conflict. Some of the case examples described had an element of a positive idealized parent imago experience, but in these cases the mother was not the primary object. Although the idealized parent imago pole may have been fulfilled somewhat by these other caregivers, it was not enough to reverse the damage caused by a lack of strong, positive nurturing by the individuals' mothers. Also, in some of the cases the clinicians identified their clients as craving so desperately to have this strong idyllic other who could provide them structure and safety. The absence was in needing this sense of security, but having it unfulfilled by a strong parental figure. For others, some of the difficulties were because the mothers did not believe their daughters when allegations of sexual abuse were presented. For these eight cases explored, a developmental difficulty in the fulfillment of the idealized parent imago pole of the self could have contributed to the clients' later path of self-injury through cutting.

In interview 4 and interview 7 examples of positive experiences in the pole of the idealized parent imago were discussed. Interview 4, the 44-year-old woman described had an experience in foster care where her foster mother was the first soothing and protective factor in her life. The clinician reported that "my client gets strength and comfort from her previous foster mother, whom she remains in contact with, she seems to take it in but cannot own it, she cannot internalize it." Perhaps, given that in this case example the client demonstrates significant pathology, the strong protective factors this foster mom was able to provide were not enough to counteract the parental failure by the biological mother. One can only speculate from the information provided that the client's relationship with her own mother was not a solid stable source of comfort, as the client was in several foster homes throughout her childhood. During interview 7, the case described spoke of a very positive, loving relationship this client, now 17, had with her grandmother. The clinician reported that, "when her grandmother died, it was a severe loss. She did have an excellent relationship with her grandmother, but was never able to properly mourn her death. There remains a lot of unresolved grief that continues to be a difficulty." Furthermore, this client was hospitalized in a psychiatric unit for the first time shortly after the grandmother's death. So, while this client did gain some positive qualities in the pole of the idealized parent imago, the sudden loss resulted in an inability for the client to internalize these qualities and take them in as her own. It seems that the difficulties in her relationship with her mother are so severe that the traumatic loss of her grandmother was intolerable. Hence, there remains a deficit in the pole of the idealized parent imago for this client.

In interviews 2, 5, 7, and 8 the clinicians spoke of their clients having a strong

desire to be close with their mothers, but even more so, to feel protected by and safe with

their parental figures. These case examples demonstrate the individuals' need to have

structure in their lives in order to feel this sense of safety and protection. When this sense

of internal safety exists, the pole of the idealized parent imago is fulfilled and can support

the development of a more cohesive sense of self. While in interview 2, the client does

not directly state that she craves this sense of security from her own parents, she has

revealed to her clinician that, "she wants to be in a foster home." When questioned

further about what she would hope to gain from living in foster care, the client responded,

"it would be really cool to have chores and rules, we don't have that at home." In this

case example, the craving for rules and structure was emphasized dramatically. The case

example provided in interview 5 described the client as wanting to put her mother on a

pedestal and idealize her. The clinician describes this client's relationship with her

mother as, "very co-dependent and enmeshed." In this case the mother uses pills and

alcohol to cope with her own difficulties. Here, it is the clinician's view that the client is

doing the same thing by cutting, i.e., "when pressure builds they both do something

physical to release; they both use maladaptive physical outlets to release tensions."

Furthermore, this clinician believed that this client "really wants strong relationships with

parents, she craves it." The clinician's view is that this client will defend her parents'

behaviors, like their own drinking, drug use and affairs.

Interview 7 describes a relationship with the mother where the client, "seeks to

have a relationship with mom and approval from her." In this case the mom has never

taken on a parental role, having multiple mental health issues of her own. According to

the clinician interviewed, there was a time when the mom lived in the home, but the grandparents were always the primary caregivers. In essence, the client sets herself up for constant rejection by her mother. When the client tries to reach out to her mother, "mom makes derogatory remarks to the client." Interview 8 provides another example of an enmeshed relationship with the mother. The clinician describes their relationship as having "no boundaries." The clinician reports that, "if asked, the client will state that the mom is her best friend." However, this mother has "no strong or protective factors." She cannot set limits and will allow the client to get into trouble by ignoring the situation. For example, "when there is an issue at school, the mom will believe the client over the other adults, mainly out of guilt." The clinician describes this mom as wanting to be there for her daughter, but lacking the ability to be a soothing, nurturing parent in a healthy and constructive manner. The client is left out there in the world, with limited sense of security, and therefore, limited fulfillment in the pole of the idealized parent imago.

For interviews 3 and 4, the case examples described difficult relationships with their mothers. These difficulties were a result of the mothers' failure to believe their daughters when they disclosed sexual abuse. In both these cases, the mothers failed to validate their daughters' traumatic experiences. This lack of parental attunement resulted in increased feelings of shame and guilt surrounding the sexual abuse. Failure by the mothers to believe their children greatly exacerbated those feelings associated with sexual victimization. During interview 3, it was reported that, "the client's mom was emotionally unavailable; since the client was not believed about the abuse the feelings of shame and self-loathing remain. The fact that she had no one to turn to when the abuse occurred contributed to the cutting." Interview 4 also describes a scenario where the

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mother of the client did not believe her about the sexual abuse. This client was sexually abused by a relative who lived only a few houses down from the home where the client lived with her mother prior to entering foster care. The client was forced to remain silent about the abuse; "in childhood the client was sexually abused and her mother did not believe her or protect her from the abuse. It was only later when the client was finally hospitalized in her early thirties that she was believed about the abuse that occurred." For both these cases the mothers failed to protect their daughters from sexual abuse while also disbelieving them when they asked for help. This is a clear failure in fulfillment of the idealized parent imago, leading to severe difficulties throughout these individual's lives.

During the discussion surrounding the idealized parent imago in interview 1, the clinician had a difficult time commenting on the relationship the client had with her parents. This lack of information is significant in itself; evidence of an idealized parent imago was absent for this client. This clinician stated that it was "almost like she did not have parents, she talked about her childhood in very vague terms." The clinician's view was that, "there was an absence of relationship, rather than a bad relationship." In interview 6, the client's "relationship with mom is awful." The origins of the difficulties in this relationship are unclear, but the clinician describes the present conflict with the mother as very tumultuous. "Mom is the person the client targets the most, she swears at her the most, and she'll harm her, kick and punch her." This is similar to case 2, where the clinician describes the environment as unruly and chaotic. In this case the client demonstrates clear anger directed towards her mother, possibly feeling that she too is rejected by her mother since in this case the mom of the client would rather fixate on the

client's baby. For the three cases described above there are certainly deficits in the fulfillment of the idealized parent imago. Indeed, for all eight cases explored in this study deficits in this pole of the self are clear. In no case were developmental needs for an idealized parent imago fulfilled. Thus, cutting can be looked at as an unhealthy manifestation of deficits within this pole.

Clinicians' Views of How They Typically Interpret Cutting Behavior

During the eight interviews conducted many clinicians viewed cutting in similar terms. Although the clinicians interviewed had varying levels of experience in the mental health field along with varying levels of experience working with client's who self-injure, common themes were identified. None of the clinicians participating in the study had previously explored cutting through the theoretical lens of self psychology. Rather, most clinicians thought of the behavior in more concrete terms, such as, the primary gains the client receives from engaging in self-injury. These responses were often explanations the clients offer for cutting, rather than analyzing the behavior in a richer theoretical context.

Three clinicians identified theoretical perspectives when looking into the behavior of cutting. Clinicians participating in interview 2 and interview 3 identified trauma theory as a lens they use when looking into etiologies of cutting. Furthermore, in interview 3 the clinician stated that the behavior may be a combination of underlying mental health issues and childhood sexual abuse, recognizing the link between borderline personality disorder and cutting. During interview 6, Dialectical Behavioral Therapy was identified as the primary treatment tool used in this clinician's work with individuals who cut, identifying a cognitive behavioral model as the theoretical lens of preference.

Three primary reasons were identified by the clinicians as to why an individual may engage in cutting. These included decreasing numbing, decreasing emotional pain and using cutting as a coping mechanism. Four clinicians stated that the feelings of being numb often prompted an individual to cut. This reason was given in interviews 2, 4, 5, and 7. In interview 2, the clinician stated that, "physical pain made her feel alive." During interview 5, the clinician spoke about how difficult it can be for a person to feel frozen, so in order to escape these feelings and come back, a person could use cutting. The clinician articulated that, "if one cuts then they are no longer frozen; they are now fighting the pain."

The second primary reason for cutting was to decrease emotional pain. Just as in decreasing numbing, four participants identified a decrease in emotional pain as a primary reason for cutting. These were the clinicians participating in interviews 1, 2, 5, and 8. The third primary reason provided by participants was that cutting served as a coping mechanism. While these three clinicians (interviews 3, 5, & 6) recognized the coping mechanism to be maladaptive, it was a consensus that their clients needed this because they did not know how else to cope. For example, in interview 3, the clinician described that, "they cut because it is their only way of dealing. It is their way of managing overwhelming feelings."

Other reasons identified for engaging in cutting behavior include peer influence, self-punishing, release of tension, and to self-sooth. Two clinicians cited each of these reasons for cutting. Participants in interviews 1 and 2 recognized peer influence as a possible cause, but not the only cause. Clinicians in interviews 4 and 5 stated that a reason for cutting may be self-punishing. That is, punishing themselves for the sexual

abuse they experienced as children. The clinician in interview 5 describes this ideology vividly, "I deserve to be punished, I deserve to have these scars, and I deserve to have no one want me." During interview 4 and 5 the clinicians also shared a view that cutting is related to tension release. Where self-soothing is concerned, clinicians in interviews 1 and 8 identify this as a possible reason to cut.

Other reasons given were the idea that cutting is a manifestation of depression, when looking at depression as a form of anger turned inward. The clinician in interview 5 states, "cutting may be aggression turned inward; they are angry at the person who abused them, but they take it out on themselves." Another reason identified by one clinician participating in interview 4 is that individuals may cut because they feel dirty, "cutting could get the poison out." Throughout these interviews conducted it is apparent that clinicians coming from different theoretical backgrounds and levels of experience can have similar views of the etiologies of cutting behavior. However, many differences describing the reasons for cutting were also recognized. Some think theoretically, but most think concretely about the behavior itself. Although the sample for this study is small, it seems clear that clinicians operate with multiple views about why an individual would cut. The answers presented by the participants in the study represent some consistencies in their thoughts about cutting, but also some discrepancies to be explored further.

Additional Areas to be Explored When Researching Cutting

These eight clinicians had different ideas about future areas for exploration in researching cutting. There were however two areas of similarity identified among the

study participants. These were looking into why it appears that cutting is on the rise especially among adolescents and exploring in more depth how cutting is used as a coping mechanism. Of the clinicians interviewed, three (interviews 2, 5, & 6) wanted to learn more about the increasing number of individuals who self-injure through cutting. The clinician participating in interview 5 asked the following questions in relation to the apparent growing epidemic, "Why are teens self-harming more? Are they doing it for recreation? Is it peer pressure? Has it become socially acceptable? Is it a natural human process to feel pain?"

Regarding the use of cutting as a coping mechanism, the clinicians in interviews 6 and 7 were interested in the social work field exploring this phenomenon further. The clinician in interview 6 feels that cutting should become less stigmatized, resulting in a reduction of the shame felt by those who cut. This clinician suggests that, "we should really look at what cutters do and find a way not to stigmatize all cutting. If the shame is taken away then people would be more likely to tell their therapist, thus preventing the behavior from escalating. Cutting really needs to be recognized as a coping mechanism and we cannot take away one coping mechanism without replacing it with another." This statement is similar to the idea put forth in interview 7, where the clinician would like to see "more research done on what kinds of tools to utilize as an alternative to cutting."

Additional areas of exploration mentioned by the study participants include looking into the similarities that cutting has with eating disorders, specifically examining if there is the same deflation and devaluing of the self with both issues (interview 1). It was also mentioned that cutting could be looked at through attachment theory, as in why do individuals who cut have such difficulty internalizing positive attachments and

attaching to others in a healthy manner (interview 3). The clinician in interview 4 would

like to see an examination for why individuals may choose this harmful behavior over

another equally harmful behavior. During interview 7, there was also discussion about

detailing how to recognize the differences in cutting and suicide and presenting the

material in a way that would be more useful for parents or other caregivers in helping the

adolescents they know who cut. Finally, the clinician in interview 8 had a few

suggestions when discussing future areas of exploration regarding cutting. One of the

areas cited was an interest in looking into why some individuals cut in secret vs. why

some individuals cut publicly. Cutting with others included either telling others openly

about their cutting or actually cutting in groups. Two additional suggestions made by this

clinician for future research are exploring a comparison between male and female cutters

and also a comparison of the relationship cutters have with their mothers vs. fathers.

CHAPTER V

DISCUSSION

Exploring cutting through the lens of self psychology allowed for an expansion of possible etiologies to the roots of the behavior. Little research has been done in terms of examining the relationship between cutting and the psychological theory of self psychology. Additionally, this researcher did not find previous works specifically looking into cutting and its relation to possible deficits in the tripartite self. This study specifically explores the relationship cutting may have to possible deficits in the twinship pole and the idealized parent imago pole of the self. The premise of this study explored the idea that if there are deficits in one or both of these poles of the self a lack of a cohesive self will develop, leading to developmental deficits in self-structure. Found consistently throughout the study in the case examples explored, there were significant developmental deficits in both the twinship pole and the idealized parent imago pole of the self. By looking at the case examples identified in this study a link can be defined between cutting and a lack of fulfillment in these poles of the self.

Implications for the Behavior of Cutting

Self psychology proved to be a valuable theoretical model aiding in the interpretation of cutting. In examining cutting for each of the case examples provided, it was apparent that a lack of fulfillment in the twinship pole may have contributed to a

manifestation of cutting. Various examples were provided demonstrating a lack of selfobject representations for twinship. Most individuals did not have peers with whom they could relate in a positive and healthy manner. Of those who did have friends or peers, these relationships proved to be unstable. Often peers were associated with the cutting and other negative behaviors. Many times cutting came as a response to a sudden disturbance in one of these peer relationships. These findings warrant further exploration of peer relationships and their association with cutting. This is important both as an area for research, but also individually when presented with a client engaging in the behavior of cutting. It seems that peer relationships and the strong innate need to have others in the world like us are vital for the development of a healthy cohesive self. When twinship needs are left unfulfilled the self remains fragmented. In response to this fragmentation cutting can occur.

Regarding the idealized parent imago pole of the self, it appears that cutting is also related to a lack of healthy fulfillment of this need. All case examples demonstrated poor relationships with parental figures. Many cases identified an abusive or neglectful background. Even when the case provided did not reveal direct physical or sexual abuse from a parent, the lack of structure and safety for the individual showed a lack of idealized parent imago self-selfobject representations. Many of the case examples explored a craving the clients had for this pole to be fulfilled. Some examples identified a relationship with a parental figure, specifically the mother that appeared close, but in an unhealthy enmeshment. While these mothers were physically present, they lacked emotional attunement with their children. Often they were emotionally unavailable and unable to provide strength and safety. These parental figures did not contain the

comforting, soothing qualities necessary for merger. In this study, the developmental

deficit left in this pole of the self contributed to cutting for the eight case examples

provided.

Implications for Prior Research

     While no prior studies directly spoke of cutting and twinship or idealized parent

imago, links to these concepts can be identified. Where twinship is concerned, many

authors speak to the impact peer relationships have on individuals engaging in the

behavior of cutting. Suyemoto (1998) draws a connection between cutting and identity

formation. Cutters may lack healthy twinship experiences and crave so intensely to be

recognized in similar others, they may cut to feel as though they belong. Yip, Ngan, and

Lam (2002) look at cutting as a response to negative peer interactions. This includes

cutting with peers is response to distressing feelings caused by peer interactions.

Throughout the present study, clinicians interviewed reported similar reasons as to why

their individual clients cut. Often mentioned was that cutting occurred as a result of a

disturbance with a friend or boyfriend. This speaks to the push-pull tendencies associated

with Borderline Personality Disorder. As Kokaliari (2005) found, these borderline

tendencies are a predictor of self-injury. Yip (2005) further emphasizes the idea that peers

may cut together due to negative peer influences that promote cutting.

     Contagion effect also relates to a possible cause for cutting when explored as a

developmental deficit in the twinship pole of the tripartite self. For those lacking in

positive twinship experiences, cutting may be a desperate attempt to seek out fulfillment

in this pole. Taiminen et al. (1998) found evidence of a "contagion effect" in small

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groups on adolescent inpatient units. Taiminen et al. (1998) describe this as an attempt to maintain feelings of togetherness, further emphasizing that the behavior even spreads to those who have not previously self-injured. Favazza (1996) similarly noted an epidemic of cutting on an adolescent psychiatric unit. Additional authors describe cutters seeking out other cutters, others with whom they can identify (Adler & Adler, 2005; Adams et al., 2005; Whitlock et al., 2006). While the results of the current study did not identify individuals seeking out others who cut specifically, there were some instances where individuals had peers who cut. Peer influence appears to be one of many contributing factors in cutting. This emphasizes the notion that a lack of healthy twinship can lead to an overwhelming desire to fill this deficit. Therefore, it is reasonable to conclude that cutting may be an attempt to enhance twinship, thus decreasing a fragmented sense of self.

Previous research suggests a connection between cutting and the idealized parent imago pole. Conterio & Lader (1998) describe the need to have a strong parental figure as a protective factor against cutting. If a strong parental other is not present in one's life, it may lead that individual to cut in search of protection and safety. The individuals may be looking for a strong idyllic presence with whom they can merge. Whitlock et al., (2006) speak of individuals seeking out guidance from other cutters. Perhaps when looking to the internet for support from other cutters they are looking to be soothed and comforted by others who can understand their pain and subsequent behaviors. When the idealized parent imago pole of the self is left unfulfilled, the individual may use cutting as a way to get this need met. It may be that the need to feel protected and safe is so great that cutting is used to emphasize that sense of desperation. Conterio & Lader (1998) describe many

of their patients cutting because of the desire to have someone protect them in a way their own parents could not. This reasoning is similar to many of the findings in the current study. Even when direct physical or sexual trauma was not present, parental deprivation was often the case. Many of the case descriptions in this study identified emotionally absent parents unable to take care of their own emotional needs, let alone the emotional needs of their child. Many parents lacked the ability to be emotionally connected to their child, and often relied on their children to be the emotional support for them.

Levenkron (2006) and Suyemoto & Macdonald (1995) believe that a breakdown in the family system can lead to cutting. The chances of cutting increase when something negative happens within the family, leaving one or both parents emotionally or physically unavailable. Such a disruption can leave an individual feeling unsafe internally. If the self becomes fragmented, cutting may occur in response. A few of the present study's participants spoke of such sudden losses in their case examples. One example detailed the events of a grandmother's death. This grandmother appeared to be the only parental figure in the client's life. Other examples spoke of mothers becoming emotionally unavailable or unaware of the emotional needs of their children after a disclosure of sexual abuse. A few cases even outlined situations where the child was not believed by the parent about the abuse. These disturbances in selfobject functions were so great they became unbearable, leading to the behavior of cutting. Such intense feelings of abandonment often contribute to cutting (Favazza, 1996; Suyemoto & Macdonald, 1995; Suyemoto, 1998). Apparently, there is a connection between the lack of a healthy idealized parent imago self-selfobject representation and the likelihood that one will engage in the behavior of cutting, as found in prior research and the present study.

Implications for Clinical Social Work

This study identifies the need for clinical social work to continue its exploration of cutting. Cutting is on the rise, particularly in adolescent populations, thus it is imperative that the field continue addressing this behavior. This study's findings outline a link between the lack of healthy fulfillment in the tripartite self and cutting. If explored further, the ideas presented may be used to better understand and treat cutting. Looking further into deficits in self-structure and linking them to a growing and potentially dangerous problem can inform the profession's understanding of the behavior. Specifically, this study explained ideas about the relationship twinship and idealized parent imago have to cutting. Clinical social workers can use these interpretations to address problems in twinship and idealized parent imago functions in their work with clients who self-injure by cutting.

While this study was small scale, thus findings are not generalizable; it can provide some groundwork in formulating the relationship cutting has with the theory of self psychology. The framework of self psychology was not used in individual work with clients who cut by any of the study's participants. Therefore, it appears to be a new area for exploration among clinicians working with individuals who cut. Application of self psychological theory can be useful and informative when looking into the behavior of cutting. Clinical social work as a field might benefit from further exploring self psychology's relationship to cutting. Utilizing this information to enhance treatment of individuals who self-injure by cutting may benefit the field, individual clinicians, and most importantly the clients seeking our services.

Implications for Future Research

As the present study addressed only two components of the theory of self psychology, more exploration surrounding the relationship between self psychology and cutting is warranted. This study outlined the importance of identifying deficits in self-structure and the role these deficits have in cutting. Further studies could expand the present work and look more deeply into the impact a lack of twinship or idealized parent imago have on individuals who cut. Given that the study sample was small, a replication of the current study could gather information from a larger sample, increasing the data available for interpretation.

Some of the information gathered in the study suggests a need to look into the pole of the grandiose self. While exploration of the grandiose self was not included in this study, some of the information gathered defined a clear devaluing of the self among individuals who cut. When clinicians were asked how they typically view the behavior, devaluation of the self was an answer shared among interviewees. This emphasizes a need for inclusion of this pole of the tripartite self in future studies. Including all three poles would allow for a more comprehensive picture of the tripartite self.

Several answers were given when clinicians were asked what areas they felt should be researched regarding cutting. The broad range of answers reinforced the notion that there is not a clear grasp of the etiology or treatment of cutting. Clearly, cutting is not looked at in a uniform manner among clinicians. While it is valuable to have many perspectives for integration into practice, it is beneficial to learn what has been successful for others. Cutting is a complicated and multifaceted behavior to understand. Continued

research may demystify cutting, enabling better prevention and intervention techniques to be developed.

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APPENDIX A

INFORMED CONSENT FORM

Dear Participant:

My name is Andrea Galeucia and I am a student at Smith College School for Social Work, working to obtain the degree of a Master of Social Work. I am conducting a research study of self-harming behaviors, specifically the behavior of cutting, where I will explore the relationship between cutting and the theory of Self Psychology. I will use a developmental model that looks at the relationship between cutting and the twinship pole and the pole of the idealized parent imago to conduct qualitative interviews with clinicians, such as yourself, to determine how you view similar links. The data obtained during the research process will be used in the final thesis report and in presentation of the thesis. The data may be used in additional publications and presentations, other than the thesis. This study is being conducted in partial fulfillment of the requirements for the Master of Social Work degree at Smith College School for Social Work.

You are asked to take part in a face to face interview, where I will ask questions that pertain to cutting and self psychology. The interviews will be allotted a time slot of 60 minutes, though this much time may not be necessary. You will be asked to provide a brief, disguised description of a case that you have worked with where the identified client engaged in the behavior of cutting. You will also be given the opportunity to provide information about how you typically view the behavior in your own practice. Sought as participants in this study are clinicians in the mental health field; i.e. clinical social workers, psychologists or mental health counselors who have at least one year of experience in working with individuals who engage in self-harm, specifically cutting. The interviews will be audio recorded on a digital recording device.

Possible risks involved with participating in the research study may include apprehension about discussing case material, as you may be concerned about breeching client confidentiality. This risk is minimal in that you will be asked to refer to your client as only "the client" and "he" or "she." Also, not every detail of the case needs to be disclosed; rather only a brief description of the case needs to be provided, while disguising all identifying demographic data.

Benefits to participation include the opportunity to contribute to growing knowledge in the field about a topic that is becoming increasingly more widespread. You will have the opportunity to reflect on your own practice and to share your own experiences in working with individuals who cut. This research may serve to increase the body of knowledge by exploring how one theoretical approach may illuminate the symptom of cutting. You may benefit from contributing to this base of knowledge, thus

allowing for future research to be conducted exploring the relationship between cutting and self psychology.

Confidentiality will be protected in a number of ways. Signed informed consent forms will be kept in a separate folder and not attached to transcriptions of the collected data to ensure that your name cannot be connected to a particular case example. The data will be digitally recorded and stored in a locked cabinet along with the consent forms and typed transcription notes. All recorded data will be self transcribed, thus not handled by others. These materials will all be kept in a locked, secured cabinet for three years as required by federal regulations. After that time, they will be destroyed or continue to be kept secured as long as they are needed. When the data are no longer needed, all data will be destroyed. The only other individual privy to the original data will be my thesis advisor. Any data replicated in the final thesis will be disguised appropriately and presented collectively. Regarding presentation of the thesis, just as in the final thesis report, any material coming directly from the data will be disguised sufficiently to ensure strict confidentiality in terms of the case examples you provide. If any direct quotes are used, in the thesis report or presentation, these statements will be carefully disguised, as your name will never be associated with a direct quotation.

Participation in this study is completely voluntary. You may refuse to answer any questions that are asked throughout the interview. Also, you may withdraw from the study during or after the interview is completed, without penalty. If you choose to withdrawal from the study, you may contact me at any time until April 1st, 2007. The final date for withdrawal of the study is April 1st, 2007. If you have any questions regarding the study or wish to withdrawal you may contact me, Andrea Galeucia, @ 413-281-7471 or through email @ agaleuci@email.smith.edu. Please retain a copy of this informed consent form for your records.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

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Signature of Participant   Date

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Signature of Researcher   Date

APPENDIX B

GUIDED INTERVIEW

<u>Demographic Questions</u>

Age:

Gender:

Race/ethnicity:

Discipline:

Degree:

Years of experience working in the mental health profession:

Years of experience working with individuals who self-harm:

<u>Qualitative Interview Questions:</u>

1. Please provide a case example that is fresh in your mind of an individual that you have worked with who engages or has engaged in self-harming behavior using the method of cutting. This can be a recent case or a case from the past that was in-depth. Only refer to your client as "the client" and "he" or "she." Only a brief description is necessary and be sure to disguise any identifying demographic data. However, please include the approximate age of onset of the cutting and if the client is no longer cutting, the approximate age the client ceased cutting.

2. Participant will be provided with a description of twinship and given an opportunity to read it over. In regards to twinship, can you talk with me about how you view this client in terms of the twinship pole? Follow up questions to provide prompts to further elicit discussion will be used such as: What are social relationships like for this client? Are there any strong relational connections for this client? What is the salience of these relationships? Are there any particular qualities this client seeks out in peers? How might the behavior of cutting be connected to the twinship pole for this case example?

3. Participant will be provided with a description of the idealized parent imago and given an opportunity to read it over. In regards to the idealized parent imago, can you talk with me about how you view this client in terms of this pole of the self? Follow up questions to provide prompts to further elicit discussion will be used such as: How has the relationship with either of this client's parents influenced this client? What is your understanding of the current status of this client's relationship with either parent? Has there ever been any quality this client admires about either parent? Was there a time when this client felt positive about either parent? How might the behavior of cutting be connected to the idealized parent imago for this case example?

4. In your daily practice in working with clients who self-injure; how do you actually understand the behavior of cutting? That is, what theories to you typically think of when working with client's who self-injure through the mechanism cutting?

5. In your opinion, are there any additional areas to explore in terms of cutting and the relationship the behavior has with the theory of self psychology? Is there any additional information you would like to add about cutting for the purposes of this study?

APPENDIX C

THE THEORY OF SELF PSYCHOLOGY

TWINSHIP POLE

The aspect of the self, contained within the tripartite self known as the twinship pole is defined by Flanagan (2002) as:

"The third pole, the pole of twinship, refers to the need to feel that there are others in the world who are similar to the self" (p. 187). Further describing that, "Too much time spent without a feeling of twinship can make people feel like they are unraveling and losing touch with themselves." And "The mature qualities that develop when the selfobject needs of the twinship pole are met are security and a sense of belonging and legitimacy" (p. 189).

Goldstein (2001) defines the selfobject need for twinship as,

"the need for a twin or alter-ego who provides the child with a sense of humanness, likeness to, and partnership with others" (p. 81). Furthermore the importance of twinship is described as, "The sudden loss of these early twinship relationships or other types of related trauma may leave the self needful of intense twinship experiences with others in order to feel alive, connected and affirmed" (p. 82).

APPENDIX D

THE THEORY OF SELF PSYCHOLOGY

IDEALIZED PARENT IMAGO

The pole of the self known as the idealized parent imago within the tripartite self is defined by Flanagan (2002) as:

"the need to have someone strong and calm to idealize and merge with in order to feel safe and complete within the self." And "the pole of the idealized parent imago needs to see strength and wonder outside of the self, in others, in order to merge with their growth enhancing qualities" (p. 185). "The pole of the parent imago is "pulled by ideals." "By merging with the calmness and competence of the selfobject, those qualities can be established within the self" (p. 186).

Goldstein (2001) describes the archaic parental imago as:

"a need to look to their parents as idealizable people who make them feel secure and soothed in relationship to parental perfection and power. In the course of life, non-traumatic experiences with the inevitable human imperfections and minor failures of these once all-powerful caretakers result in their gradual deidealization, which is necessary for optimal self-development" (p. 82). Furthermore, "The absence of idealizable parents, traumatic deidealization experiences, or loss may result in weakness in the self or narcissistic vulnerability" (p.82).

APPENDIX E

HUMAN SUBJECTS REVIEW COMMITTEE: LETTER OF APPROVAL

January 27, 2007

Andrea Galeucia
P.O. Box 2004
Pittsfield, MA 01201

Dear Andrea,

Your revised materials have been reviewed and everything is now in order. We are, therefore, happy to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Roger Miller, Research Advisor